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The Reorganization of Health Care in Alberta: Change in an Organizational Field

By

Patricia Allison Reay 

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of Doctor of Philosophy

in

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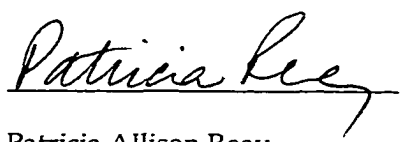

Patricia Allison Reay
15612 - 75 Ave.
Edmonton AB
T5R 2Z3

Date: December 23, 1999

University of Alberta

Faculty of Graduate Studies and Research

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled The Reorganization of Health Care in Alberta: Change in an Organizational Field submitted by Patricia Allison Reay in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Organizational Analysis.

C.R. Hinings, Supervisor

Karen Golden-Biddle

Doh Philippon

Royston Greenwood

Ann Langley, External Examiner

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Abstract

This research builds upon theory about organizational fields to develop new theoretical frameworks that help to increase our understanding of change in tightly connected communities of organizations. Through the analysis of longitudinal data related to a health care restructuring initiative in a Canadian province, I develop theoretical models that help to explain how changes occurred over time in this organizational field. In particular, I focus on the importance of considering both structural changes and the development of associated cognitive changes in key field level actors. As well, I propose a theoretical framework that links field actors' sense of identity, level of power within the field, and way of interacting with each other to help understand how change or stability occurs at the organizational field level. In the final part of this research, I draw on these theoretical frameworks to provide recommendations for policy makers to plan for and implement change in an organizational field. I suggest that by thinking of their task as one of managing an organizational field, policy makers can incorporate theoretical knowledge about the process of change that will help to improve their ability to achieve sustainable change.

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Introduction

Organizational fields are "communities of organizations that interact frequently and fatefully with each other" (Scott, 1994:207-208) and are made up of "suppliers, resource and product consumers, regulatory agencies, and other organizations that produce similar services or products" (DiMaggio & Powell, 1983: 63-64). The importance of these fields in understanding organizational issues is continually growing in a world of increasingly connected organizations. By thinking of organizations as they exist within a larger organizational context where activities must recognize and be coordinated with others, we can move organizational studies to a level that better reflects actual experience. So far, research involving the concept of an organizational field is at its infancy and is based on only a few theoretical articles (DiMaggio, 1983; DiMaggio & Powell, 1983; Scott, 1994; 1995) and a limited number of empirical studies.

The concept of organizational fields is theoretically situated within an institutional approach where strong isomorphic forces lead organizations to adopt similar forms and where taken-for-granted assumptions tend to perpetuate the status quo. The focus of institutional theory has been strongly biased toward stability, but recent theorizing has begun to point out the potential for addressing radical as well as convergent change within an institutional approach (Greenwood & Hinings, 1996). Similarly, other studies within institutional theory (Brint & Karabel, 1991; Oliver, 1991) have attempted to incorporate some of the attention to change within "old institutionalism" (e.g. Selznick, 1949) into the newer, more isomorphically focused institutional literature. It is within this newer approach to institutional theory that this research based on organizational field theory is situated. It attempts to incorporate more attention to change.

What research has been done on organizational fields has suffered from the same criticism as institutional theory in general, that it fails to adequately address issues of change (e.g. Powell, 1991). Most research into organizational fields has focussed on the processes by which fields become established over time. This type of research highlights institutional forces of isomorphism and mimicry in explaining how activity converges within an organizational field, and actors within the field become more closely connected over time (e.g. DiMaggio & Powell, 1983; DiMaggio, 1991). Thus, the concept of a field has been one where strong forces hold the field together in an increasingly steady state that is very difficult to disrupt. Such a conceptualization leaves little room for change to occur, and therefore leaves many questions unanswered. For example, is it possible for a field to decompose? That is, could the reverse process to the establishment of a field occur, and how can organizational field theory explain such a possibility? As well, could a field recompose, or change into a new form? What is needed is additional theory about organizational fields that builds upon established ideas to incorporate the possibility of change away from the entrenched steady state. The development of such theory is an overall goal of this thesis.

Organizational field theory has identified the importance of connections between key actors in a field (Scott, 1994; 1995) but has yet to incorporate an understanding of the way in which these connections affect the field. Particularly in developing ways to understand change processes within a field, I propose that studying the connections themselves provides a new approach to organizational field research that holds great promise in beginning to develop theory about how change occurs. By focusing on a lower level of analysis than previous studies have done -- the level of actor interactions -- I suggest that we can begin to incorporate concepts related to politics, interest and action

that have so far been missing from field level analyses. Such an approach begins to address calls for injecting some important aspects of the "old" institutionalism of Selznick (1949) into our current studies (Greenwood & Hinings, 1996; Hirsch & Lounsbury, 1997). As well, it begins to permit an understanding of change in organizational fields that incorporates ideas of powerful actors (Clegg, 1989; Fligstein, 1990). Therefore, by moving to focus my analysis on connections between field level actors in understanding how change occurs, I begin to incorporate ideas of interest, action and politics to provide a richer theoretical explanation for field level change.

In general, there has so far been insufficient research into *how* change occurs in organizational fields. In order to begin to address this, it is first important to recognize that change occurs in fields over a relatively long period of time. Therefore, in order to study such a change process it is necessary to gather longitudinal data that captures events over time as well as the surrounding contexts (Pettigrew, 1995). Any sort of snap-shot data simply cannot provide sufficient insight into how long term change processes occur. Therefore, in order to study organizational field change, it is critical to gather and analyze rich data over a sufficiently lengthy period of time to begin to understand changes as they occurred. I believe that it is only through qualitative research methods that it is possible to understand not only events that occurred throughout a change initiative, but also the surrounding context for those changes.

The case study that I have chosen to investigate is a government-led change initiative to restructure the health care system in Alberta, Canada. The Alberta health care system provides an excellent example of a mature, tightly-connected organizational field where suppliers (hospitals and health care providers), consumers (patients and prospective patients), and regulatory agencies (government and professional associations) interact

closely with each other to ensure that health care services are available for all citizens. As part of overall government redesign and cost-cutting initiatives, health care was restructured to a regionalized system controlled by Regional Health Authorities. Legislation to implement this restructuring was introduced in 1994 and implemented in 1995, but in order to understand the change process it was necessary to gather data back to 1988 and forward to the present time (1999). Since health care is publicly provided in Alberta, and since a growing tradition has been for almost all actors to publish large amounts of publicly available material, it was possible to accumulate a large data set of archival information that provided not only a written record of chronological events, but also contextual information particularly in terms of opinions expressed by actors involved in the change process. For part of my thesis research, I was also able to gather interview data from key informants who provided more contextual information concerning one particular change initiative. It was the ability to gather rich information concerning this change initiative, plus the characteristics of the Alberta health care system illustrating an organizational field that led me to develop theoretical ideas about change in fields through the analysis of this case study.

Previous research approaches to change in the public sector and more specifically to health care reform have focused either on decision-making within a public policy setting or on economics based analyses. The study of policy led change initiatives within a political science approach is grounded in work by Lindblom (1959; 1979) concerning the way in which decisions are made when opposing stakeholders of varying strength become part of the process (Pal, 1997). Some research continues this tradition by focusing on the decision-making processes of competing groups in health system changes (e.g. Mechanic, 1991; Tuohy, 1988). A more recently prevalent approach to the study of health reform has

been one based on economics (e.g. Angus, Auer, Cloutier & Albert, 1995; Bolmqvist & Brown, 1994; Sutherland & Fulton, 1994) where understanding the health system and mechanisms for change are based on free market principles. Lindblom (1977) suggested that neither a strictly political nor economics based approach held the ability to capture concepts important to public sector change, and he proposed the integration of economics into a political science approach. I propose that understanding health system changes can best be done by moving to a broader perspective than Lindblom suggested. By taking an organizational view, and more particularly, by considering the Alberta health care system as an organizational field, I believe that concepts related to public sector decision-making as well as economic views can be considered within an overall organizational model. By situating this research project within the organizational field literature, I propose that our understanding of public sector change can be enhanced beyond previous approaches.

Each of the three papers contained in this thesis deal with issues of change in an organizational field. The first paper develops an overall theoretical framework of field level change to increase our understanding of how both structural and cognitive changes are required in order to achieve a return to stability, or a state of dynamic equilibrium. In the second paper, I delve more deeply into the issue of cognitive change in key actors by attempting to understand issues that encourage or prevent such cognitive change. By focusing on the interactions between key actors, I develop a theoretical framework that shows a relationship between actor identity, perceived level of power, and the way in which actors interact, as important factors contributing to field level change or stability. And finally in the third paper, I draw upon the theoretical frameworks developed in each of the first two papers to provide recommendations for policy makers attempting to plan for and implement change in an organizational field. I propose that by thinking of their

task as managing an organizational field, policy makers can incorporate a theoretical understanding of the process of change in fields that will serve to improve their ability to achieve sustainable change. In the following paragraphs I provide a short summary of each of the three thesis papers, and elaborate upon the connections between them.

Paper 1: *The Recomposition of an Organizational Field: Health Care in Alberta*

This paper uses archival data to trace the changes over time (1988 to 1999) in the Alberta health care system. I build upon established organizational field theory (DiMaggio, 1991; DiMaggio & Powell, 1983; Scott, 1994; 1995) to develop a theoretical framework allowing for change in a field from one form to another. Previous theory has focused on institutional processes that help to explain stability rather than change (Greenwood & Hinings, 1996), and where field level forces tend to result in continually tightening connections between actors and a growing sense of common purpose (DiMaggio, 1983; DiMaggio, 1991). By examining the Alberta reforms from both a structural and cognitive change perspective, the importance of both becomes evident. Although the government was able to implement structural changes relatively quickly and easily, the necessary cognitive changes in key actors were much slower and much more difficult. Cognitive changes in different actors appeared to occur at different rates, and for physicians, there is very little evidence of cognitive change supporting restructuring. It appears that unrest in the system has resulted from this lack of cognitive change for physicians. As well, there appears little likelihood of the system returning to stability until the contradiction can be resolved between physicians' view of the system as one centered on the physician-patient relationship, and the government's view of a customer-driven system through RHA board members' identification of need.

Paper 2: *Patterns of Collaboration: Interacting Frequently and Fatefully in an Organizational Field*

In this paper I investigate more deeply the idea of cognitive change in field level actors as developed in paper 1. In order to do this, I expand upon previous ideas concerning the importance of interactions between key actors in an organizational field (Scott, 1994) and attempt to understand how these relationships affect the field as a whole. Since the relationship between physicians and the provincial government emerged as a critical issue in my analysis of the overall change process in paper, I chose to investigate in more detail this relationship in paper 2.The data set for this study comes from a particular set of interactions between Alberta physicians and the provincial government over time -- discussions regarding Fee-for-Comprehensive Care (FCC) from 1995 to 1999. FCC was initially proposed by the Alberta Medical Association as an alternative method of payment for physicians. If implemented, it could have created significant changes for the health care system, since physicians would receive financial incentives for keeping patients healthy and providing the minimum number of treatments. As well, FCC allowed physicians to hire other health practitioners to provide services, which would also have resulted in system-wide changes. Although both physicians and the government have shown their support for such an initiative, and discussions concerning FCC have been ongoing for four years, even pilot projects have yet to be implemented.

Through the analysis of archival data concerning FCC (news releases, government documents, newspaper articles, etc.) and interview data gathered from people who had direct involvement with FCC, I develop a theoretical framework regarding field level interactions and their role in effecting change or maintaining stability. This framework incorporates field level actors' sense of identity and perceived level of power within the

system to assist in explaining how cognitive changes do or do not occur. As well, I investigate the nature of the interactions between key actors and how this may affect field level change.

Paper 3: *Public Policy Change Initiatives: Managing an Organizational Field*

This paper applies the theoretical frameworks developed in papers 1 and 2 to provide recommendations to policy makers based on lessons learned from the Alberta health reform experiences. That is, I identify and expand upon implications for public policy makers arising from my previous two studies. Building on ideas of Baum and Dutton (1996) and Oliver (1996) indicating the need to consider the embedded nature of strategy within a particular context, I apply theory about change in organizational fields to the public policy setting. In particular, I focus on the current economic focus of public policy and provide ideas concerning the role of field level interactions in implementing sustainable change initiatives. I suggest that the task of public policy makers is essentially one of managing an organizational field, and by thinking of their role in this way, they can improve their ability to create effective policies.

Taken as a whole, this thesis has significance in two broad areas. First, these investigations may help to increase understanding of organizational fields as part of overall organizational theory. Although the study of organizational fields is becoming increasingly popular in the organization studies literature, our knowledge remains limited. The level of inter-organizational activities in both the public and private sector is steadily growing, and there is a need for more organizational research into how communities of organizations work together. There has been little research so far into understanding change processes in

these types of settings, and this thesis begins to fill that gap. In particular, research into the actions of field level actors has been missing. By focusing on interactions between these actors, I bring forward ideas about change in organizational fields that is based on an active version of institutional theory where interest and politics are important components. This part of the research helps to address calls for more attention to action within institutional theory (DiMaggio, 1988; Greenwood & Hinings, 1996; Hirsch & Lounsbury, 1997).

As well, this research helps to improve our understanding of the organization of health care, and the importance of full participation from all health care sectors in achieving overall goals of health reform. The health care system relies upon the joint efforts of many different providers, and changes to the way in which the system is organized have dramatic effects on the overall provision of care. By incorporating knowledge about how the delivery of health care is organized and the importance of interactions between key actors in the health system, health reform initiatives can be improved. All too often, the results of theoretical research do not reach appropriate practitioners in a useful format (Vaughn & Buss, 1998). By attempting to translate the theoretical conclusions made in my first two papers, to more practical recommendations in my third paper, this research is designed to begin to fill that void. The translation of theoretical research may thus be useful to future change initiatives in Alberta or in other jurisdictions.

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Chapter 1

Paper 1

The Recomposition of an Organizational Field: Health Care in Alberta

As organizations increasingly exchange information with each other, form strategic alliances or compete with one another, the arena in which they carry out these activities becomes more and more important. One way of describing this level where organizations interact is the concept of an organizational field which is built upon the more conventional idea of "industrial sector," or a population of organizations operating in the same domain as indicated by the similarity of their services or products. However, a field includes not only the firms typically considered to exist within an industrial sector, but also incorporates different organizations that interact with them in a significant way. As well, the field concept places specific emphasis on the connections between organizations and on forces that tend to hold the field together. Organizational theorists have only recently begun to recognize the value in studying organizational fields and the theory-building process so far remains incomplete.

Most approaches to the study of organizational fields have focussed on mimetic processes that result in the establishment of the field, and on institutional forces that are seen to bring convergence of activities and appearances among organizations within the field (e.g. DiMaggio & Powell, 1983; Powell, 1991). The endpoint of theoretical work so far has been the steady-state, mature organizational field which has stronger forces holding it together and encouraging its members to behave in a similar fashion, than any forces

which tend to disrupt the field. What is missing, is the possibility of change away from the steady-state, including the possibility of decomposition and recomposition of the organizational field. If fields change, how are they likely to change? If there are external shocks forcing a field to change, is it likely to recompose in a similar or a totally new form, and how might such processes occur?

Powell (1991) addressed the issue of recomposition of an organizational field, but to date the challenge has remained unanswered. He stated:

> When the structure of fields changes in such a profound fashion, established organizations scurry to protect their interests and to reestablish rules and practices that favour the status quo. But boundary changes also bring upstarts to the fore and create the possibility for a redefinition of rules and assumptions that favour newcomers or challengers at the expense of incumbents.
>
> ... The key question is how much can institutions alter their practices and reshape their environment in response to exogenous shocks or internal stress? Explicit attention to sources of heterogeneity and change should enable us to learn just how pliable and adaptive institutions are. (1991: 200)

In this paper, I attempt to develop a theoretical framework to allow for and explain the process whereby an organizational field may change from one form to another, but I restrict my focus to organizational fields that are tightly interconnected, where resources are highly centralized and where the boundaries of the field tend to clearly distinguish its components from outside influences, that is, a mature field. Initially I examine the development of the organizational field concept in the literature, particularly focussing on issues relating to inertia and change in a field. Then, I adapt theories pertaining to change at the organizational level by Oliver (1992), and Greenwood and Hinings (1996) to form a conceptual basis for analyzing change in an organizational field. To explore these ideas, I

describe and analyze the Alberta health care system which experienced a radical structural change when government legislation transformed it from one where more than 200 hospital boards, public health boards and other health organizations delivered health care, to one where 17 Regional Health Authorities (RHAs) together with separate provincial authorities for mental health and cancer treatment, control the delivery of health care services throughout the province.

Organizational Fields

There is a growing literature on organizational fields in which the dominant theoretical positions have been developed by DiMaggio and Powell (1983) and Scott (1994). DiMaggio and Powell (1983) first used the term "organizational field" defining it as follows:

> By an organizational field we mean those organizations that, in the aggregate, constitute a recognized area of institutional life: key suppliers, resource and product consumers, regulatory agencies, and other organizations that produce similar services or products. (1983: 63-64)

This definition suggests a relatively concrete concept of a field. Identifiable actors constitute a field, and by identifying those relevant actors, it should also be possible to identify an organizational field. The field as portrayed is a collection of organizations with overlapping interests that could theoretically be listed and counted. This structural basis of an organizational field is clearly confirmed by DiMaggio (1983) in his application of the field concept to public policy, when he stated:

> By organizational field, I refer to sets of organizations that together accomplish some task in which a researcher is interested. In the economic context, a field is similar to what economists call an industry, although not necessarily restricted in membership to direct producers. (1983:148)

But he also recognized more cognitive aspects of a field when he further elaborated on its characteristics:

> I use "field" in the dual sense in which Bourdieu (1975) uses "champ," to signify both common purpose and an arena of strategy and conflict. (1983: 149)

By commenting upon the way in which field members interact, DiMaggio indicated that the concept of a field is not only related to the organizations within it, but also the relationships formed between them. Scott (1994) takes a more directly cognitive approach to the concept of a field, and moves between a completely theoretical construct and a more concrete mediating entity that is a community of organizations. He postulated that an organizational field is both a "level of analysis" and an intermediate system between organizations and society and he defined an organizational field in the following terms:

> The notion of field connotes the existence of a community of organizations that partakes of a common meaning system and whose participants interact more frequently and fatefully with one another than with actors outside of the field. (1994: 207-208)

Empirical studies based on these definitions of an organizational field have further developed the concept through the analysis of specific fields and the process by which they were established. Meyer, Scott, Strang and Creighton (1988) studied the public education system and found evidence over time of increasingly tight connections between schools and school districts, creating what we would now call a mature organizational field. DiMaggio (1991) analyzed the process by which organizational fields develop when he traced the structuration, or the establishing process of the U.S. art museums field, and similarly, Powell (forthcoming) traced and analyzed the development of a biotechnology

field. It is this idea of structuration based on Giddens (1984) and applied to the field concept by DiMaggio (1983; 1991), DiMaggio and Powell (1983), and Scott (1995) that is critical to understanding an organizational field. DiMaggio (1983) explained his choice of the word "structuration" to signify "a process that must be enacted continually in the course of interactions among organizations in a field," (1983:159-160) rather than the simpler term "structuring" which for him implied an event that occurred only once. The ongoing process of field structuration, observed and analyzed by DiMaggio (1991) and Powell (forthcoming), describes an aging process that leads to a mature organizational field where strong isomorphic forces maintain stability and prevent significant change.

Some studies of organizational fields have looked at changes in an established field over time, and have focussed on the role of individual actors in relation to observed changes. Leblebici, Salancik, Copay and King (1991) examined changes in the radio broadcasting industry, centring on the role played by actors from the field's periphery, who engaged in unorthodox practices that gradually became accepted and thus changed the field as a whole. Galaskeiwicz (1991) found that change in the field resulted from the actions of interorganizational field leaders who acted as change agents by consciously introducing new systems of social control. Brint and Karabel (1991) drew attention to the role of powerful actors within a field and their ability to slow down or constrain change in an organizational field, and Fligstein (1997) proposed that institutional entrepreneurs may be able to influence and potentially control a change process within a field. By focussing on the role of particular actors within a field, the above studies tend to emphasize the structural basis of an organizational field.

Other studies of change in an organizational field suggested that change results from factors beyond the influence of individual actors. For example, Thornton (1995) identified management practices and organizational structures in the college publishing industry as the conduit for the importation of new ideologies that changed the field as a whole. Davis, Diekmann and Tinsley (1994) argued that the de-institutionalization of the multi-divisional form in what they termed an organizational field -- the Fortune 500, occurred through both voluntary and involuntary processes at political, economic and cognitive levels. Reuf, Mendel and Scott (1998) found that changing institutional logics, actors and governance regimes were associated with changing eras observed in the San Francisco Bay area health care field, and in related studies, Scott, Mendel and Pollack (forthcoming) identified change in the organizational field as a result of alterations in institutional logics and regulatory mechanisms. And finally, in research into changing attitudes about environmental practices, Hoffman (1997) proposed that the organizational field moved from one cognitive frame to another through a series of regulative and normative changes. This second group of research studies tend to focus more on the cognitive rather than structural bases of a field. But so far there has been little study of how changes at the field level occur over time, and how the structural and cognitive aspects of a field interrelate in the change process.

[Table 1.1 and Table 1.2 about here]

Although DiMaggio (1983) proposed that a field was an arena for strategy and conflict, only a few studies of organizational fields have focussed on the perspective of power for their analysis. In much earlier research, Warren (1967) proposed that interorganizational fields were in a continual state of partial conflict, where it was normally

in the best interests of all organizations concerned to "satisfice" in order to get along with each other. Clegg (1989) based his reference to organizational fields on the theoretical work of DiMaggio and Powell and Scott, but believed that the underlying power relationships between field members had received insufficient attention. He stated that "fields exist only to the extent that they are an achievement of episodic power in the institutional field, stabilizing relations of power between organization agencies." (1989: 225). Similarly, Fiigstein (1990, 1991) stated that organizational fields are set up to benefit their most powerful members, and that these powerful organizations greatly influence the field as a whole. The need to examine power relations within organizational fields was raised by DiMaggio and Powell (1991) but so far there has been little integration of the work done in relation to power differentials with the stream of analysis focussing on institutional forces. Recently, Oakes, Townley and Cooper (1998) analyzed change in an organizational field and found that language and power were controlling aspects of the change process. Scott, et al. (forthcoming) have begun to address power issues within an institutional framework, and more consideration of these issues is likely to bring greater understanding to the concept of the organizational field. In this paper, I focus on the institutional theoretical base, but will attempt to integrate some of the concepts developed from issues of power.

[Table 1.3 about here]

To this point, there are theoretical explanations regarding the way in which organizational fields become established and undergo minor alterations (DiMaggio &Powell, 1983; DiMaggio, 1991; Leblebici, et al., 1991), but each of these discussions leads to the concept of a mature organizational field as a steady state with strong forces

preventing significant change. In order to better understand the concept of an organizational field, a theoretical basis regarding forces that might break an established organizational field out of that steady state is required. As well, a theoretical explanation regarding the predicted future of the field after those forces impact would also be useful, but so far there has been little work published in this area. Thornton (1995) described the decomposition of the organizational field of college publishing, Lounsbury, Hirsch and Klinkerman (1998) investigated the effects of deregulating commercial U.S. banks, and Scott et al. (forthcoming) found evidence of de-structuration with some indication of recomposition in the Bay area health field. But further theory based work and more examples are needed to explain the decomposition of a field in a more general way, and to explain how decomposition may be followed by recomposition in a changed form. If it is possible for a mature field to change, then there must have been a process of movement from the "old" field to the "new" field, and that process requires further consideration.

There are several points in the organizational field literature where discussion centres around a process of change in the field, but does not address the possible demise of a field nor its recomposition. I have identified five such points and explain them below.

First, it seems logical that by looking back at comments made by DiMaggio and Powell (1983) regarding the construction of an organizational field, we may be able to gain insight into the reverse process. DiMaggio and Powell suggest that structuration is the process over time leading to homogenization of an organizational field (1983: 148). They define structuration as the build-up of a field by increasing interaction of key actors and the development of interorganizational structures resulting in an interconnected group of organizations. They do not mention the possibility of a de-structuration process, but

they do suggest that a field has a life cycle, and by implication we can assume that they leave open the possibility of change into another form, or perhaps even death for an organizational field. In most studies of organizational fields to date, we are led to believe that the steady state phenomenon is likely to persist forever, but this is not consistent with the concept of a life cycle.

Second, DiMaggio and Powell (1983) state that the structure of a field cannot be determined *a priori*, and that fields only exist to the extent that they are institutionally defined (1983: 148). DiMaggio and Powell discuss only the process of building an organizational field, or structuration, and they propose that the process can be recognized by the following four components:

1. increasing interaction among members of the field;
2. the emergence of interorganizational structures;
3. increasing levels of information being transmitted between organizations;
4. the recognition of member organizations that they are connected to each other through their involvement in a common enterprise.

If these four factors serve to define a field as it is being established, it is logical to assume that changes in these factors will alter that definition and may lead to the recomposition of a field. The recognition by field members of the nature of the common enterprise in which they are mutually involved is an important step in establishing the cognitive links holding a field together, and therefore changes in the interpretation of the common enterprise are likely to result in changes to the organizational field itself. An example of this kind of change is apparent in Leblebici et al. (1991) where change in the radio broadcasting field appeared to stem from newcomers or fringe players who became recognized by other

organizations as being part of the same field. Once their connection was identified and their success recognized, their actions were copied by other organizations, changing the nature of the field.

A third gap in the literature is shown when DiMaggio (1991) advanced the idea that fields are not simply investigators' aggregative constructs, but are meaningful to participants (1991: 267-268). He proposed that members of the field see value in interacting with one another, and that the meaning they give to the organizational field is important to its existence. Therefore, if the composition of the participants and/ or how they relate to one another changed, then the result may be a change in the field itself. The idea that fields are defined by the meaning given to them by their participants is consistent with a cognitive view (Scott, 1995), and suggests that the forces holding the field together are based on deeply ingrained, taken-for-granted assumptions held by actors within the field. Change is likely to occur only rarely, but theory must be developed to explain how such change may take place.

Fourth, in building a theoretical base, DiMaggio (1991) proposed that fields are defined by intentional, directive and conflict-laden processes that are a part of structuration (1991: 268). He proposed that these forces which are directly related to varying levels of power held by organizations are important to taken-for-granted, non-conflictual evolutionary forces in determining the field's destiny. DiMaggio and Powell (1983) proposed a similar view of organizational fields when they stated that fields are defined by the nature of the interorganizational structures of domination and patterns of coalition. These concepts are consistent with Fligstein's (1991) view that purposeful processes are likely to be controlled by the most powerful actors within the field.

Therefore, powerful actors may indirectly control the field by cooperating with other organizations only when it is in their best interests to do so, and consequently, when they choose to exercise their power in a different way, or if they somehow lose their power and are replaced by other actors, we would expect to see a changing field. More thorough theoretical explanations for change as a result of organizational power differentials are needed.

And finally, Scott, et al. (forthcoming) expand on the concept of institutions within a field, and suggest that formal rule systems holding a field together can be altered by newer, ascending actors as their presence increases in significance. These rule systems can also be influenced by forces external to the field, such as changing societal values and beliefs. Governance structures are not normally imposed on a field externally, but instead, they are codified in social structures and intertwined with a field's power structures and operating logic. Such rules are highly institutionalized and are therefore extremely resistant to change, however external forces, or a change in the power held by actors within the field may result in a change of rules. When the rules under which a field operates are changed, then the field itself will also likely change into a new form. By way of analogy, if all the rules of the game are changed, then it really is a new game.

I have identified five different points in the literature where existing organizational field theory allows for the possibility that established fields can change into new fields (recompose) or perhaps disappear. But so far there has been insufficient discussion regarding decomposition or recomposition of a field, and in order to explain these possibilities, it may be helpful to apply theories that have been developed regarding change at the organization level. Thus, a starting point for theory about change in organizational

fields may be knowledge about the change process in individual organizations, and by building on research at the organizational level, it may be possible to develop testable theories that can be modified with further knowledge.

Although fields are composed of organizations, developed theory suggests that it is the forces causing these organizations to interact "more frequently and fatefully" (Scott, 1994) with one another that are the most important part of the organizational field concept. Thus, organizations within a field are bound together by their proximity, intertwining relationships, and similar values and beliefs. Even though small disruptions to the field may occur from time to time, feedback mechanisms tend to maintain the steady state. That is, processes exist that serve to hold the field together, and these processes are stronger than any forces tending to pull the field apart. Therefore, it is logical to base theoretical development of the field concept on established theories relating to processes rather than organizations themselves. This leads to an examination of work done by Oliver (1992) who pointed out that institutionalized organizational activities or practices sometimes disappear, phase out, or suddenly change, which is contrary to predictions of institutional theory, that once institutionalized, activities or practices are likely to become ingrained and resilient within an organization. Oliver showed the importance of studying organizations in which particular practices or activities were deinstitutionalized and she identified potential antecedents of deinstitutionalization. In an earlier article (Oliver, 1991), she discussed the possibility and probability that organizations would resist institutional pressures to conform, and theorized that organizational change in institutional settings depends upon characteristics of organizations themselves and the environment

they face. She has provided theoretical explanations for change that do not necessarily lead toward a steady-state equilibrium.

Greenwood and Hinings (1996) also examined organizational change within an institutional context. They proposed that an understanding of intraorganizational dynamics is necessary in order to understand radical organizational change, which they described as an organization breaking out of a mold defined by an interpretive scheme (1996: 1025-1026). Greenwood and Hinings also suggested that these intraorganizational dynamics, which are grounded in the values and beliefs held in particular organizations, tend to be the glue holding organizational fields together. Institutional theorists have generally been more interested in stability rather than change (e.g. Meyer & Rowan, 1977), and even the "old" institutionalists who were concerned with change as a result of influence, coalitions and competing values (e.g. Selznick, 1949) focussed on slow, evolutionary types of change processes. Greenwood and Hinings (1996) proposed that institutional theory may be an excellent basis for understanding radical change because it provides a clear distinction between radical and convergent change, and it signals contextual dynamics necessary for radical change to occur. They developed a framework to explain organizational change based on a division of precipitating and enabling factors that first make conditions for change likely (precipitating) and then allow and encourage change to actually occur (enabling).

It may be helpful to apply the concepts described above to the study of change in an organizational field. If we could identify both an "old" and "new" version of an organizational field, it may be possible to trace the path (and therefore the process) that the field has followed during the change. As part of the same process, it may be useful to

apply the work done by Oliver in determining likely antecedents of deinstitutionalization at the organizational level, and look for characteristics necessary for change at the organizational field level.

In summary, the existing organizational field literature lacks a theoretical basis for how an organizational field may radically change and why. There is a need for new theory that allows for change, and includes discussion of the decomposition of an established field followed by either its recomposition in a new form, or its disappearance. In the next section I apply the work done by Oliver (1992) in determining likely antecedents of deinstitutionalization at the organizational level, as well as theories of change developed by Greenwood and Hinings (1996) to develop a theoretical framework that helps to explain conditions under which we might expect radical change in an organizational field, and a process map to better understand the resulting pathway of change in the recomposition of the field.

Development of a Theoretical Framework

I propose that by applying theory developed at the organizational level to the field level, it may be possible to gain a better understanding of field level change, but suggest that this must be considered as only a first step for two reasons. First, there has so far been very little research done that relates to change at the field level, and most of those studies that have examined organizational field level change have done so in order to better understand change at the level of individual organizations (Greenwood & Hinings, 1996; Fligstein, 1990). There is no established base upon which to work, and thus the application of organizational level theory must be first tested more widely before it can be

considered appropriate. Second, there are characteristics of the organizational field that lead to questions about whether processes of change will be significantly different at the field level compared to the organizational level. For example, there is no key actor in an organizational field that is completely analogous to top management in an organization. I believe this to be an important point in the consideration of change because many organizational studies focus on the role of management in identifying the need for, introducing, and managing the change process. Even in organizational fields where the state plays a very significant role, it does not possess the controlling ability usually attributed to top managers, and because of this, change at the organizational field level must be more consensual than organizational change. In most organizational fields, more than one actor will hold significant levels of power, at least for some periods of time. And therefore, although one actor may be the instigator of change, other actors must cooperate for the change to be effective.

Oliver (1992) pointed out that institutionalized organizational activities or practices sometimes disappear, phase out, or suddenly change, in spite of institutional theory's prediction that once institutionalized, activities or practices are likely to become ingrained and resilient within an organization. Her focus on pressures within organizations led to a categorization of identifiable factors leading to the disappearance of institutionalized practices, or antecedents of deinstitutionalization. Oliver hypothesized that political, functional, and social pressures, moderated by entropy and inertial pressures could be examined to predict whether institutionalized organizational practices were likely to fall into disfavour or disuse. The application of these factors to the field level may be a useful starting point in predicting the conditions under which an organizational field is

likely to change, or in Greenwood and Hinings' (1996) terms, the precipitating factors of change. I have modified Oliver's classification of forces to change the focus from interorganizational pressures to those associated with environmental issues that impact upon the organizational field. Thus, where Oliver proposed that political pressures could be identified as mounting performance crises and conflicting internal interests, I propose that at the field level, the appropriate pressures to include are: threats to the established resource flows throughout the field and changing power distributions within the field, including the formation or breaking of alliances. In considering functional pressures, I propose that similar to an analysis at the organizational level, technological change may result in pressure to deinstitutionalize specific practices or to decompose the field. But while increasing goal clarity may result in pressure to deinstitutionalize at the organizational level, I suggest that structural changes in the field itself (that is, an alteration of the actors within the field) may result in pressure toward field decomposition. And finally, where Oliver proposed that critical social pressures at the organizational level include increasing social fragmentation, and decreasing historical continuity, I theorize that at the field level, it is appropriate to discuss sociocultural pressures that may result in increased tendency of the field to decompose or recompose: (1) changing cognitive views of key actors within the field; (2) the imposition of values and rules from outside the field; and (3) changing opinions of member organizations regarding their mutual acceptance that they are involved in a common enterprise. These potential predictors of the likelihood that a field will undergo decomposition or recomposition are summarized in table 1.4.

[Table 1.4 about here]

Greenwood and Hinings (1996) and Hinings and Greenwood (1988) have stressed the complex composition of all organizations and the importance of considering the "mosaic of groups structured by functional tasks and employment status" (1996: 1033) in developing theory about organizational change. This recognition of diversity within organizations, and the resulting impact on change processes translates relatively easily to a discussion of change at the field level where interactions between key actors will obviously be critical to understanding any field transformation. But where Greenwood and Hinings (1996) have clearly delineated the requisite factors for radical change into two categories--*precipitating* (composed of *interest dissatisfaction* and the *pattern of value commitments*) and *enabling* (composed of *capacity for action* and *power dependencies*), analysis at the field level appears to require consideration of a much more blurred situation. That is, because of the important cognitive links holding an organizational field together, capacity for action may be a precipitating factor in the change process as well as an enabling factor. The field exists to the extent that it is defined by its members (DiMaggio, 1991), and key actors must first believe that at least one actor holds sufficient capacity for action to manage a change process before the possibility of change will be recognized. For example, in organizational fields dominated to some degree by the state, other key actors need to believe in the state's ability to gain the cooperation of field members, or the inertial forces within the field will prevent even the beginning of a radical change process. In my study of the Alberta health care system, although the provincial government could introduce legislative reforms, it was critical that key actors accepted, or came to accept the ability of the government to enforce and maintain those changes. Similarly, the presence of interest dissatisfaction (which Greenwood and Hinings (1996) propose must

be linked with a competitive or reformative pattern of value commitments in order to result in radical change) must not only be considered as a precipitating factor, but also as an enabling factor at the organizational field level. This is because, without the equivalent of top management in a field, the process of change will easily stop if interest dissatisfaction is not sustained. I believe that the forces of stability and reluctance to change within a mature, tightly-coupled organizational field are so strong that even though a radical change process begins, field members may be able to force a return to the old ways. Therefore, the continuation of interest dissatisfaction, and belief that the changed state of the field will result in some degree of improvement is critical to radical change at the organizational field level. In the Alberta health care system, it is apparent how the repeated government message of the province's fiscal inability to continue with the former system was an essential factor in maintaining the change initiative.

Fligstein (1990) is one of the few organizational theorists who has addressed the possibility that organizational fields may change radically and recompose in a new state. Although he also stated that stability is usually found in organizational fields, he proposed that organizations from outside the field may upset the status quo and create new rules for the field, resulting in radical changes. He proposed that innovative behaviour will more likely be found in newly emerging organizational fields rather than mature fields, and goes on to suggest that in order to find radical change in an established field, some event equivalent to a macroeconomic or political shock will be needed to destabilize the power structure. "In such a situation, actors in leading organizations within a field can respond to internal or external crises by changing their behaviour and thereby altering the rules" (Fligstein, 1990: 7). In my current study of health care in Alberta, I observe that the stable

field received a significant shock when the government announced that not only was the total operating budget for the system being reduced by 17%, but that the structure for delivering health care services was also to be dramatically changed (Alberta Government News Release, 1994a).

Change in organizational fields is continual, but most of the time it is very slow and perceptible only after long periods of time. However, although radical change occurs only rarely in tightly-coupled, highly centralized organizational fields with a high degree of normative embeddedness and relatively impermeable boundaries, I propose that when it occurs, it is likely to occur at a revolutionary pace, because the strong forces promoting stability prevent the occurrence of gradual but significant adjustments over time that allow a field to adapt to changing circumstances. This rare, radical, revolutionary change process must obviously be considered a major event for the organizational field and all its actors, and thus it is logical that the catalyst for change must be of significant stature to be recognized and accepted by all field actors. Fields of this nature (tightly coupled, etc.) are most likely to occur in the public sector, consistent with arguments put forward by DiMaggio and Powell (1983). Because of the state's level of power, control over resources, and centralized location with the field, it is one of the most likely actors to successfully orchestrate a radical change process.

As part of my conceptual framework, I propose that it is critical to consider both the structural and cognitive components of the organizational field. It is the structural component that is within the power of the state to change through governance mechanisms, and therefore, I propose that radical, revolutionary change within tightly-coupled, highly centralized organizational fields will occur separately in the component

over which the state holds the most control -- the structure. In the Alberta health care system, the structural change of the field was announced and between then and the actual implementation of the structural change, other key actors had time to assess whether or not the government was serious and had the power and initiative to proceed. Once it was recognized that structural changes would in fact be implemented, the more informal cognitive links and relationships between key actors began to be re-established, moving toward completion of the recomposition process. I believe that structural change could occur at almost any time during this process, but the important concept is that it will occur at a specific and identifiable time, while the cognitive changes of the field will occur much more slowly, will be much more difficult to identify, and will be equally critical to establishing a recomposed form for the field. If new actors enter the field, or if previously powerful actors are downgraded in the new structure, the way in which connections between actors are established, either to incorporate the new actors or work around them, and to exclude the demoted actors or to informally continue to include them, will be critical to the recomposition process. Such political changes to the field may arise through structural changes, but supporting cognitive change in other actors will be important to the overall effect. Similar to the process outlined by Hinings and Greenwood (1988) regarding organizational archetypes, I propose that the structural and cognitive components of organizational fields may be de-coupled temporarily during a change process but must reunite to sustain the change. Thus, if an imposed structural change at the organizational field level is not matched by the appropriate cognitive changes the field may persist in this relatively unstable state. Alternatively, the new structural arrangement of the field may not be sustainable, and the resulting situation will be analogous to a failed

excursion organizational track. Without the supporting cognitive changes, I propose that the organizational field will not recompose to a new form of stability. That is, the state may be able to impose structural changes, but will be unsuccessful in returning the field to stability if the strong cognitive links holding a field together fail to change in a manner supporting the structural change.

[Figure 1.1 about here]

Figure 1.1 gives a schematic impression of my proposed framework for the recomposition of a tightly coupled, highly centralized organizational field. The process must transpire over a period of time, but the actual structural change will occur at some point recognizable and meaningful to key actors in the field. In the Alberta health care system, regionalization has created a historical marker dividing discussion about the health care world into pre-regionalization and post-regionalization. Before, during, or after the structural change, there must be a period of time during which the cognitive links between key actors in the organizational field are re-established to support the structural changes, and the recomposition of the field can be considered complete. Without alteration of the cognitive components of the field, I suggest that change will not be sustained.

Also shown in Figure 1.1, are the forces and conditions that I propose are critical to the recomposition process. Before the process can be initiated, there must be at least some, if not all of the pressures derived from Oliver's (1992) research, present internally or externally to the field. That is, the functional, political or social situation must be ripe for change, and organizational field members must believe, or must be convinced, that change is inevitable. Although this readiness for change is critical to the process, and is likely sufficient to accomplish the structural change phase, the field will only recompose

when a combination of factors occur and are sustained over time to prevent the very strong tendencies of the field to return to its previous state. These factors allowing the required cognitive changes to transpire include sustained commitment to change by those powerful actors responsible for accomplishing the structural change, and the grudging, if not whole-hearted, cooperation of key actors within the field. Such changes can be observed through close examination of how key actors relate to each other over time, and whether their views of the field are compatible with each other. While I propose that precipitating and enabling factors (Greenwood & Hinings, 1996) are important in understanding the process of field recomposition, it appears that there is no clear distinction between which factors are precipitating and those which are enabling. Instead, a more appropriate division at the field level seems to be the division between structural and cognitive changes, both of which are critical to the recomposition process, but are facilitated by different elements inside and outside the organizational field. It is these elements that I have begun to identify, and suggest that further research with different fields will help to clarify this part of the change process.

In the next stage of this article, I examine in detail the recomposition of one organizational field, the Alberta health care system, and analyze the factors that I believe were critical to the change process. This case study may serve as a starting point toward a better understanding of how tightly-coupled, highly centralized organizational fields change and possibly recompose.

The Alberta Health Care Example

The health care system in Alberta, Canada serves as an excellent example of a tightly-coupled, highly centralized, mature organizational field with a high degree of normative embeddedness. Following DiMaggio and Powell's (1983) definition, the field is structurally composed of the following key actors: *key suppliers* (hospitals, physicians and other health professionals, pharmaceutical companies, medical suppliers, etc.), *resource and product consumers* (patients and prospective patients), *regulatory agencies* (provincial government, medical association), and *other organizations that produce similar services or products* (alternative medicine providers, social service providers, etc.). This group of organizations interact both formally and informally with each other to provide health care services throughout the province. The provincial government is responsible for funding all medically necessary health care services, and thus all providers interact with the provincial government on financial issues. As well, the government is responsible for ensuring that high quality services are available when required, and relies upon professional associations for ongoing review and evaluation of overall standards. More informally, key actors in the field deal with each other in the course of providing health care services. In some cases, actors see patients sequentially and rely upon other practitioners to provide specific portions of treatment plans. For example, physicians send patients for laboratory or x-ray examinations in order to make diagnoses. Physicians develop ongoing relationships with technicians providing such services. In other cases, physicians team up with other professionals to deliver treatments (e.g. surgery). Physicians also interact with other health professionals, hospital administrators, pharmaceutical companies and possibly social service agencies in the course of their activities. Interactions such as these provide tight links between actors within the field.

The cognitive basis of the field relates to the common meaning system held by field level actors. Based on the definition of a field as "a community of organizations that interact more frequently and fatefully with one another than with actors outside the field" (Scott, 1994: 207-208), this sense of "community" is an important characteristic in describing a field. Actors in the Alberta health care field, as in other health care settings, are highly professionalized, with long training periods for most health care workers leading to similar ways of thinking and a high degree of normative embeddedness. The common goal of providing appropriate and adequate health services for patients in need is recognized by all actors in the field, and is a key component of the field's common meaning system. All actors have developed an understanding of how they contribute to overall field level goals, and they have also developed expectations concerning the appropriate contribution of other actors. In the Alberta example, there is evidence of variation over time in actors' cognitive view of the field which plays an important role in understanding field level change. This variation is explained in greater detail throughout the case analysis.

Therefore the Alberta health care system is an interesting example of an organizational field where the government plays a centralizing role, and all other actors interact closely. Information flows freely throughout this field on many different levels, resulting in tight-coupling. For example, physicians have many opportunities to share information with each other through professional journals, conferences and hospital staff meetings. They also interact with most other health care professionals in hospitals, clinics or other health care sites. Similarly, other health care professionals receive information from professional associations and interactions with each other. The government also

plays a role in maintaining tight connections throughout the field by distributing information throughout the system in order to keep all field members abreast of current or proposed public policies. Thus it is apparent that the health care system in Alberta is an example of a mature field that is tightly connected, and according to established theory, most likely to continue in a stable state where change will happen only very slowly, perhaps imperceptibly.

This relatively stable state is a good characterization of the Alberta health care field until 1994. Up to that time, health care organizations provided services in much the same way since completely publicly funded health care (Medicare) was introduced in the 1960s. Hospitals and qualified health care providers supplied services they deemed appropriate for all citizens, and then were reimbursed for their services by the provincial government according to negotiated fee structures (in the case of physicians and other professionals) and with fixed annual totals on expenditures (for hospitals and long term care facilities). The system changed little in spite of initiatives throughout the late 1980s and early 1990s calling for rationalization of services, employing new health care delivery strategies, and finding ways to reduce overall public expenditures on health care (e.g. Premier's Commission on Health, 1989; Alberta Health document, 1992). But in 1994, a newly elected provincial government implemented legislation to replace more than 200 hospital boards, public health boards and nursing home agencies with nineteen health authorities[1] that were given authority over all health providers (except physicians) within

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The nineteen health authorities are composed of seventeen geographic divisions, plus two separate authorities with provincial responsibility for delivering cancer and mental health services respectively.

their geographic region. Although changes were announced approximately one year in advance of their implementation, the actual structural change occurred virtually overnight, as hospitals and other health facilities lost their legal identity and all their assets, and government appointed board members took over the responsibility of managing health care resources for their RHA.

Thus there is evidence in this case of a mature field that is tightly-coupled, highly centralized, with a high degree of normative embeddedness, that moved out of its stable form. The structural changes experienced were radical and occurred at a revolutionary pace (Greenwood & Hinings, 1996), and through the analysis of this change process, we may be able to better understand mature organizational fields and the process by which such a field may recompose.

Data Sources and Research Design

I have undertaken this research within a framework of stakeholder analysis (Burgoyne, 1994) in order to highlight the different key actors involved in the Alberta health care change process. This research follows established qualitative methods for the analysis of documents (Forster, 1994) utilizing a rich source of insight into health reform from different perspectives. It is also consistent with a qualitative case study approach (Hamel, 1993) that attempts to generate theoretical knowledge from the in-depth study of a particular case. In order to understand change in an organizational field, I analyzed the structural and cognitive change processes in the Alberta health care field by examining publicly available documents relating to health care and the reform process from 1989 to 1998. The data set includes three categories of written materials -- documents and news

releases prepared by field level actors; transcribed recordings of debate on health care in the Alberta Legislative Assembly; and local newspaper articles concerning health care reform. Each type of data provided important information. First, the large quantity of documents and news releases over the time period, shows the prevalence of written, publicly accessible communications in the Alberta health care field, and these documents provide enduring texts and historical insight into the change process (Hodder, 1996). In addition, these documents are records of a prime method of communication between key actors in the health care field, since almost all actors publish information about ongoing events that is directed not only to members of their own group, but also to others in the field. For example, the Alberta government publishes annual reports, yearly business plans and budget documents, as well as issuing frequent news releases pertaining to policy initiatives. The written record of these documentary communications captures important information about how actors respond to each other. The second category of data is transcribed recordings of legislative debate concerning various health care issues. Both the amount and intensity of debate over health care concerns indicate the importance given to these issues at the provincial government level, and provide valuable context for understanding the government's approach to health care reform. Newspaper articles are the third category of written materials included in this data set, and they provide a more objective, reporter based view of events. Also, these articles include quotations and reactions from individuals speaking on behalf of key actors at the field level, which provides valuable information in attempting to recognize cognitive changes. A list of all data sources examined is shown in Table 1.5, as well as the approximate number of pages for each type of material, adding to a total of 2,890 pages of text reviewed.

[Table 1.5 about here]

I analyzed the content of all written materials in order to identify and categorize events and patterns of events that occurred during this time period, keeping separate the categories outlined above. First I collected and categorized all documents according to the role of the actor. That is, I separated government documents from physician generated materials, as well as from other key actors. Each group of documents was sorted chronologically, and then reviewed for evidence of both structural and cognitive field level changes. Similarly, both the transcriptions of legislative debate and newspaper articles were sorted chronologically, reviewed for information concerning structural and cognitive changes, and compared with the documentary data. The categorization of these events in chronological order are shown in Table 1.6.

[Table 1.6 about here]

In particular, I analyzed the written materials for opinions expressed from each key actor's perspective that helped to explain their view of the health care system. Through this analysis of the data, I used the case study to advance the theoretical framework about change in tightly coupled, mature organizational fields, as well as to understand changes in the Alberta health care field.

Changes in the Alberta Health Care System

[Figure 1.2 and Figure 1.3 about here]

Structural changes as result of regionalization are relatively easy to identify in the Alberta health care system. Figures 1.2 and 1.3 give a visual representation of the field's structure both pre-regionalization (before the creation of the RHAs) and post-

regionalization. The most obvious change is in the overall configuration of the field, where pre-regionalization (see Figure 1.2) the field can be conceptualized as a "hub and spoke" arrangement with all publicly funded health care organizations dealing directly with the central provincial government. Each organization negotiated their financial arrangement separately with the government -- most requested specific funding on an annual basis and received a specified amount with which to provide services as promised, and some (e.g. physicians) agreed upon a fee schedule for reimbursement on a fee-for-service basis. The provincial government also required that organizations adhere to legislated standards, and enforced the provisions of more than thirty different legislative acts containing controls over various aspects of the health care system.

Post-regionalization, the general structure of the organizational field changed. (See Figure 1.3) The new entrants to the field, the RHA boards, were composed of community members selected from a group of applicants by the Minister of Health. RHA board members receive no salary, but are reimbursed for expenses according to established government standards, and these boards became the interface between the government and health care providers in all cases except that of physicians, altering the previous relationships substantially. Hospitals, nursing homes, public health and other organizations were forced by legislation to disband their boards of directors and turn over control to their appointed RHA.[2] These RHAs became decision-makers, determining which health care organizations received contracts for providing health care services in their geographic

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Voluntary hospital boards, usually religious organizations, negotiated agreements to maintain their boards of directors but operate under contract with their RHA.

area. For example, contracts for physiotherapy services funded by the provincial plan were awarded to only a few clinics in each region. Other physiotherapists who had formerly been able to treat patients and then bill Alberta Health were forced to find clients willing to pay privately (or access private insurance) for services received (Alberta Government News Release, 1995a). Similarly, several RHAs decided to award contracts to specific ophthalmology clinics for all publicly funded cataract surgery. The fact that almost one-half of appointed RHA board members had prior business experience, while less than one-quarter had previous experience in health care (Alberta Government News Release, 1994b) indicates the government's focus on business principles for reform, and may have paved the way for such contracting procedures to occur.

While the structural changes are quite clearly identifiable, I propose that in accordance with the framework developed in this paper (Figure 1.1), cognitive changes by field level actors were necessary both prior to, and after, the actual implementation of the structural changes. That is, key actors had to alter their well-established ideas, values and beliefs about the health care system (Ranson, Hinings & Greenwood, 1980) that were interwoven with long standing structures in the field. And consistent with DiMaggio and Powell's (1983) theory of field structuration, field level actors had to respond to a new government view of the enterprise (health care system) in which they were mutually involved. In the case of Alberta health care, the government increasingly developed its view of the health system as one that should be based on business principles, where consumer demand as determined through community priorities formed the cornerstone of the delivery system. As well, the government view was based on a vision of health care providers working together to maintain a healthy population within clearly established

fiscal constraints (Alberta Health, 1994). Other field level actors responded first to discussions of this view, and later to more concrete restructuring plans. A longitudinal examination of government and other key actors' view of the health care system is presented in Table 1.6, together with statements made and actions taken during the time period. From the analysis of government documents, newspaper articles and other written accounts pertaining to regionalization, I have identified key events and turning points throughout the change process that indicate cognitive changes by field level actors that first allow the structural changes to occur, and later either provide support for the new structural form of the organizational field, or for one actor group in particular (physicians) show the lack of a supporting cognitive change.

The proposed new regionalized system was announced on March 31, 1994, the first RHA members appointed June 9, 1994, and the actual transfer of authority on March 31, 1995 (Alberta Government News Release, 1994; 1995a). I have identified four stages associated with the above events, and point out that although the government altered the structure of the field through legislative change, the critical points separating one cognitive stage from another are not always legislative events.

1. **Relative Stability**
   (until the introduction of RHA Act, March 1994)

2. **Resisting Change**
   (from RHA Act introduction to appointment of first RHA board members -- March 1994 to June 1994)

3. **Acquiescence or Acceptance of Change by Other Key Actors**
   (from appointment of RHA board members to conclusion of fee negotiations between physicians and provincial government -- June 1994 to December 1995)

[This stage includes the structural changes occurring March 31, 1995.]

4. **Attempting to Work Out the Details – Uneasy Truce**
   (from physician fee agreement -- December 1995 to present)

Previous theoretical work on change in organizational fields did not lead me to expect that cognitive changes would occur in identifiable stages, but through my analysis, the importance of turning points emerged. In the following section I outline the stages of cognitive change for organizational field actors as I perceive them to be, indicating the rationale for choosing each period as well as examples of cognitive changes, or lack of changes, that I believe were important components of the change process.

Stage I: Relative Stability -- until March 1994

At the beginning of the time period studied, the Alberta health care field was relatively stable, and had been since the introduction of Medicare in the late 1960s. As indicated in Table 1.6, cognitive views of the health care system were relatively consistent for all key actors. Government statements indicate that the provincial health system was designed to provide health care services for those in need, and that government would respond to a need for services as identified by providers -- especially physicians. Physicians' view of the health system was consistent with that of the government. Physicians should determine appropriate care for their patients, other health professionals should assist in providing that care, and the government's responsibility was to provide the necessary funding. Health professionals other than physicians (e.g. physiotherapists and nurses) focussed their view of the system more on meeting the needs of their patients, but

expressed opinions about the system that were consistent with an overall approach of physicians determining need, and government providing funding as required. The power relationships between actors appears to be steady at this point, since physician and other health professional journals provide little evidence of dissatisfaction with the system as a whole, and government documents indicate a comfortable relationship with other field level actors.

But toward the end of Stage I, the government view of the health system began to change (see Table 1.6). Where government had previously been content to provide resources based upon physician-determined need, by 1992, government documents began to reflect a new focus on maintaining wellness rather than treating disease. By 1993, government plans also included the concept of a health system placing "the needs of consumers above those of providers" to "ensure that the right service is provided at the right place, by the right provider, at the best price" (Alberta Health, 1993: 12). During this time period, health care providers such as nurses and physiotherapists presented views that were consistent with a focus on wellness, although not at the expense of treating disease, but did not indicate support for a consumer-driven system. Physicians, however, indicated no changes in their view of how the health system should operate. Their consistent message was the ongoing importance of treating illness and disease, although health promotion was a laudable addition, and the critical role of the physician-patient relationship in the health system as a whole. Thus, the Relative Stability Stage was one where the Alberta health system was structured in a way that matched relatively well with all key actors' views until the government began to change its view around 1992. Toward the end of this stage the government presented intentions to alter the system, but did not

appear to be taken seriously by other actors until restructuring legislation was introduced in March 1994,

In terms of the theoretical framework (figure 1.1), by the end of Stage I, the political, functional and sociocultural situation was ripe for change. There was increasing concern over the escalating cost of health care and some acceptance by key actors that significant changes to the system were inevitable. The provincial government spearheaded a number of initiatives designed to garner support for system wide changes that would increase effectiveness and reduce overall costs (Alberta Health, document, 1992), and attitudes in Alberta were consistent with those throughout the western world where growing health care costs received increasing attention (Angus, Auer, Cloutier & Albert, 1995). For example in Alberta, the president of the medical association recognized impending change in his 1989 address:

> For if we fail to adapt to these changing realities, if we attempt to retain a status quo which is 'out of sync' with the political and social realities, then we will have engineered our own downfall. (*Alberta Doctors' Digest*, Jan/ Feb 1989a)

This increasingly prevalent recognition by health care providers that the system needed changing, although there was no agreement about what those changes should be, was combined with a political climate of public concern regarding continual provincial government deficits and taxpayers' refusal to pay more.

The theoretical framework developed in this paper (figure 1.1), helps to understand this phase of relative stability in relationship to the upcoming change process. The Alberta health reform experience shows that at the field level there is evidence of political pressures in terms of a threat to the established resource flows throughout the

field, because the newly elected provincial government was dedicated to cost reductions in all sectors, including health care (Alberta Health, February 1994). As well, there is evidence of ongoing disagreement between the government and physicians (*Alberta Doctors' Digest,* 1993), that illustrates conflicting interests at the field level. In considering functional pressures, technological changes reducing the need for hospital stays, for example, may have resulted in pressure to deinstitutionalize specific practices or to decompose the field, and it appears that proposed structural changes in the field itself resulted in pressure toward field decomposition. Finally, documentary data shows that in the Alberta health care field, social pressures had a considerable impact because ideas of financial efficiency which had previously been of minor concern, began to be acknowledged by key actors within the field (*Alberta Doctors' Digest*, 1994a). Thus the observations of a situation that was ripe for change fits with this paper's theoretical model of the recomposition of an organizational field.

In this Relative Stability stage, there are increasing indications of the provincial government's intentions to revise the health care system in a way that changed the focus from illness to wellness, and from a system based on physicians determining treatment for patients to one based on consumer need. This changing government view of the health care system is evident in documents over time. As shown in Table 1.6, in 1989, the Minister of Health characterized the health care system as a group of providers whose services needed coordination in order to deliver services most appropriately (Alberta Hansard, 1989). There was no indication of shifting to a consumer based model, and instead the focus was on those delivering services such as physicians. The government delayed responding officially to the Premier's Commission on Health Care (1989) which

advocated a regionalized health care system and increased focus on wellness rather than treatment of disease and injury. A shift in the government view of the system toward one based on consumer need became increasingly apparent in 1992, with a series of government consultations (Alberta Health, document, 1992), and later in a summary of public meetings titled, *Starting Points* (Alberta Health, 1993). (See Table 1.6) These documents presented a consistent message that the health system had to change in order to maintain the provision of high quality services, keep people healthy, and remain affordable, and that this could best be accomplished by focusing on consumer needs. Although there were many meetings and discussions, the structure of the system remained virtually unchanged. For example, administrators of hospitals in close geographic proximity met regularly for a number of years to develop ways of working together to increase overall efficiency and effectiveness, but were unable to reach agreement on implementing action. Thus this stage can be characterized as one where one key actor (government) was developing a new cognitive view of the way the health system should operate, but had yet to convince other key actors of imminent action. Other actors were aware of government's changing view, but had little incentive to change their own views or actions. For physicians in particular, their view of the health care system as one where patients trust physicians to provide appropriate advice and treatment, was inconsistent with an approach based on consumer need.

Toward the end of the stability stage of this case study, there is evidence of interest dissatisfaction as illustrated by a changing power distribution of a modest but significant shift in public opinion from control over health care decision-making by physicians and other health care providers to the government itself in its role as paymaster. Consistent

with the government view of a more business-like health care system, the voice of health economists began to be heard more prominently at the government level, and this loss of authority for physicians was poorly received by Alberta's doctors. The following excerpt from the medical association newsletter is indicative of physicians' frustration:

> The health-care economist apparently convinced the paying agencies that much of what we do is unnecessary and that it probably costs too much. We better back up any of our claims in the future with a fairly heavy dose of research ... Unfortunately, they [the research projects] will cost more money out of the pot than is currently available for the payment of physicians, researchers, etc. (*Alberta Doctors' Digest*, Mar./ Apr. 1992)

By the end of this stage, power distributions began to change slightly as economic considerations began to over-rule medical advice, technology changes were driving a shift from in-patient to out-patient forms of treatment, and one key actor (government) within the field had changed its view of the common enterprise. But although other actors gave verbal approval to the need for change, they were unable to reach agreement among themselves as to appropriate reforms that should be implemented. As proposed in the theoretical framework (figure 1.1), by the end of Stage I, there is evidence of political, functional and sociocultural pressures for change, as well as increasing interest dissatisfaction. The government was changing its cognitive view of the health system, and was talking about structural changes consistent with that view. Other key actors had not yet recognized that any one actor held the capacity for action -- that is, that significant structural change could actually occur, and occur quickly.

Stage II: Resisting Change -- March 1994 to June 1994

The introduction of the Regional Health Authorities Act (March 31, 1994) can be identified as the first turning point in cognitive changes at the field level, because this legislation clearly set out the specific intentions of the provincial government to impose structural changes, and together with statements made by government members, signified a strong commitment to imminent change on the part of the government. Many key actors were taken by surprise when the RHA Act was quickly introduced, and they responded initially with criticisms of specific changes, worries about various implications, and little belief that short time lines could be met. For example, as indicated in Table 1.6, nurses, hospital administrators and municipal officials made public comments criticizing various aspects of the bill (*Healthcare Advocate*, 1994; *Lethbridge Herald*, 1994; Schuler, 1994), but did not argue against the government's underlying view of the health system.

The Regional Health Authorities Act, 1994 outlined the government's plans for changing the system to one based on geographic regional control, but designated separate, provincial control of mental health and cancer services through two separate authorities. Initial reactions to the proposed changes from other key actors included incredulity, opposition, and a general sense that either the government would never be able to enforce such changes, or that they would be distracted and lose interest along the way. For example, the Alberta Healthcare Association, representing all active treatment and long-term care hospitals in the province called for delays to the initiative and outlined labour issues that they believed would impair employers' abilities to operate within collective agreements under the new act (*Alberta Healthcare Association*, 1994). Physicians and others receiving income through the public health system were excluded by legislation from full membership status on the RHA boards (*Regional Health Authorities Act, 1994*),

and physicians demanded to be included as decision makers. The AMA president put forward these demands as part of a fee negotiating strategy.

> Physicians have to have an integral relationship with the regional boards ... absolutely. Physicians have to be included in any health reform issues. (Walker, 1994a)

In response to specific criticisms, a number of clarifying amendments were made to the proposed legislation, but physicians receiving income from the public system continued to be excluded from RHA positions. In June 1994, the act was passed, and the first RHA members were appointed (Alberta Government News Release, 1994b). This announcement appeared to trigger acceptance on the part of most key actors that they could no longer resist the proposed change. With identifiable people functioning as RHA members, and as these individuals began to put plans in place for the transfer of authority, the implementation of the new field structure appeared to become an accepted reality.

Throughout this stage, and in spite of resistance from other key actors, the government adhered to its stated program with firm dates for the actual transfer of authority, continually indicating that changes would occur on schedule even if some issues were left unresolved. In response to a request to extend the deadline for RHA board member applications, the Health Minister responded:

> ... it is certainly not my intention to extend the deadline. ... There's been a fair amount of discussion. Besides that, it has been known for some considerable time that we would be appointing regional health authorities. So I would certainly encourage people to take the time to make their interest known by May 12, which is Thursday of this week. (*Alberta Hansard*, 1994a)

Through this steadfast commitment to change, by the end of Stage II, the provincial government was successful in convincing most key actors that the government held the

capacity for action, and that they would use it to implement structural changes as promised. Government members successfully maintained and cultivated the interest dissatisfaction that allowed health reform to begin -- worry on the part of the public, that as taxpayers they could not sustain continually increasing healthcare costs. (e.g. *Alberta Hansard*, 1994b). Thus, by sustaining interest dissatisfaction and steadfastly establishing its reputation as a determined change agent, the provincial government gradually convinced other key actors to accept its capacity for action in implementing structural change.

The government continued to solidify its view of a reformed health care system based on business principles of efficiency and effectiveness, by acting in accordance with this view. The RHA Act put people who generally had more business experience than health care experience in charge of restructuring health care within their region (Alberta Health News Release, 1994). Since physicians and other health professionals earning income from the public system were excluded from holding RHA board positions, the government was able to encourage a consumer focus at the RHA level. Thus, the new actors to the field, RHAs, arrived with a view of the health care system that had been molded by the appointment process. RHA members were expected to follow the government's view of the health care system since criteria for appointment included "commitment to health restructuring"; and while a background in health care was not required, "experience and contributions in professional, management, business or community services" was listed (Alberta Health, Backgrounder, 1994). Thus, the screening process appeared to bring forward RHA board members who were familiar and comfortable with a business-like approach. Other key actors such as registered nurses and

physiotherapists held views of the system that were largely consistent with a focus on wellness and prevention of injury, and seemed to believe that reforms could result in a higher profile for their profession (AARN, 1994). Some key actors such as hospital administrators, acting at the field level through the Alberta Healthcare Association, reacted against their elimination as a field level actor, but their criticisms centered around difficulties in implementing changes. The passage of the RHA Act diminished the importance of their view, since their association ceased to exist in the restructured system. Thus the Resistance to Change Stage is characterized by the government's ongoing commitment to a business-like model of health care. Some actors, such as nurses, raised objections to particular issues, but generally held cognitive views of the system including some focus on wellness that could be adjusted to incorporate a system based on consumer need. But physicians in particular, held onto their cognitive view of health care which placed them (rather than consumers) as central to the decision-making process.

Stage III: Acquiescence and Acceptance of Change -- June 1994 to December 1995

It is during this period of time bounded by the announcement of the names of the first RHA board members (June 1994), and the acceptance of physicians to work within the new system through a formal agreement with the government (December 1995), that the actual structural changes to the field took place. This is also the stage where indications of most supporting cognitive changes are observable. The originally announced deadline of March 31, 1995, for transfer of authority from all health care facilities and other institutions to the nineteen health authorities was met in every instance. No exceptions were made, and some RHAs took over authority several months prior to the

deadline. These structural changes to the field, represented by the before and after regionalization Figures 1.2 and 1.3, were accompanied by shifts in the structural power base of the organizational field from the government itself to its appointed RHA board members. Although many of the same actors are present in the organizational field both pre-regionalization and post-regionalization, the way in which they relate to each other changed. Alberta Health formally appeared to take a role of lesser influence, but because the relationship between the government and the RHAs is not open to public scrutiny, it is unclear how much control the government exerted over the RHA board members. These new actors to the field, the RHAs, have taken the primary role of importance, essentially removing the formerly powerful hospital administrators from influential positions at the field level through the centralized management of all sites within a region. Physicians and others receiving income through the public health system continued to be excluded from full membership status on the RHA boards in spite of physicians' protests. Physicians believed that their opposition to the regionalized system was largely ignored (Arnold, 1995a; Mullen, 1994), and continued to argue vociferously against powerful RHAs where they would have no voice (*Edmonton Sun*, 1994; *Alberta Doctors' Digest*, 1995b). They entered into a multi-phase public relations campaign to establish their role in the new system, and to make clear that for physicians, patients together with their doctors should be central to the restructured system (Arnold, 1995b).

In terms of the theoretical model, in Stage III it is apparent that physicians continued to resist change, and also attempted to maintain similar connections between themselves and other key actors under the new structure as existed in the old. Their cognitive view of the health care system remained constant, as illustrated in Table 1.6. As

well, physicians began to establish the way in which they would relate to the new RHAs. Outgoing Alberta Medical Association president, Dr. Margaret Kirwan stated in her address,

> My message is, Mr. Premier, be very careful because your operation may be a success, but the patient may die. The people leading the regional health authorities will benefit by communicating, listening and involving others. Doctors want and need to be involved to keep change on track, maintaining a quality of care level with which we can all live. (Alberta Doctors' Digest, 1995a)

Reluctant acceptance of the new structure by physicians does not appear to have occurred until December 1995, when the government and the physicians agreed upon a new contract (Alberta Government News Release, 1995b), and it appeared at that time that physicians may have been settling into a position where they could maintain their own view of health care, while working within the new structure of the system.

During this stage, the government's steadfast commitment to change, and the adherence to all established deadlines began to have an effect on most health care providers. The consequences of this persistent and enduring assertion of the government's capacity for action in the field are apparent by the fall of 1995, when professional groups began to accept that system-wide changes would occur. Many hospital administrators began to search for alternative employment opportunities, since their positions did not exist in the new regionalized system where all administrative duties would be regional responsibilities. Physicians, however, continued to strongly voice their opposition to the regional boards from which they were legislatively excluded. A number of prominent physicians left the province for positions in other provinces or the U.S. (O'Neill, 1995),

but the government remained steadfast in their commitment to regionalization and overall reduced expenditures.

It is during this stage of gradual acceptance of the change process by most health care providers, that the consistent pressure and authority maintained by the government appears to be extremely significant. The strong institutional forces within the field made change difficult. Physicians wanted to maintain their role as primary leaders of the system, and were prepared to accept the regional boards, but only if they could gain a significant degree of control over them (*Alberta Doctors' Digest*, 1994b; 1994c;1995a; 1995c). After launching their very successful public relations campaign titled "Tell Us Where It Hurts," the physicians were able to show public support for their claims of a deteriorating system. Extra government funding to reduce surgical waiting lists was promised, and physicians negotiated a satisfactory fee schedule, but the regional system remained unchanged. The government's coercive power in steadfastly showing its capacity for action, and continually reminding other actors within the health care field that public dissatisfaction with overall spending was supreme, were fundamental elements in convincing key actors (other than physicians) to adapt their view of the system to conform with the government view.

Stage IV: Attempting to Work Out the Details -- Uneasy Truce -- December 1995 to present

As key actors accepted the reality of the new system, most of them gradually began to change their cognitive views of the system to correspond with the new structure of the field. This is especially apparent with physiotherapists who were at first outraged

with the need to contract with their regional authorities for the provision of services, but soon either adjusted to the new system, found clients outside the public system, or closed their doors. The president of the College of Physical Therapists of Alberta reported:

> Change has been forced upon us in every aspect of our profession from practice patterns in the private and public sectors, to contract arrangements and the Regulatory Board functions. The changes will affect, forever, our fundamental practice patterns and our sense of autonomy. I began my year as President of the College recognizing that it would be a year of transition. I believe that the Council, the Registrar and office staff have pulled together to move the College through this year of transition (with periods of chaos and change) to a point of stability. (*Alberta Physiotherapy News*, 1996)

The physicians, however, appear to be reluctantly willing to work within the new structure, but are not content. As indicated in Table 1.6, their view of the health care system continues to focus on the doctor-patient relationship as the key component. They have agreed in two separate formal agreements (1995; 1998) to continue providing medical services in a way that keeps them relatively segregated from the regionalized system. To this point in time, physicians have maintained a separate financial agreement with the provincial government, with a relatively large fee increase negotiated in April 1998 (*Agreement*, 1998), but in their roles as hospital or public health department heads, physicians have come to grudgingly accept the necessity of working with RHAs on contractual bases (Alberta Government News Release, 1996b; *Alberta Doctors' Digest*, 1995d). There is no evidence that physicians have altered their cognitive view of the system. Neither have they come to see value in the regionalized system. Although they accepted non-voting roles on RHA boards, they continue to argue for the return of individual medical staffs for each hospital, rather than the region as a whole (Report,

1996). Physicians continue to be funded directly from the province, and thus their fee negotiations remain times where they publicly display some of their ongoing concerns with the new structure. They have repeatedly raised their objections to how the health care system is managed, and have recently commissioned and then publicized the results of a comprehensive study outlining the disparity between the length of time physicians believe is reasonable for patients to wait for various surgical procedures compared to the actual waiting time experienced (Burke & Associates Inc., 1998). Obstetricians showed their disfavour with the system for a period of time, by refusing to take new patients except on an emergency basis (Pedersen, 1998). These ongoing events appear to be evidence that physicians remain committed to the same cognitive view and want to show they also hold capacity for action. In June 1999, physicians voiced their strong disagreement with government attempts to allow RHAs to control funding for physician services, pointing out that physicians must retain the authority and autonomy to look after their patients in the way they believe to be most appropriate (AMA, 1999).

In terms of the theoretical framework, it appears that key actors other than physicians have developed cognitive changes to support the continued existence of a recomposed organizational field in the Alberta health care system, but ongoing resistance from physicians leaves the field in an unstable state. Since there is no evidence that physicians are willing to change their view of the health care system to one based on business principles, where consumers drive the provision of services through RHA boards, and where lowest-cost health care providers are given priority, the stability of the Alberta health care field remains tenuous. Until a point in time where the key actors agree upon the nature of their common enterprise (DiMaggio & Powell, 1983), the recomposition of

the organizational field cannot be seen as complete. In this case study, we may be observing a process of incomplete recomposition, and might expect repeated flare-ups from physicians until a time when their cognitive view of the system is aligned with that of other key actors. Given the powerful nature of physicians in the health care system and their capacity for action, it is not clear whether stability is more likely to occur through a shift in the cognitive view of physicians, or through a shift in the view of all other actors to one compatible with that of physicians.

Conclusions

Through the use of this case study, regionalization in the Alberta Health Care system, I have developed a theoretical model that helps to explain change in mature organizational fields by emphasizing the need for both structural and cognitive changes. In this organizational field example, structural changes imposed by the provincial government required cognitive changes by other field level actors in order to support the overall change initiative. By examining the context in which the government implemented legislative changes, it appears that there is support for the theoretical framework developed here, indicating that political, functional and social pressures were present prior to the decomposition, and in this case -- at least partial recomposition, of the organizational field. The theoretical framework is also supported by the mixture of interest dissatisfaction and capacity for action (Greenwood & Hinings, 1996) found throughout the recomposition process. While it is apparent that a sufficient level of interest dissatisfaction was necessary for the government to proceed with legislative changes, other field actors took some period of time to accept that the government actually held the

capacity to make structural changes. Then, after structural changes were made to the field, ongoing cognitive changes required sustained commitment to change, maintained interest dissatisfaction and continued acceptance of the government's capacity for action. From the data analysis, it was also possible to identify variability in the rate of cognitive changes to support field level structural changes among different actors -- most notably the relatively rapid change observed in physiotherapists' acceptance of the new configuration, compared with that of physicians who have agreed to work within the system but do not support the government's and RHAs' cognitive views. It continues to be unclear how long the organizational field can remain in this state of only quasi-stability. Similar to the process proposed by DiMaggio and Powell (1983) of the structuration, or establishment of an organizational field, it is critical to the long term existence of the field that key actors maintain a mutual awareness that they are involved in a common enterprise. In this case study, one key actor (government) changed its view of the enterprise, starting a process of recomposition of the field that cannot be considered complete until all key actors again support the same concept.

This study of the Alberta health care field highlights the difficulty of successfully reforming a health care system, even when virtually all key actors agree that the system needs reform. In this case, the government was able to implement structural changes relatively easily, but the development of associated supporting cognitive changes proved to be much more difficult and time consuming. It has been helpful in understanding the change process to consider the health care system as an example of an organizational field with tightly interconnected key actors who provide health care services. By applying established theory from previous research in organizational fields and organizational

change processes, it has become apparent that both structural and cognitive changes are critical in Alberta health care and more generally in organizational fields.

In this example, change was driven by government determination to substantially reduce expenditures in all areas, including health care, but political decisions to accomplish budget reductions through restructuring of the entire health delivery system resulted in a series of events that quickly changed the field structure. The supportive changes necessary for field recomposition, and a return to stability have been a much slower process. The relationship between key actors, in particular between physicians and the government, was and continues to be critical in this change process. The government remained steadfast in its commitment to change, and I identified this as essential in convincing other actors of its capacity for action, but from the physicians' perspective, although they have reluctantly accepted to work within the structural changes, it is still not clear whether their attitudes, beliefs and values about the provision of health care services will ever change to support the new structure. Relationships between other key actors are also important to field level changes, and the introduction of a new field level actor, the RHAs, has forced all others to renegotiate their connections. Through the appointment process, the government was able to control the cognitive view of the health system held by the newly created and powerful RHAs. In the Alberta experience, this was important in facilitating cognitive change for other key actors. It is interesting that the connections, or cognitive links between key actors usually result in stability for the field as a whole, but when one key actor holds the capacity for action to impose change, it seems that those same connections can be the source of instability when structural and cognitive components are not in alignment.

Through the use of previously developed theoretical research and the Alberta health case study, I have developed a theoretical model that helps to explain change in mature organizational fields by emphasizing the need for both structural and cognitive changes. However, there are obvious limitations to theory developed through one case study. Although the Alberta health care system is an excellent example of a mature organizational field, these findings may not be generalizable beyond this particular case. Based on a review of previously published theoretical and data based analyses of other organizational fields, I believe that the framework will be applicable to mature fields in other sectors, particularly in those where governmental regulative control is significant, but further study of change initiatives in other organizational fields will be necessary to determine similarities or differences.

Stability is a critical concept in the study of organizational fields and is also an important component of any health care system, because prospective patients demand that appropriate services be readily available when, and if, they are needed. Therefore, it is crucial to the process of reform that health systems return to a state of stability as quickly as possible. This has not been the experience in Alberta, and perhaps instigators of reform in other systems can learn from this example the importance of supportive cognitive changes in a radical restructuring process. It seems from this study that the cooperation of powerful actors within a field is an important consideration in evaluating the likelihood of quickly re-establishing stability after the implementation of reform initiatives. Health system reform in an effort to reduce overall costs has been an important issue throughout the western world, and is likely to remain so. It is essential for those in positions of

authority to understand the implications of structurally led reform initiatives, in order to ensure that confidence in the system to provide quality health care continues to exist. In this study, by linking the analysis of health reform initiatives with theoretical concepts about change in organizational fields, there is potential for both theory and practice to be advanced. It is in these two connected areas that I hope this research can make a contribution.

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Table 1.1: Theory Based Studies

Author	Year	Summary of organizational field theory
DiMaggio & Powell	1983	• Provides definition that organizational fields are 'those organizations that, in the aggregate, constitute a recognized area of institutional life: key suppliers, resource and product consumers, regulatory agencies, and other organizations that produce similar services or products.' • Highly structured organizational fields provide a context in which individual efforts to deal rationally with uncertainty and constraint often lead, in the aggregate, to homogeneity in structure, culture, and output.
DiMaggio	1983	• Focus on structural basis of organizational field, particularly in public policy settings, in which 'sets of organizations together accomplish some task,' but also recognition of the field as 'an arena of strategy and conflict.'
DiMaggio	1986	• Focus on structural basis of an organizational field. • Describes the structure of one particular field -- nonprofit resident theatres -- in order to clarify what constitutes an organizational field.
Scott	1994	• The notion of field connotes the existence of a community of organizations that partakes of a common meaning system and whose participants interact more frequently and fatefully with one another than with actors outside the field.
Scott	1995	• Organizational fields intermediate between organizations and wider institutions. • The length of time an organizational field has been in existence affects the stability and coherence of its structure.

Table 1.2: Studies Examining Change In An Organizational Field

Author	Year	Summary of organizational field theory
DiMaggio	1991	• Structuration (the process by which organizational fields are established) is traced in the art museum field. • Findings indicate that the creation of this organizational field was intertwined with the efforts of museum workers to define a profession and increase their own authority. • Organizational fields must be viewed not simply as investigators' aggregative constructs, but as meaningful to participant actors. Specialized organizations constrain, regulate, organize and represent at the level of the field itself.
Brint & Karabel	1991	• The transformation of the community college organizational field from a focus on liberal arts to vocational studies included a long period of resistance to change followed by eventual goal displacement through market forces and changing managerial capacity. • Organizational fields are arenas of power relations, where actors who possess superior material and/or symbolic resources, are able to influence the field as a whole. In particular, these actors may constrain or shape the possibilities for others in the field.
Galaskeiwicz	1991	• Organizational fields are created through the establishment of programs and rule systems within the field, as illustrated in a corporate urban community. • Interorganizational field leaders can act as change agents to consciously introduce new systems of social control that change the field.
Leblebici et al.	1991	• Successive transformations of the radio broadcasting industry were initiated by actors peripheral to the established organizational field, whose unorthodox practices were recognized and adopted by more central actors, thus changing the field as a whole.
Davis et al.	1994	• By examining the deinstitutionalized multi-divisional form for Fortune 500 companies, found that change to a new form of 'boundary-less production' occurred abruptly. • Change is theorized to occur through both voluntary and involuntary processes at political, economic and cognitive levels.
Thornton	1995	• By tracing the life cycle of an organizational field (College Publishing), management practices and organizational structures are identified as conduits for importing new ideologies to the field. • When organizational fields have undergone a high degree of structuration and are tightly coupled (mature), they are highly susceptible to collective diffusion of management trends. In this case, because of the life stage of the organizational field during a time of peak merger activity, the field decomposed.

Fligstein	1997	• Strategic actors play different roles depending upon whether an organizational field is forming, stable, or being transformed. • Change in organizational fields is rare because 'challenger' actors must have an established point of view and collective identity, and must recognize that the possibility for transformation exists. • Change is most likely to happen under times of crisis, when skilled strategic actors from a challenger group can offer new cultural frames and rules to reorganize the organizational field.
Hoffman	1997	• The transition over time, from one cognitive frame to another was accomplished through regulative and normative mechanisms, resulting in a new institutional relationship or organizational field.
Reuf et al.	1998	• Changing institutional logics, actors and governance regimes are associated with three eras of the health care field in the San Francisco Bay area. • The entrance of new actors to the field (government agencies or alternative providers) may influence the organizational field as a whole.
Powell	forth-coming	• Traces the structuration of a new biotechnology organizational field, emphasizing the importance of frequent contact between key actors in establishing the field.
Scott et al.	forth-coming	• An organizational field may change as a result of changes in institutional logics and regulatory mechanisms. These may introduce new sources of funding or customers, or redefine the role played by some actors. • Findings show evidence of de-structuration of an organizational field, and early recomposition. Changing institutional logics and governance structures are identified as the underlying factors for organizational field transformation.

Table 1.3: Studies Based on a Power Analysis of Organizational Fields

Author	Year	Summary of organizational field theory
Clegg	1989	• Equates organizational field with Foucauldian 'field of force.' • Fields exist only to the extent that they are an achievement of episodic power in the institutional field, stabilizing relations of power between organization agencies. • Organizational fields tend not to change from their steady-state form because there is an absence of collective organization to do otherwise.
Fligstein	1990	• The organizational field is established by the mutual recognition of actors in different firms of their interdependence. The function of organizational fields is, first and foremost, to promote stability. • Organizational fields are set up to benefit their most powerful members because they formulate the rules and have the power to enforce them.
Fligstein	1991	• The role of norms in the construction of organizational fields has been over-estimated, and the relative power of actors in organizations has been under-estimated. • Organizational fields are a construction of powerful organizations that is based on the interests of those organizations.
Oakes et al.	1998	• Change in a public sector organizational field is found to occur as a result of the implementation of business plans as a pedagogical tool containing controlling language. • An organizational field changes when symbolic, cultural, political or economic capital of the field is changed.

Table 1.4: Pressures for Deinstitutionalization of an Organizational Practice and Decomposition of a Field

Type of pressure identified	Organizational level pressures identified by Oliver (1992)	Proposed field level pressures
Political	• mounting performance crises • conflicting internal interests	• threats to the established resource flows • changing power distributions within the field (including formation or breaking of alliances)
Functional	• technological change • increasing goal clarity	• technological change • structural changes in the field itself
Social	• increasing social fragmentation • decreasing historical continuity	(Socio-Cultural pressures) • changing cognitive views of key actors within the field • imposition of values and rules from outside the field • changing opinions of member organizations regarding their mutual acceptance of being involved in a common enterprise

Table 1.5: Data Sources Published 1988 to 1998

Type of Written Material Analyzed	Amount	approximate page count
MATERIAL PUBLISHED BY KEY ACTOR		
Alberta Government News Releases	140 documents	200
Alberta Government Department of Health Publications	43 publications	1075
Alberta Medical Association Publications	25 publications	200
Physician Professional Journal Articles	101 articles	250
Other Health Professional Journal Articles (Registered Nurses; Physiotherapists; Dieticians; Practical Nurses; Health Administrators; Chiropractors)	84 articles	190
TRANSCRIBED RECORDS		
Hansard Recordings of Alberta Legislature Debate	13 days of debate on legislation 141 days of question period debate	260 215
NEWSPAPER ARTICLES		
Alberta Newspaper Articles (Edmonton Journal; Calgary Herald; Edmonton Sun; Calgary Sun; Red Deer Advocate; Lethbridge Herald; and other Alberta daily or weekly newspapers)	555 articles	500
total pages		2890

Table 1.6: Timeline of Key Events

Date	Public Reports or Consultations	Legislative Events	Structural Changes	Representative statements indicating cognitive view of system	Cognitive view of health system
Stage I: Relative Stability					
1989		Department of Health Act passed into law, to combine government departments of Community and Occupational Health, and Hospitals and Medical Care.		Govt. view: The single agenda of the Minister of Health – "providing the best health services to the people of Alberta that we possibly can." (Alberta Hansard, 1989)	Govt. view: The health system should provide needed services in a coordinated way.
1989				Physician view: AMA president looks forward to "changes in the health care system so that other health care professionals will be able to contribute more, will be able to realize more satisfaction from fully applying their special skills. This will allow physicians to provide better care to patients." (Alberta Doctors Digest, 1989b)	Physicians: The health system is centred on physicians providing care, and other health professionals assisting.

(Timeline of Key Events – continued)

Date	Committee Reports	Legislative Events	Structural Changes	Statements indicating Cognitive view of system	Cognitive view of health system
1989	Premier's Commission (Rainbow Report) recommends restructuring to 9 health regions & increasing focus on health promotion, prevention of disease.			Govt. view: No official comment on report – except to "study it." Physician view: While commending the report for "spotlighting the importance of preventative medicine, individual well-being and quality of life through healthy lifestyles" the AMA "wishes, however, that the report had dealt more thoroughly with the problems of sickness, disease and poverty." (Alberta Doctors' Digest, 1990)	Physicians: The health system can address prevention of disease and health maintenance, but must keep a focus on the treatment of sickness and disease.

(Timeline of Key Events – continued)

Date	Committee Reports	Legislative Events	Structural Changes	Statements indicating Cognitive view of system	Cognitive view of health system
1989 (cont.)	Rainbow Report (cont.)			Physiotherapist: "Our major concern is that there is no objective research indicating that implementation of the recommendations will achieve the desired outcome. ... While encouraged by the increased emphasis on health promotion, we do not think that active treatment should be capped to free up funds for this." (Alberta Physiotherapy News, 1990)	Physiotherapist view: Both health promotion and treatment of injury or disease should be important to the system. Decisions regarding change to the system should be based on objective indicators, not the whims of powerful actors.

(Timeline of Key Events – continued)

Date	Committee Reports	Legislative Events	Structural Changes	Statements indicating Cognitive view of system	Cognitive view of health system
June 1992	Strategic Planning Sessions by Alberta Health			Govt. view: "Alberta's health system will strive to keep Albertans healthy and independent." "All health professionals and organizations will work together in a spirit of cooperation and collaboration ... to provide a continuum of high quality health services." (Alberta Health doc., 1992)	Govt. view: System should be based on maintaining wellness, not treating disease, and all components of system are important in accomplishing this goal.
Sept. 1992	Alberta Association of Registered Nurses: Scope of Nursing Practice Document released.			Nurses view: "The goal of nursing is to assist clients to attain and maintain optimal health." (AARN, 1992)	Nurses: Clients are the centre of the health system, with nurses assisting to maintain their health.
June 1993		Progressive Conservative Party re-elected provincially on campaign to reduce government expenditures.			

(Timeline of Key Events – continued)

Date	Committee Reports	Legislative Events	Structural Changes	Statements indicating Cognitive view of system	Cognitive view of health system
Aug. 1993	AMA document released: *Task Force on Physician Resources*			Physicians: "Central to them [prevailing attitudes of the medical profession and Alberta society] is a recognition that the profession, through its organizations such as the Alberta Medical Association, must help develop options and solutions for government." (AMA, 1993)	Physicians: The health system can be improved by the government, but only with input, advice and direction from physicians.
Nov. 1993	*Starting Points* document summarizing Roundtables on Health recommends: 1. Putting the consumer first 2. Restructuring the health system 3. Accountability 4. Paying for the health system 5. Getting on with the job			Govt.: "Our current health system has been built in a random manner with an acute lack of accountability. This structure has allowed the preservation of bureaucracy to take priority over the true needs of health consumers." (Alberta Health, 1993)	Govt.: The health system should be restructured to include accountability, and make it consumer driven.

(Timeline of Key Events – continued)

Date	Committee Reports	Legislative Events	Structural Changes	Statements indicating Cognitive view of system	Cognitive view of health system
Feb. 1994		First business plan for Alberta Health released.		Govt.: "Our current system focuses principally on an institutionally based illness model. ... The health system needs to be reorganized to focus on the health needs of Albertans. ...the future health system must be wellness-based."(Alberta Health, 1994)	Govt: Health system must centre on wellness, and operate on business principles based on consumer demand.
March 1994	Business consultants advise various hospital closures.				Govt. view: Decisions about hospital closure made on 'business model.'

(Timeline of Key Events – continued)

Date	Committee Reports	Legislative Events	Structural Changes	Statements indicating Cognitive view of system	Cognitive view of health system
March 1994		Regional Health Authorities Act introduced.		Govt.: "This Bill allows government to proceed on the necessary restructuring of the health system based upon community-based planning and a more co-ordinated and integrated health delivery system." (Alberta Hansard, 1994a)	Govt.: Community-based planning is the focus for restructuring, and the basis of such planning is the interests of the consumer.

Stage II: Resistance to Change

March 1994		Regional Health Authorities Act introduced.			
April 1994				Nurses: Government wants the ability to charge user fees, and nurses believe this is a step backward. (United Nurses official quoted in Schuler, 1994)	Nurses: The health system should be equally accessible for all people, regardless of ability to pay.

(Timeline of Key Events – continued)

Date	Committee Reports	Legislative Events	Structural Changes	Statements indicating Cognitive view of system	Cognitive view of health system
April 1994				Physicians: "Physicians have to have an integral relationship with the regional boards ... absolutely. Physicians have to be included in any health reform issues." (AMA president quoted in Walker, 1994)	Physicians: Changes to the system will be neither appropriate nor effective unless physicians are key decision makers in the process.
May 1994				Municipal council: Municipal officials are "worried that appointed bodies will have greater-than-ever powers to requisition local taxes, with no accountability except to the minister of health." (Lethbridge Herald, 1994)	Municipal councils: Little concern about the way in which health care system operates, but instead concerns about how it is funded.

(Timeline of Key Events – continued)

Date	Committee Reports	Legislative Events	Structural Changes	Statements indicating Cognitive view of system	Cognitive view of health system
May 1994				Hospital Administrators: "The Association now feels its concerns and proposals for dealing with labour policy under the proposed bill are being ignored by government." (AHA, 1994)	Hospital Admin.: Little concern over the basis of the health care system – instead concern with lack of legislative framework to deal with staffing issues.
May 1994				Physicians: "Doctors should remain the sole gatekeepers to the system." (AMA president quoted in Fisher, 1994)	Physicians: The key point of all access to the health care system should be physicians.

(Timeline of Key Events – continued)

Date	Committee Reports	Legislative Events	Structural Changes	Statements indicating Cognitive view of system	Cognitive view of health system
June 1994		Appointment of RHA board members announced.		Govt.: "The people selected to serve on the Regional Health Authorities have a great deal of experience and long records of service to the people of their communities. ... The first job of the new authorities will be to develop a three-year business plan for their regions." (Alberta Health News Release, 1994a)	Govt.: Community members serve as representatives of the consumer. They are the appropriate people to make health system decisions within a business-like approach.

Stage III: Acquiescence and Acceptance of Change

June 1994		Appointment of RHA board members announced.			

(Timeline of Key Events – continued)

Date	Committee Reports	Legislative Events	Structural Changes	Statements indicating Cognitive view of system	Cognitive view of health system
June 1994				Nurses: "Nurses recognize there is a distinct need for change to the health system.... The consumer's desire for choice, participation, and a controlling interest in the health care industry make sound sense as does the notion that care providers must be accountable to the public they serve." (AARN, 1994)	Nurses: The health system should centre on the desires of consumers.
July 1994				Physicians: "We have to have medical input. We are the major players in the provision of health care." (AMA president quoted in Edmonton Sun, 1994)	Physicians: The health care system is focussed on medical services provided by physicians.
July 1994		Health Minister announces future closure of 3 hospitals (2 in Calgary; 1 in Edmonton) based on reports from business consultants.			Govt.: The system must be based on business principles. Hospital closures must be a business decision.

(Timeline of Key Events – continued)

Date	Committee Reports	Legislative Events	Structural Changes	Statements indicating Cognitive view of system	Cognitive view of health system
Sept. 1994		RHA boards required to submit regional business plans to Health Minister.			Govt.: Planning for RHAs must take a business approach.
Sept. 1994				Nurses' view: "We endorse the direction this government is taking. It is the way these ideas are translated into practice that creates concern." (Pedersen, 1994)	Nurses: Health reform is needed to focus the system on the client, increasing home care and decreasing hospital care.
Oct. 1994		Health Minister approves initial RHA business plans.		Govt.: "These business plans have laid a solid foundation for the work that lies ahead in updating the delivery of health services." (Alberta Health News Release, 1994b.)	Govt.: The health system must be reformed by using a business like approach.
Nov. 1994		Cash infusion to RHAs even though RHAs not officially functioning. Funds earmarked for disease & injury prevention, and health promotion.			Govt.: Health promotion and prevention of disease & injury will be focus of newly structured system.

(Timeline of Key Events – continued)

Date	Committee Reports	Legislative Events	Structural Changes	Statements indicating Cognitive view of system	Cognitive view of health system
Dec. 1994				Physicians: Plans to allow professionals other than physicians to admit patients to hospital "ought to be viewed with concern and distress by patients as well as physicians." Doctors should have a "leadership role based on the body of scientific knowledge and responsibility they have." (Walker, 1994b)	Physicians: Doctors should be the leaders of the health care system. Patients rely upon doctors to provide appropriate care.
Feb. 1995		Funding for rehabilitation services transferred to RHAs.			Govt.: Health system focus on maintaining health supported through emphasis on rehabilitation.
Feb. 1995		Provincial budget sets maximums for RHA expenditure on acute care, residential care & lab service, and minimums on community service & rehabilitation.			Govt.: Health system focus must be on increasing community care & rehabilitation, and decreasing acute care. Decisions will be budget driven.

(Timeline of Key Events – continued)

Date	Committee Reports	Legislative Events	Structural Changes	Statements indicating Cognitive view of system	Cognitive view of health system
Feb. 1995		Alberta Health business plan released.		Govt.: Restates focus of 1st business plan – to "reorganize the health system to emphasize wellness-based approaches while sustaining essential treatment services under a value-for-money orientation to the health system." "...the health system will operate on a regional basis to provide treatment services and emphasize healthy behaviors to prevent, delay and reduce the effects of illness." (Alberta Health, 1995)	Govt.: Health system should focus on wellness, treat disease when essential, and provide value for money expended.
March 1995			Actual transfer of authority and assets from hospital boards, etc. to RHAs.		

(Timeline of Key Events – continued)

Date	Committee Reports	Legislative Events	Structural Changes	Statements indicating Cognitive view of system	Cognitive view of health system
May 1995				Physiotherapists: "There have been times of perceived danger but opportunity has been the major character." (Association president, Alberta Physiotherapy News, 1995)	Physiotherapists: The nature of health care is outside control of physiotherapists, but they can benefit from the increased focus on prevention & rehabilitation.
Aug. 1995				Physicians: AMA president strongly objects that regulations regarding medical staff bylaws were implemented without physician approval. "Unless they have a say, doctors could wind up being treated like employees instead of independent professionals with a recognized right to speak out for their patients." (Arnold, 1995a)	Physicians: Physicians should be key decision makers in the health care system, and their ability to speak on behalf of patients must not be compromised.

(Timeline of Key Events – continued)

Date	Committee Reports	Legislative Events	Structural Changes	Statements indicating Cognitive view of system	Cognitive view of health system
Oct. 1995				Physicians: As part of a provincial campaign to gather public support for their position, physicians began wearing label buttons saying "Patients First." Campaign message: "If anyone should have a say in the quality of your health care, it's you. And your doctor." (Arnold, 1995b)	Physicians: The health system must revolve around the doctor - patient relationship. Doctors need to be an integral part of the decision-making process.

(Timeline of Key Events – continued)

Date	Committee Reports	Legislative Events	Structural Changes	Statements indicating Cognitive view of system	Cognitive view of health system
Dec. 1995		Agreement signed between government and AMA.		Physicians: AMA president "insisted the AMA deal puts quality care first, by giving doctors more clout to protect patients, as reforms like managed care are introduced." (Pedersen, 1996) Govt.: "The first principle in the agreement recognizes that the goal of health reform is to maintain or improve quality of care while achieving targeted savings." (Government of Alberta News Release, 1995b)	Physicians: Quality care is central to the system, and doctors will act on behalf of patients to protect their interests. Govt.: Quality care is important, but it must be provided within the allotted budget.

Stage IV: Attempts to Work Out the Details (Quasi-Stability; Uneasy Truce)

Dec. 1995		Agreement signed between government and AMA.			

(Timeline of Key Events – continued)

Date	Committee Reports	Legislative Events	Structural Changes	Statements indicating Cognitive view of system	Cognitive view of health system
Jan. 1996		Additional $11.4 million transferred to RHAs to reduce waiting lists for specific procedures – "one time only."		Govt.: "This is a one-time investment in a set of programs that have been facing unusually high demands in the last few months." (Government of Alberta News Release, 1996)	Govt.: The system should be focussed on prevention, but unusual circumstances call for increased funds for active treatment. The business model approach allows for investment in certain specific areas.

(Timeline of Key Events – continued)

Date	Committee Reports	Legislative Events	Structural Changes	Statements indicating Cognitive view of system	Cognitive view of health system
June 1996			End of first term for RHA members. Some re-appointed; some resign; some new members appointed – varies greatly by regions.	Govt.: "Over 200 people have been selected from more than 600 applicants to serve on Alberta's Regional Health Authority Boards. 47 of the 233 members are newly appointed. ... Regional Health Authorities have a broad range of responsibilities to promote and protect the health of residents in their region, and to ensure they have reasonable access to health services." (Alberta Health News Release, 1996)	Govt.: The system relies upon RHA board members to focus on the needs of their residents, first through health promotion and prevention of disease, and also by ensuring treatment is available.

(Timeline of Key Events – continued)

Date	Committee Reports	Legislative Events	Structural Changes	Statements indicating Cognitive view of system	Cognitive view of health system
June 1996				Physician: "The AMA believes that Alberta's primary medical care system should be based on the following principles: -Care should be patient centred and built on sustained, caring, compassionate and trusting patient-doctor relationships." (AMA, 1996)	Physician: The patient-doctor relationship is the key component of the system to provide health care services.
March 1997		Conservative government re-elected with greater majority. Commitment to continue with established plans.			
April 1997				Nurses: "Community-based health care shouldn't mean lower standards of health care for Albertans." (Nursing Union advertisement, Edmonton Journal, 1997)	Nurses: Community based health care is appropriate strategy for the system, but nurses require better financial rewards, and more input in quality of care issues.

(Timeline of Key Events – continued)

Date	Committee Reports	Legislative Events	Structural Changes	Statements indicating Cognitive view of system	Cognitive view of health system
Sept. 1997		Negotiations regarding new contract between physicians and government begin.		Govt. position: "... our responsibility lies primarily in two key areas: getting the best results for taxpayers' dollars, but just as important, creating the right incentives so we work together to build a better health system for Albertans. ... We're confident that the result of our discussions will be a new foundation for how Alberta's physicians, the provincial government and regional health authorities work together to improve health and provide quality health services for Albertans." (Alberta Health, 1997)	Govt.: The health system should consist of all parties working together to reduce expenses and increase overall health.

(Timeline of Key Events – continued)

Date	Committee Reports	Legislative Events	Structural Changes	Statements indicating Cognitive view of system	Cognitive view of health system
Sept. 1997				AMA position: "Negotiations could be about protecting some of the most cherished principles in health care such as patient advocacy and physician autonomy, as well as physician funding." (AMA, 1997)	Physicians: Physicians are central to the delivery of quality health care and require appropriate resources to maintain their autonomy in this position.
Apr. 1998		Agreement signed between AMA and government, including large increase in total budget for physician services.	Same structural relationship between physicians and government maintained.	Govt.: This agreement "will help to ensure that all Albertans continue to have access to quality patient care and a quality publicly funded health system." (Government of Alberta News Release, 1998)	Govt.: The health system must be focussed on the needs of citizens, and this must be achieved within appropriate fiscal constraints.

(Timeline of Key Events – continued)

Date	Committee Reports	Legislative Events	Structural Changes	Statements indicating Cognitive view of system	Cognitive view of health system
Apr. 1998				Physicians: "... we not only worked for a better situation for physicians, but also for an improved health climate where all Albertans can receive accessible, timely, quality health care. We will continue to advocate for the best possible health care for our patients." (AMA, 1998)	Physicians: The health system must centre on the physician-patient relationship. Physicians must act on behalf of their patients.
June 1998	Survey of Alberta physicians commissioned by AMA found that patients waited for many urgent procedures longer than physicians deemed "reasonable."			Physicians: "But if funding levels are not sufficient to provide timely access to quality care, the system begins to fail. ... Doctors find actual waiting times for both urgent and elective services, tests, and procedures are more than three times what they believe is 'clinically responsible'." (AMA, 1998)	Physicians: Physicians are best able to determine whether health reform has resulted in a deterioration of service provision. It is up to physicians to ensure that the health care system 'puts patients first.'

(Timeline of Key Events – continued)

Date	Committee Reports	Legislative Events	Structural Changes	Statements indicating Cognitive view of system	Cognitive view of health system
June 1999				Physicians: "When it comes to health care, 'accountability' should be about more than money. ... Because we (physicians) consider ourselves accountable, first and foremost, to you, the patient." (AMA, 1999)	Physicians: The health system should be designed around the most important part – the trusting relationship between patient and physician. Physicians must hold the autonomy to act in the best interests of their patients.

Figure 1.1: Theoretical Model of the Recomposition of an Organizational Field

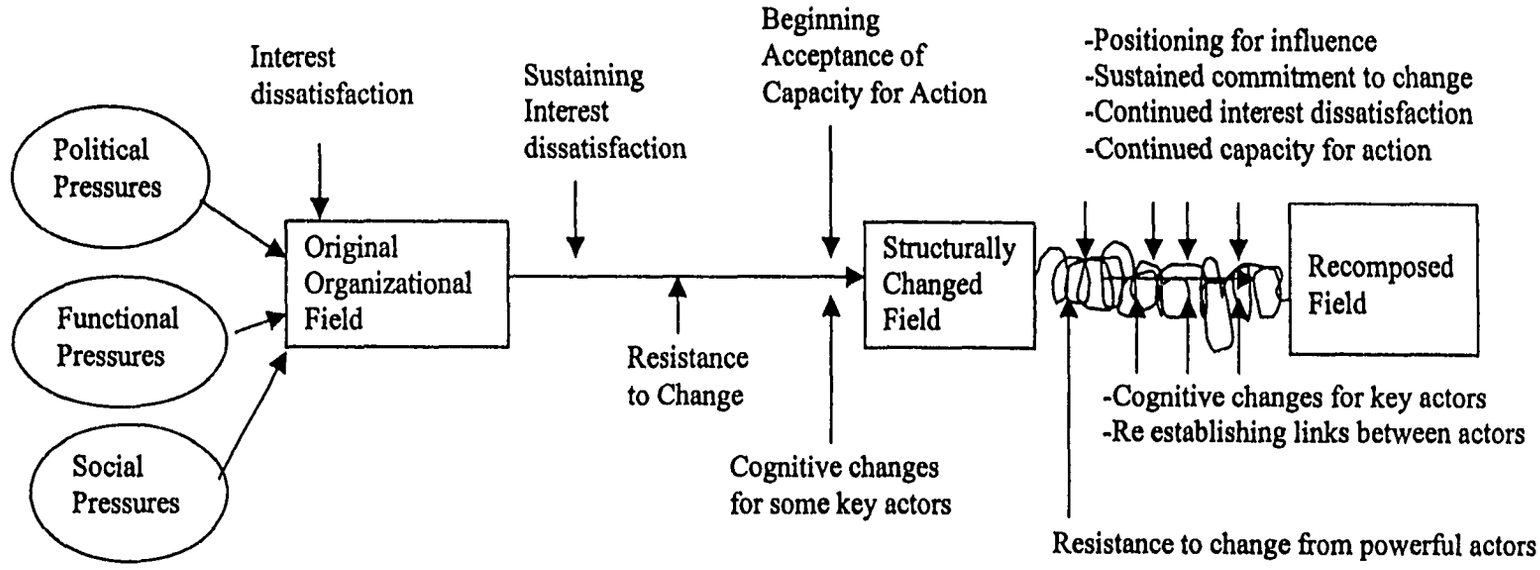


Figure 1.2: Pre-Regionalization Organizational Field

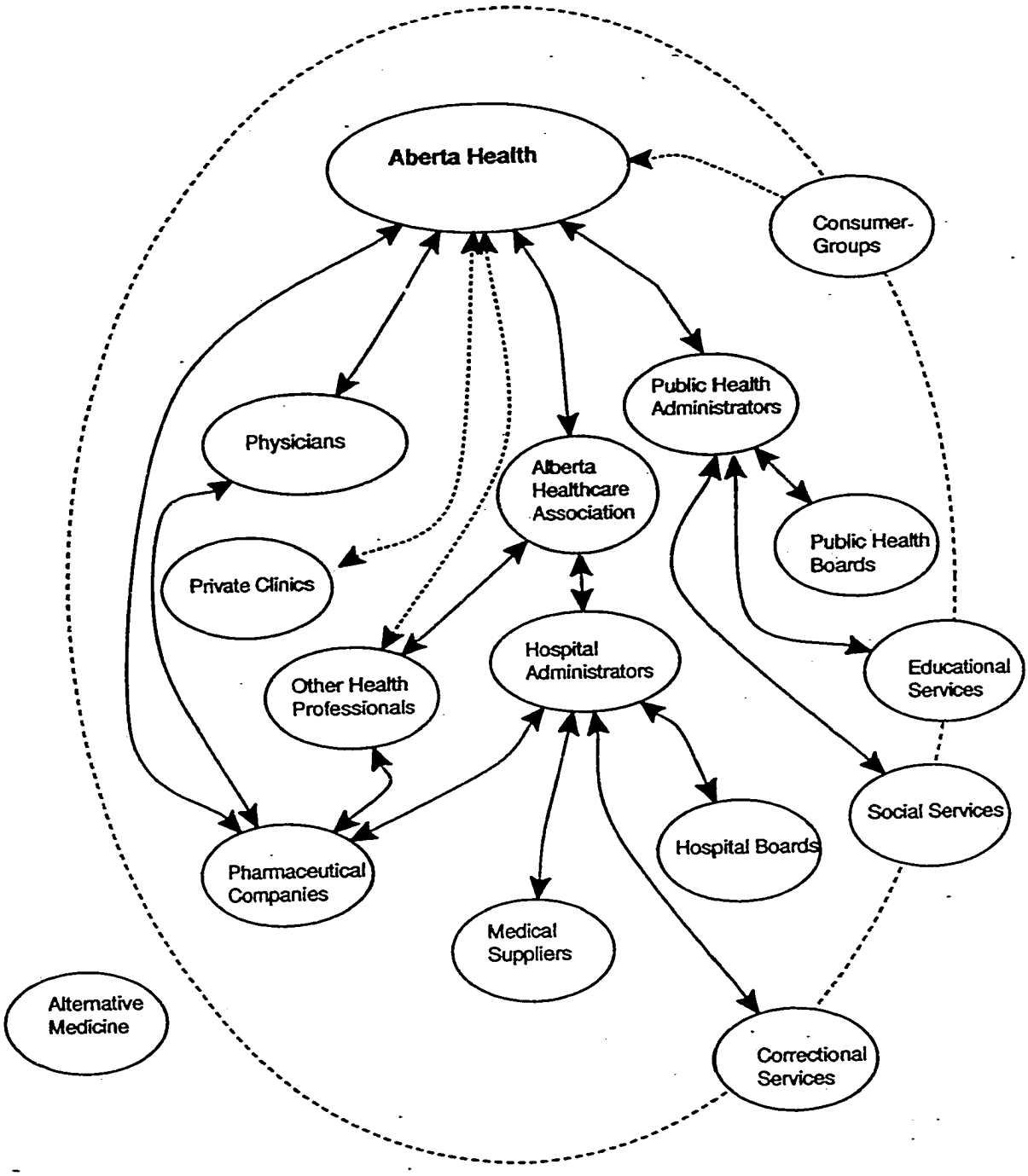
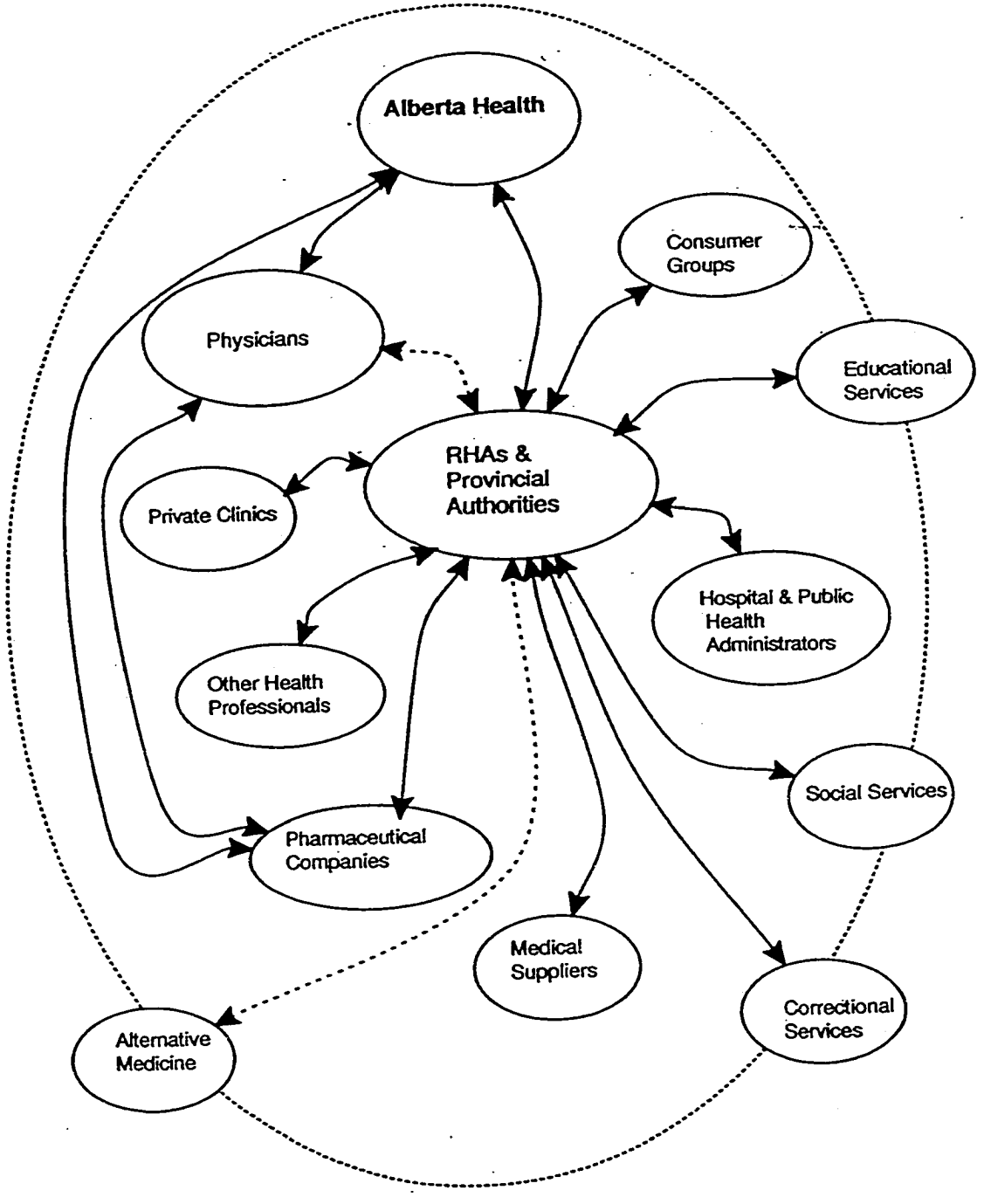


Figure 1.3: Post-Regionalization Organizational Field



Chapter 2

Paper 2

Patterns of Collaboration: Interacting Frequently and Fatefully in an Organizational Field

Organizational fields are increasingly seen as an important concept in organizational theory. The tight connections that hold a community of organizations together have been identified as a critical component of a field, particularly by theorists such as Scott (1994) who proposed that actors within a field interact "frequently and fatefully with one another" (1994: 207-208). Other researchers have also recognized the importance of the relationship between field level actors (e.g. DiMaggio & Powell, 1983; DiMaggio, 1983) but so far there has been little research into how the connections between field level actors impact on the organizational field as a whole. In this paper, I investigate the relationship between two key actors in the Alberta health care field in order to gain insight into how actors' interactions contribute to field level stability or change.

The health care system in Alberta, Canada provides an excellent example of a mature, well-established organizational field where stability is expected. However, the field underwent a major change when a restructuring process was introduced in 1994 and implemented in 1995. This restructuring altered the relationships between field level actors by introducing a new actor to the field, Regional Health Authorities (RHAs), and many related changes continue to work through the system in 1999. Most field level actors (for example, health professionals other than physicians, hospitals and nursing homes) were brought under the funding control of the new RHAs, but physicians continued to negotiate

and receive funding directly from the provincial government. However, although the funding mechanism for physicians remains the same, they must work with RHAs who control the provision of all other health services, such as surgery, x-ray and laboratory services, which are critical to physicians in diagnosing and treating their patients.

This relationship between physicians and the government is of interest because it is different from those between other key actors in this organizational field, and has been identified in paper 1 as an important factor in delaying cognitive level changes during the restructuring initiative. In this study, I focus on how physicians and the government have interacted with each other during one critical segment of their relationship, as they attempted to develop an alternative payment plan for physicians that would change the method of remuneration from fee-for-service (FFS) to one based on a capitation model. Although the new payment plan was not directly related to the health reform initiatives, the process of attempting to change the remuneration plan occurred within a newly restructured system. As shown in paper 1, the Alberta health organizational field was moving through a process of recomposition, and interactions between physicians and the provincial government concerning a new remuneration plan were surrounded by ongoing changes to the overall health system. The capitation based remuneration model had the potential to significantly change the way in which medical services were provided since the proposal called for increased use of nurses, nurse practitioners and other health professionals, and altered financial incentives for physicians to reward fewer rather than more office visits. What is particularly interesting about this Fee for Comprehensive Care (FCC) proposal, is that discussions have been ongoing for four years, all key actors

continue to see value in FCC, but implementation has yet to occur. That is, field level interactions have been occurring but the field level result thus far is the status quo.

In this paper, I use the FCC case study to expand upon established organizational field theory and develop a theoretical model that may help to better understand the relationship between interactions of key actors and stability or change at the organizational field level. Since such interactions seem to be driven by the actors themselves and are associated with active rather than passive relationships, how can this activity be consistent with the overall concept of stability for an organizational field? And, how do these interactions relate to field level change? To answer these questions, I first attempt to understand factors initiating field level interactions as well as the nature of the interactions themselves, and then consider overall effects at the field level. It is within such an overall approach that this research is situated.

I embarked upon this research project with a keen interest in the relationship between physicians and the provincial government, and the role this relationship played during a major health care restructuring initiative (paper 1). Since physicians appeared to be the strongest resistor to field level change and unlike other health professionals, had maintained a separate financial relationship with the government, I was intrigued with questions surrounding how that process had occurred over time. As well, my previous research together with significant portions of established organizational field theory pointed to the importance of interactions between key field level actors. In the FCC case, key actors with an interesting relationship interacted intensively over a relatively long period of time, providing a rare opportunity to closely examine field level interactions and

their effect on the field as a whole. Thus, armed with interest in the physician-government relationship, hunches that this set of interactions would provide interesting and useful research material, and an *a priori* theoretical framework based on previously established organizational field theory, I began this research project. I have attempted to follow that research approach in presenting my findings. Thus, this paper is set out in the following way. I first explain the *a priori* theoretical framework that I used to guide my research. I identify points in the literature where theory indicates the importance of actor relationships to the organizational field, but gives little detail in how this connection is made. In particular, I investigate concepts related to Scott's (1994) characterization of field level interactions as frequent and fateful. Then after describing my research methods, I present the FCC case study where I bring in further theoretical concepts as required to analyze and make sense of the data within an overall approach consistent with organizational field theory. That is, I build a theoretical framework incorporating concepts from organizational level theory concerning identity, power differentials, and collaboration in order to explain how key actors interact, and the effect of these interactions in relationship to stability or change at the organizational field level. And finally, I set out conclusions that include potential areas for further research.

A Priori Theoretical Framework

Although established theory concerning organizational fields recognizes the importance of connections between key actors in developing and sustaining a field (DiMaggio & Powell, 1983; Scott, 1994; 1995), to date there has been little research into

how these connections contribute to either stability or change for the field as a whole. In particular, there are three theoretical points that indicate the critical nature of the connections between key actors, but provide little assistance in understanding how field level relationships influence the organizational field.

The first point in the literature emerges through the analysis of DiMaggio's (1991) statement that fields are not simply investigators' aggregative constructs, but are meaningful to participants (1991: 267-268). He proposed that members of the field see value in interacting with one another, and that the meaning they give to the organizational field is important to its existence. Therefore, key actors relate to each other in a purposeful way. If their purpose or perceived value for interacting changes, then we should expect to see corresponding changes at the field level. The idea that fields are defined by the meaning given to them by their participants is consistent with a cognitive view of the field (Scott, 1995), and suggests that the forces holding the field together are based on deeply ingrained, taken-for-granted assumptions held by actors within the field. Both DiMaggio (1991) and Scott (1995) indicate the theoretical importance of links between actors to the field concept, but identifying and explaining how the connection between key actors' relationships and change at the field level relates to the overall concept of an organizational field has so far received little attention.

The second theoretical point where actor relationships are identified for their importance, but not examined thoroughly, arises from DiMaggio's (1991) proposition that fields are defined by intentional, directive and conflict-laden processes that are a part of structuration (1991: 268). He suggested that these forces which are directly related to

varying levels of power held by organizations, are important to taken-for-granted, non-conflictual evolutionary forces in determining the field's destiny. Scott (1995) proposed a similar view of organizational fields when he stated that they are defined by the nature of the interorganizational structures of domination and patterns of cooperation (1995: 106). These concepts are also consistent with Fligstein's (1990; 1991) view that purposeful processes are likely to be controlled by the most powerful actors within the field. Therefore, powerful actors may indirectly control the field by cooperating with other organizations only when it is in their best interests to do so, and consequently, when they choose to exercise their power in a different way, or if power differentials are altered, we would expect to see these changes reflected at the overall field level. How power differentials and conflict between actors relate to changes at the field level is an important theoretical perspective that is currently missing in the established literature.

And the third theoretical point raised concerning actor relationships, relates to explanations provided by Scott, et al. (forthcoming), who expand on the concept of institutions within a field and suggest that formal rule systems holding a field together can be altered by newer, ascending actors as their presence increases in significance. In addition to actor-induced rule changes, forces external to the field such as changing societal values and beliefs, may also influence established rule systems. Governance structures are not normally imposed on a field externally, but instead, they are codified in social structures and intertwined with a field's power structures and operating logic. Such rules are highly institutionalized and are therefore extremely resistant to change, however external forces, a change in actors, or changes in the power held by actors within a field

may result in a change of rules. When the rules are altered, the way in which actors relate to each other changes, and the field itself is likely to undergo significant change. This connection between the rule systems of an organizational field and the field itself appears to be a critical theoretical component that requires further investigation.

I have identified three points in established theory concerning organizational fields where the relationship between field level actors has been identified as a key concept, but the connection between that relationship and the field as a whole remains unclear. These three points are linked together by a common underlying concern with the role of interest and agency within an organizational field. So far, only a few institutional theorists have incorporated the concept of actors' relationships influencing the field as a whole (DiMaggio, 1988; Greenwood & Hinings, 1996; Selznick, 1949), but an increased focus on action may help to understand organizational fields. Research in the 1970s proposed that organizations were linked together in a system, but that they were equally likely to be linked through conflict as through accord (Turk, 1973). Turk's model allowed for organizational action to protect and further organizational interests, but these ideas have yet to be incorporated into our contemporary model of relationships at the organizational field level. More focus on concepts related to interest and agency, allowing the recognition and integration of ongoing political strategies may help in understanding the connection between field level interactions and field level change.

Within the literature that describes and analyzes specific organizational fields, the importance of actor relationships has also been identified, but has not been thoroughly analyzed, and the connection between relationships and field level changes has not been

addressed. For example, although several studies of organizational fields refer to the links between key actors, the focus of research has been at a different level. Thornton (1995) identifies the importance of interfirm relationships and structures within the field to the overall field concept, but her research focuses on the intermediating function of a field between organizations and society. Similarly, other research (Hoffman, 1997; Oakes, Townley & Cooper, 1998; Reuf, Mendel & Scott,. 1998; and Scott, Mendel & Pollack, forthcoming) has acknowledged the importance of actor interactions, but emphasized more broadly based factors in a change process such as changing societal cognitive frames regarding environmental issues, symbolic, cultural, political or economic capital of a public sector field, and institutional logics and regulatory regimes in the health care field. Other approaches to change in organizational fields have focused on the role played by new actors to the field (Leblebici, Salancik, Copay & King, 1991) or on recognized field leaders who take the initiative to introduce changes (Brint & Karabel, 1991; Galaskeiwicz, 1991; Fligstein, 1997).

Only a few studies begin to investigate the connection between field level change and the nature of relationships between key actors. Fligstein (1991) proposed that one of the four main factors affecting field level change was "turbulence in organizational fields whereby actors with interests based on their position in the corporation can articulate new strategies and have the power to implement them" (1991: 311). Powell (forthcoming) emphasized the importance of frequent contact between key actors in establishing a biotechnology field. As well, Kondra and Hinings (1998) focus on interactions within an organizational field as they relate to the degree of isomorphism and propensity for change.

Most recently, Hoffman (1999) has examined changes in the U.S. chemical industry, basing his analysis on an underlying theory of the organizational field as actors who are connected through their interest in a particular issue. All of this research shows that the way in which key actors relate to each other is a critical component in understanding organizational fields, and more research into these relationships and their connection to change or stability at the field level is likely to bring greater clarity and understanding to established theory about fields.

Frequent and Fateful Interactions

In order to analyze the connections between key actors and begin to understand how they impact upon the field as a whole, it is necessary to focus on the relationship between actors – an approach which has so far been missing from organizational field theory. Scott (1994) provided an interesting starting point through his concise and alliterative definition of an organizational field where interacting "frequently and fatefully" is critical to the theoretical concept. Scott stated:

> The notion of field connotes the existence of a community of organizations that partakes of a common meaning system and whose participants interact more frequently and fatefully with one another than with actors outside of the field. (1994: 207-208)

What needs to be examined is how the frequent and fateful interactions of key actors relate to the field as a whole. Scott has combined specific characteristics describing these interactions with the development of a common meaning system, but a more in-depth analysis of frequent and fateful interactions may lead to a greater understanding of the

linkage between interactions and field level change or stability. It is relatively easy to visualize actors interacting frequently, and it may be possible to evaluate the number of interactions in order to determine a measure of the frequency, but what does it mean to interact fatefully?

From the ***Oxford English Dictionary***, five meanings of fateful are possible. First is "revealing the decree of fate" or "prophetic of destiny." Applying this definition to organizational field level actors, suggests that the inherent qualities of actors may predispose certain outcomes when two or more actors come together. Second is "fraught with destiny," which provides similar implications to the first definition but adds the idea that consequences will be momentous and that they will be played out over a period of time. The third definition is "marked by the influence of fate; controlled as if by irresistible destiny," and suggests that some interactions are predictable and possibly inevitable. Fourth, the word is defined as "bringing fate or death" which implies a time when one or more actors cease to exist. And finally, the fifth definition is "having a remarkable fate; an eventful history," that suggests an important and significant consequence of the interaction.

Considering the above definitions, it is important to keep the meaning of the word in context. That is, Scott (1994) stated that actors interact both *frequently* and *fatefully*. "Fatefully" alone suggests a chance encounter that altered the course of history, but this definition is ruled out by including frequently. Thus, combining the word fatefully with frequently, eliminates random and unusual interactions, and highlights the idea that serious and significant consequences result from the interactions of field actors. This combination

leads to a focus on the first, second and fifth definitions of fateful, which, applied to the concept of actors within an organizational field, suggests that actors interact often, although not necessarily regularly, with a direct future effect on the field as a whole. The interactions of key actors may become institutionalized over time, leading to established patterns that continually increase the stability of the field. Alternatively, interactions may hold the propensity to result in future field level changes. Interactions are latent with opportunities for change, and the frequency or infrequency with which these interactions occur may act as a catalyst to trigger action. Scott's (1994) definition of an organizational field would have been much different if he had only stated that actors interact frequently. That would be a bland description, but with the addition of *fatefully*, the interactions take on meaning, importance, and potential impact on the future of the field. They cannot be classified as routine, which is more consistent with taken-for-granted explanations of institutional theory. Instead, these interactions between actors can be seen as a source of rich information that is critical to understanding how an organizational field changes or remains the same over time.

Scott (1994) emphasized the importance of frequent and fateful interactions between field level actors, but did not elaborate on how such connections affect the organizational field as a whole. Therefore, his description and explanation together with other theoretical perspectives highlighted above, leave many questions unanswered in building a theoretical model. I indicate in Figure 2.1 the theoretical building blocks I have identified from the literature, but also show that the relationship between field level interactions and change or stability remains undeveloped, and provided only a very rough

guide for my research.

[Figure 2.1 about here]

Scott's focus on connections between actors strengthens the argument for further investigating points where established theory allows for the existence of important relationships between key actors, but fails to clarify how the relationships influence the field. I suggest that an explanation for *how* connections between actors affect the field may lie in investigating the nature of the connections themselves. This is where I have built upon the dictionary meanings of "frequently and fatefully" to push the analysis toward understanding the critical characteristics of such relationships where actors who operate within established rule systems have control over their own actions, and may use their power differential in conflictual situations. As well, they believe that what they are doing has value, and that the future may hold stability or change as a result of these interactions.

Data Source and Research Methods

In order to investigate field level actors' interactions and their relationship to change or stability at the field level, I used a qualitative case study approach (Hamel, 1993; Stake, 1995) within a methodological framework of stakeholder analysis (Burgoyne, 1994) to analyze the ongoing interactions between two key actors -- physicians and Alberta Health (the government department responsible for health) -- in the Alberta health care organizational field from 1993 to 1999. I view physicians and Alberta Health as key actors in the field because in Canadian style health care, all medically necessary services are paid for by the provincial government, giving the department of

Alberta Health a key position as the single payer for health services. Physicians hold the role of gatekeeper to the system, since almost all services can only be accessed through a doctor's direction. The Alberta Medical Association (AMA) holds the authority to negotiate and act on behalf of all provincially registered physicians, and is therefore the focus of my investigation of physicians at the field level.

During the time period studied, a major restructuring of the health system was designed and implemented by the provincial government. Over two hundred hospital and other health care boards were disbanded and replaced by a regionalized system where nineteen health authorities[1] took over responsibility for all publicly provided health services within their jurisdiction (Alberta Government News Release, 1994; Philippon & Wasylyshyn, 1996). The relationship between physicians and Alberta Health during this time is of particular interest because financially it has remained relatively unchanged, but in order to access patient services such as x-ray, laboratory, surgery or other hospital care, physicians must now deal directly with the newly created health authorities. Physicians continue to negotiate with the Alberta government and are reimbursed for their services directly from the government, unlike other health professionals such as physiotherapists who, since regionalization, receive government funding only through Regional Health Authorities (RHAs) (Alberta Government News Release, 1995).

It is the way that government and physicians interacted within this overall change process that I sought to understand and in order to do so, I selected a segment of the

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1 The nineteen health authorities are composed of seventeen geographic divisions, plus two separate authorities charged with provincial responsibility for delivering cancer and mental health services, respectively.

relationship which met a number of characteristics. First I needed a defined issue on which physicians and government interacted over a lengthy period of time in order to gather rich, longitudinal data focused on a particular issue that would be suitable for meaningful qualitative analysis (Maxwell, 1996; Pettigrew, 1990). Second, the data source had to potentially provide insight into the four theoretical points identified in Figure 2.1 that guided my research. That is, I wanted to collect data on an issue that appeared to have meaning for field level actors; held the potential to show power differentials and conflict between actors; showed evidence of rule systems within the field; and provided the opportunity to investigate Scott's (1994) idea of frequent and fateful interactions at the field level.

Therefore, I chose to investigate in detail and analyze over time discussions surrounding a specific proposal initiated by the Alberta Medical Association, acting on behalf of all physicians in the province, to allow physicians the opportunity to change their method of remuneration. This proposal could have resulted in significant changes, not only to the physician - government relationship, but also to the field as a whole. The proposal provided the option for physicians to change from fee-for-service (FFS) to a new method based on capitation payment -- Fee For Comprehensive Care (FCC), and was publicly released in a written document in 1995 (Alberta Medical Association, 1995a). If implemented, physicians would shift to a payment system with financial rewards for keeping patients healthy, and would be allowed to delegate the provision of some services to allied health professionals. It could be argued that changing to a FCC system of payment would be in line with the goals of regionalization, which likely require a change in

the method of physician payment.

Thus, a case study of the FCC proposal provided a rich, longitudinal, qualitative data source surrounding one particular initiative within an overall context of province-wide health reform. It met the criteria for studying field level interactions in the following ways. First, FCC had meaning for key actors within the field. The issue of how physicians are paid is one which impacts upon the system as a whole because a closer working relationship between physicians and other health professions was likely to occur under FCC, and paying physicians for keeping patients healthy was likely to create other changes in practice patterns. Second, the case of FCC appeared to provide an opportunity to consider the role of power differentials and conflict within an organizational field. Physicians had resisted government initiated health reforms (paper 1), and had publicly criticized government on several occasions. Both government and physicians appeared to be powerful actors within the field, and any longitudinal set of data concerning their interactions seemed likely to hold information relevant to understanding field level conflict. Third, the FCC case appeared to include information that would be helpful in understanding how actors interact within the rule systems of a field. Physicians and government had established patterns of dealing with each other and with other actors in the field, and investigating physician-government interactions on the particular issue of FCC provided an opportunity to examine a defined set of interactions occurring within previously established rules of interacting. And finally, the FCC case study provided a rich source of data on the nature of physician-government interactions. Since it was possible to gather both archival and interview data concerning the course of FCC discussions from

their beginning and as they proceeded over a four year period of time, this case seemed likely to provide valuable information to better understand interactions between key actors at the field level.

The FCC initiative received ongoing discussion from 1994 until the present (1999) by both the Alberta Medical Association and Alberta Health. While the obvious thrust of FCC was to change the financial relationship between physicians and the government, it also attempted to establish a mechanism for connecting physicians with the newly established health authorities -- a rationale that is stressed in AMA generated documents (AMA, 1995a; AMA, 1995b; AMA, 1996b). In 1995, when the FCC proposal was first publicly released, both physicians and the government expressed interest in moving ahead to implementation (Walker, 1995), but four years later in 1999, even approved pilot projects have yet to start. Over this time period, these two key actors in the Alberta health care organizational field have communicated with each other directly and through published documents and the media extensively. The written records together with the memories of people directly involved with the proposal provide a rich source of information about how two actors have interacted over time, but the result to date has been no change to the status quo. This provides an excellent opportunity to longitudinally examine the connection between two key actors in a mature organizational field, in order to analyze the way in which links between these actors and the rest of the field influenced (or did not influence) the field as a whole.

The data sources for this study are two distinct sets of information -- archival documentary data and interview data from individuals involved with the FCC proposal.

Both sets of information are equally important to this study because each represents a key method of communication between physicians and the government. Closed door negotiations and privileged conversations between representatives of physicians and government are one established method by which the field level actors interact. I used information gathered through interviews to better understand this method of interacting. As well, the use of published material to communicate with each other, as well as to other health care actors in the field and the general public has become increasingly central to how the physicians and government define and structure their interactions. For example, for the first time ever, both the AMA and Alberta Health issued lengthy printed documents outlining principles and objectives of upcoming fee negotiations in the fall of 1997 (*Alberta Health*, 1997; *Alberta Medical Association*, 1997). Both documents contained references to alternative payment plans, and the fact that both actors publicly presented their opening position was important to the context of negotiations. Therefore, analyzing publicly available archival data as well as interview data, helps to bring a clearer understanding of both public and private interactions between these key field level actors.

First, regarding the archival data, I have collected publicly available documents and newspaper articles dealing with FCC or the associated Alternative Payment Plan discussions from 1994 until the present, 1999. I first segregated the written material making up this data set by author, giving three separate categories -- Alberta Health documents; Alberta Medical Association documents; and local newspaper or magazine articles. These categories represent views from three different perspectives on the FCC proposal -- first, the government; second, the physicians; and third, a more neutral

perspective of local reporters. Within each of these perspectives, I have organized the content of the printed material chronologically, and in a table format in order to compare and contrast the viewpoint and specific comments made by representatives of both field level actors over time. That is, by comparing written statements prepared by both the physicians and the government, as well as newspaper accounts, at specific time points, it was possible to identify both similarities and differences between the physician and government perspective, as well as trends over time. In total, approximately 210 pages of textual material is included in this archival data set.

Interview data was collected through purposeful sampling. I estimate that there are approximately 16 people who have had direct involvement with the FCC proposal at a working level, and I have interviewed 11 of these individuals. Every person contacted agreed to participate in this research study, and interviews were conducted until saturation was achieved (Hartley, 1994; Morse, 1994). Two interviews with knowledgable informants not previously interviewed were also completed after the preliminary development of a theoretical model in order to check the believability of the themes identified and to confirm that saturation had been attained (Lofland & Lofland, 1995; Morse & Field, 1995). All interviews were tape recorded and transcribed verbatim, except when recording was not permitted. In these instances, detailed notes were taken during the interview, and expanded to establish a written record within hours of the interview (Lofland & Lofland, 1995; Morse & Field, 1995). Each informant was selected as a representative view of one of the field level actors -- either the physician or government, and each person interviewed fit the category of expert informant (Flick, 1998). Of the 11

interviewees, 5 represent physicians and 6 represent government as key actors. All informants were assured that their responses would remain anonymous. Interviews were semi-structured with an average length of 45 minutes. The transcribed interviews generated 135 pages of text for analysis. Informants were asked to answer three broad questions: How did the FCC proposal originate? How has it happened that the proposal has still not been implemented, four years later? And finally, how do you see this proposal impacting the health system if it were implemented on a broad basis? Within each of the three broad question areas, informants were asked to answer as they deemed appropriate and with as much detail as possible.

Once transcribed, I analyzed the interview data through a two-stage process -- first manually and second with the assistance of computer based qualitative analysis software. Following established qualitative methods of data analysis, I coded for identity of the informant and field level actor represented. Then statements made were categorized according to common themes that emerged in order to reconstruct the categories used by informants to conceptualize their own experiences (Lincoln & Guba, 1985). Thus, statements about how FCC originated, why it has yet to be implemented, and what the future of FCC is likely to be, as well as, statements regarding the nature of the relationship between physicians and the provincial government were categorized according to emerging themes. These themes or categories were continually evaluated for appropriate fit with the data, and were modified as required throughout the data analysis. Information from the archival data was then compared, contrasted and integrated with themes derived from the interview data, in order to gain a more complete explanation of how the

relationship of physicians and Alberta Health with respect to FCC could be characterized over time, and how their ongoing actions and connections have resulted in little or no observable change at the field level.

From these explanations, I developed a preliminary theoretical model that fit with previously developed organizational field theory and helped to explain information about physician-government interactions gained through both interview and archival data. I then repeated the coding and categorization of all data through the use of QSR NUD-IST software for qualitative data analysis. That is, with the assistance of qualitative software, I re-analyzed interview and documentary data in light of my preliminary theoretical model, making modifications as appropriate and resulting in the model shown in Figure 2.2. Since I was interested in both public and private interactions between physicians and the Alberta government, the ability to integrate both data sources for analysis in QSR NUD-IST was an important factor, and it is through this process that I have attempted to develop a theoretical framework to better understand the role of field level interactions in relationship to change and stability at the organizational field level.

[Figure 2.2 about here]

The Case of a Fee for Comprehensive Care Proposal

In the following section I present my analysis of the interview and archival data showing the development of a theoretical model to explain the relationship of key actor interactions to the organizational field as a whole (see Figure 2.2). First, I have organized key points from both the interview and archival data that answer the three major

questions:

(1) how did FCC originate?

(2) how has it happened that FCC has yet to be implemented?

(3) and, what are the benefits (if any) of implementing FCC?

[Table 2.1 about here.]

Table 2.1 provides a summary of this information and indicates both similarities and differences between publicly stated positions in the archival documents, and views of informants gathered through interviews. In both interview and archival data the AMA was identified as the FCC proposal originator, and informants generally agreed that government focus on cost reduction led to increasing pressure to move away from physician reimbursement on a fee-for-service (FFS) basis. But particularly in the archival data, a difference between physicians and government concerning the rationale behind support for FCC is evident. Where physician generated documents focus on finding ways to maintain the nature of physician-patient relationships while adapting to regionalization and RHAs, government documents focus on changing the way in which physicians are paid in order to encourage the maintenance of health rather than the treatment of illness as well as reducing system wide costs by increasing the number of services provided by professionals other than physicians.

With regard to reasons for the non-implementation of FCC, I could find no explanation in the archival data. Instead, there is a gradual reduction in material pertaining to FCC, and the proposal was decreasingly referred to in government business plans, negotiation documents, and physician generated reports. In some cases, the term

"alternative payment plan" was used to indicate any method of physician payment other than FFS, but even this term is rarely seen in current documents. However, informants who were closely involved with the FCC proposal provided several explanations for the lack of implementation, and representatives of physicians and government were generally consistent in their descriptions of the process and reasons for inaction -- that insufficient resources were available to work through the implementation strategy; that actual implementation threatened internal relationships between physicians; and that attempts to develop a satisfactory working relationship between RHAs and physicians as part of the FCC proposal proved to be extremely difficult.

Also shown in Table 2.1, is the ongoing unanimous belief among informants that FCC could be of great benefit to physicians, government and the health system as a whole, although not surprisingly, physicians tended to focus on how FCC would benefit physicians, and government informants focussed on how the overall health system could be improved. Enthusiasm for FCC is also evident in the archival data, but a difference between the physician and government underlying view of FCC is more apparent. Physicians focus on their central role in the health care system, with FCC allowing them to improve direct patient care through better use of auxiliary resources, as well as negotiate new working partnerships on an equal basis with RHAs. On the other hand, government documents indicate a continual focus on efficient use of resources by increasing the number of services provided by health practitioners other than physicians. As well, this material reflects the ongoing government view that the health system should be driven by a focus on wellness rather than treatment of disease, and that consumers rather than

physicians should drive the system.

In general, the information presented in Table 2.1 indicates the importance of considering both public and more private interactions between key actors within a field. In this example, although there are consistent themes in the archival and interview data, there are also areas where one source provides information which the other does not. In the archival data, there is no explanation for the non-implementation of FCC. It is only through direct discussions with anonymous informants that potential factors can be examined. Conversely, even though individual informants were well versed in all facets of FCC, the overall government and physician views are expressed more clearly and consistently through published documents that have been carefully prepared for public distribution. Thus, the information presented in Table 2.1 shows the need to examine both interview and archival data in more depth, in order to better understand how interactions between these two key actors in the Alberta health care field affected the field as a whole.

[Table 2.2 about here]

In Table 2.2, I have indicated how my analysis progressed from the data information (Table 2.1) to the identification of common themes emerging through data analysis, to the construction of a theoretical framework that helps to understand the importance of interactions between key actors to the organizational field as a whole. The lack of explanation in the archival data for FCC's non-implementation and ongoing statements of support for FCC in both archival and interview data, combined with my theoretical interest in understanding key actor interactions at the field level, led me to focus on the actual interactions between physicians and the government, and to organize

further qualitative data analysis around the three question areas identified for each column in Table 2.2:

Why was FCC proposed by physicians? (What drove these interactions?)

How did FCC discussions address issues?

How did FCC discussions progress?/ What was the outcome?

Each of these areas appeared to be important in understanding the relationship between key actor interactions and change or stability at the field level. I combined information from both archival and interview data concerning future benefits of FCC (Table 2.1) with ideas about the cognitive views of physicians and government developed in paper 1, to assist in understanding FCC's relationship to the health system as a whole. In the next section of this paper, I discuss the process of my qualitative analysis by explaining my transition from data collected (both interview and archival), to the identification of emergent themes, and finally, to building a theoretical understanding for each of the question areas listed above and identified in Table 2.2. In each case, I incorporate my use of organizational theory outside that so far associated with organizational fields in order to help explain the relevance and importance of interactions between key actors. After developing concepts from each question area, I then show how I have integrated them in my theoretical model (Figure 2.2) addressing the relationship between key actor interactions and change or stability at the organizational field level.

Background and Genesis of the FCC Proposal

Even prior to health restructuring in Alberta, physicians were coming under

increasing pressure from the provincial government to reduce health care costs. A hard cap on total physician billings had been implemented by government in 1992 (Philippon &Wasylyshyn, 1996) and a newly elected provincial government in 1993 presented itself as cost conscious, determined to eliminate government debt, and committed to efficiency and accountability in the public sector. In the first ever business plan for Alberta Health, initiatives were proposed to reduce the number of procedures requested or performed by physicians in order to reduce costs. The strategy was stated as follows:

> Realize $100 million in savings by introducing a physician resource management strategy; providing other services in more efficient ways; enforcing payment rules more stringently; ensuring third parties pay for services they generate; introducing clinical practice guidelines; educating the public about how to best use the health care system; introducing alternate payment arrangements for practitioners where appropriate; reducing the need for physicians to practice defensive medicine and other related measures. (*Alberta Health*, 1994: 7). [2]

From statements such as the one above, the government view of physicians can be characterized as health care providers whose efficiency could be improved by externally determined incentives and guidelines. This approach that tended to treat physicians as a problem was based on analyses by critics such as Sutherland and Fulton (1994) who singled out doctors as profit maximizers driving up health care costs across the country and throughout the western world.

Restructuring of health services in Alberta, with a government goal of providing better services for less money (*Alberta Health*, 1994) met with initial skepticism from physicians which quickly turned to outrage when the government announced that

---

2

The total budget for physician services in 1993-1994 was approximately $ 700 million. Therefore, the government plan was to reduce overall spending in this area by 1/7 th.

physicians and other health care workers receiving revenues from the public system were ineligible to sit on the newly created RHA boards (*Regional Health Authorities Act*, 1994). One example of physicians' dissatisfaction is shown in the following excerpt from an editorial in their provincial newsletter:

> I am angry, not at the reduction of deficit financing of government activities, nor the reorganization of health care, but at the blind arrogance that has excluded doctors from membership of the rural health authorities that constitute a balkanized health care delivery system. Twenty-one nurses, 22 teachers, 45 business people, eight lawyers, six real estate dealers, 35 farmers, six social workers, 85 administrators from local authorities, health administration and voluntary groups, three University of Alberta professors are among the members of the RHAs. (Higgins, 1995a: 4)

And in a later editorial in the same year, the following comment appeared:

> Patients are seen as consumers, physicians as health care providers and hospital boards, appointed because of their political allegiance, are inflated to a status no less than health care **authorities**. (Higgins, 1995b: 4)

From the interview data, dissatisfaction is shown in one physician's comments:

> If you carry health economists' position to the extreme, we put all doctors on salary. I know lots of specialists who say great! Put me on salary. I'll work 8 hours and you find someone else to look after things after that. Put on a second shift. I won't operate at 3 in the morning just because there is OR time available.
>
> There is a perception that doctors are grossly overpaid. There has been a push, since about the mid 1980s, away from FFS [fee for service] because gross earnings for doctors look too high. You have to remember that after the reported figures, doctors have to pay overhead and that is reported to be 40 to 50 percent. That means that if your gross income is $200,000, you take home $100,000, pay tax, and have only $50,000, and then divide that by the number of hours worked, and doctors are definitely not overpaid.

Other physicians indicated their frustrations as follows:

> The whole thing with restructuring for physicians, is that we have been told

> to stay out of the process. We have been legislated out of the process. And doctors feel like they have been considered part of the problem as opposed to part of the solution.
>
> Physicians are accused of only treating disease. That everyone else in the system is doing preventative things except for physicians. The atmosphere is very bad for physicians right now. People are giving up, they are very discouraged, they're looking elsewhere, and they're demotivated.

Government informants recognized physicians' dissatisfaction. For example:

> [Referring to physicians' perceptions of the reform process] I think that there was a perception that things were happening in other provinces or in other jurisdictions and before they screw us, let's work out the reform by ourselves. The profession [physicians] felt that reform was happening dramatically, and they needed to do it themselves or somebody would do it for them.

It is within the climate described above that FCC as a specific proposal was put forward by the Alberta Medical Association (AMA). The archival data indicates that the proposal was, at least in part, designed to proactively respond to financial criticisms and repeated calls from health care economists and other critics, to remunerate physicians in some way other than FFS, where the payment plan contains financial incentives for doctors to see as many patients as possible. National reports (e.g. Barer & Stoddart, 1991; Birch, 1994; Advisory Committee on Health Services, 1995) were identified by the AMA as significant in the following way:

> There appears to be a sense of urgency, on the part of federal and provincial/ territorial governments, that remuneration for primary care physicians must be changed in short order. They believe that payments to physicians can -- and must -- be reduced to decrease health care costs. (AMA, 1995: 3)

Interview data from both physician and government informants confirms that physicians believed not only that they were being pushed into changing the method of remuneration,

but also that they were being identified as an excessive expense to the health care system. Thus, the FCC proposal was seen as a proactive step on the part of physicians to address these concerns. One government informant stated the following:

> The response from AMA was the FCC proposal. They were under pressure to adopt some kind of capitation model, and this proposal gave them the opportunity to study the issue and report that they were making progress on moving away from FFS.

Physician informants confirmed that FCC was proposed at least partly in response to calls for movement away from FFS, but included two other reasons for proposing FCC which are consistent with material published at the time (AMA, 1995a; AMA, 1995b, AMA, 1996a; 1996b). First, FCC was designed to respond to requests from primary care physicians who disliked the style of medicine they felt forced to practice under FFS, with a focus on office visits rather than overall patient care. And second, FCC was intended to address the need for a formal understanding of how physicians and the newly created health authorities would relate to each other. The proposal included the possibility of physicians receiving lump sum funding based on a capitation model which they would be able to combine, in a joint venture sense, with health authority funding to undertake specific programs. Physician informants indicated how much different this would be from a proposal where health authorities received total funding and then decided "how much to pay the doctors." They also identified that the ability of physicians to control their portion of the funding was critical.

It appears that physicians believed their role, status and identity within the organizational field was potentially threatened. To summarize their comments, they

believed that they were overworked, underpaid, under-appreciated and being prevented from taking a leadership role in the reforming system, when in contrast, they saw themselves as being key to the health care system and impossible to replace. For example, one physician informant commented:

> So we have an industry with a bunch of players -- with three identifiable, big major players. One is government, the payer; two is the deliverer of services, the RHAs; and the third is the docs. And I know that there are a whole slew of other providers and all that, but it's really the physicians who are the key to it.

It appears that the threat perceived by physicians was consistent with the views of at least some segments of government. One government informant stated:

> I think that [government official's name] really saw this [FCC] as an important thing, and I think that [he/she] wanted doctors to do more than to make a lot of money, working bankers' hours. [He/she] wanted to have access for people on weekends, and evenings. [He/she] wanted there to be a little more accountability for physicians. And I think the government did too.

In order to categorize the data concerning the origin of FCC into consistent themes, I required a theoretical perspective that helped to explain the AMA's actions in putting forward a relatively controversial proposal to remunerate physicians on a capitated basis. Since interview data from both physician and government informants had highlighted the contrast between physicians' view of themselves as a central and critical player in the health system, with physicians' perception that government viewed them as an expensive problem, I investigated the applicability of concepts related to identity and social identity.

Identity

Working at the individual level, Albert and Whetten (1985) defined identity as a view of yourself which is central, distinctive and enduring. Ashforth and Mael (1989) and Pratt (1998) expanded on this idea and provided a basis for discussing identity at an organizational field level. They proposed that groups develop a sense of identity through a process of comparing and contrasting themselves with other groups over time. That is, they not only seek to determine who they are within a set of relationships, but also who they are not (Ashforth & Mael, 1989). In a mature organizational field that has undergone the lengthy process of structuration, field level actors have developed clearly defined roles for themselves and for others. In particular, in organizational fields with high levels of professionalization, the key distinguishing characteristic of controlling an unambiguous body of knowledge (Freidson, 1993) contributes to the development of clear boundaries concerning the identity of one actor. For example, in the health care field, traditions have developed over time and become entrenched in legislation about who doctors are compared to other actors, and also what role they play. Through intense socialization processes that are central to the professions, medical students learn to act and think like physicians (Becker, Geer, Hughes & Strauss, 1961). They also learn who they are not. They are not nurses -- they do not take orders. They are leaders, not followers in health care. And, they develop a worldview that is consistent with who they are (Berger & Luckmann, 1967), and with how they make sense of other actors' reactions to them (Weick, 1995). This established identity is likely to influence the way in which physicians interact with other actors at the field level. Viewed through a theoretical approach based

on identity, the exclusion of doctors from decision-making RHAs threatened physicians' well-established identity as critical health care leaders whose advice was always requested and almost always followed. And since identity reflects core, central and enduring qualities, threats to identity are likely to provoke responsive action.

Building upon the idea of identity, Dutton, Dukerich and Harquail (1994) introduced the concept of construed external image -- "how members believe others view their organization." They showed how a perceived difference between *identity* (how members view their organization) and *image* (how members believe others view their organization) resulted in action to make identity and image consistent with each other. Other research (Gioia & Thomas, 1996; Dutton & Dukerich, 1991) also focussed on the effects of inconsistency between identity and image. Dutton and Dukerich (1991) showed that a tarnished image could threaten identity, and Gioia and Thomas (1996) showed how strategically changing the organizational image for top management in an academic institution, made it possible over time to change the organizational identity. For Alberta physicians, a discrepancy between their established identity and perceived image began to motivate action aimed at repairing their image and preserve their identity.

I propose that the concept of reputation (how others view an organization or one particular actor) is also related to image and identity, particularly in an organizational field where actors are tightly connected and the way in which they relate to each other is important to the field itself. In this setting, how field level actors view themselves (identity) will be in constant comparison with how others view them (reputation), and their perception of this view (image). During times of stability, identity, image and

reputation will be in a state of equilibrium, but during times of change the likelihood of disparity between these elements is high since both image and reputation involve the opinions of other field level actors. For example, in the Alberta health case, physicians became increasingly concerned that government no longer considered them to be leaders and authorities in the system. Their professional judgement was overruled by financial considerations, and they believed they were labeled as a problem rather than part of the solution. The incompatibility between physicians' reputation as a cost-driver, their perceived image of a somewhat insignificant trouble-maker, and their identity of leadership, centrality and filling a critical role in the system, affected the nature of the physician - government relationship. In this three way relationship between identity, image and reputation, it appears that identity is the key component. That is, although image and reputation are important, it is in their relationship to identity -- when a tarnished image or reputation threatens identity -- that action is likely to occur. From this perspective, the FCC proposal can be viewed as an attempt on the part of the AMA to address their reputation as uncontrolled cost-drivers, and move their image from 'a problem with the system' to a proactive team player that was committed to providing solutions. The FCC initiative would thus help to protect and preserve physicians' identity by bringing their reputation and image back into line.

Power

As well as the theme of a threatened identity provoking the AMA to propose FCC, interview data gathered in this research project showed the importance to both physicians

and government of maintaining or improving their level of power within the health care system. Physicians expressed ongoing opposition to any suggestions that their funding be brought under the control of RHAs (*Alberta Medical Association*, 1995b; 1999). The AMA's position in proposing FCC was clearly set out in the following:

> It's important to physicians whether they're paid through fee-for-service or alternative arrangements. But what's more important to the AMA and its members is that **physicians maintain control over their own funding** regardless of the payment model they choose.
>
> ... **Some regional health authorities allege they need ALL health care funding -- their 70% plus physicians' 30% -- in order to effectively manage health care delivery.**
>
> But the AMA's position is firm: physicians **must** retain control over their own funding if they are to maintain quality care, accountability and clinical autonomy. (AMA, 1995b: 2) [Emphasis on selected words recorded as in original text.]

Although government controlled the overall amount of money available for physician services, the AMA was (and continues to be) responsible for allocating financial resources to individual doctors. From the physicians' point of view, their established control over resources, and therefore level of power within the system, was threatened by the potential disaggregation of their overall budget to the nineteen newly established health authorities. Instead, the FCC proposal provided an alternative method of cooperation between physicians and RHAs where physicians, or groups of physicians could develop jointly funded initiatives with local RHAs. In this way, physicians would maintain control over their part of the funding, and would also be able to withdraw funding if they so chose. One physician informant explained the importance of funding arrangements as follows:

> ... in any negotiation like that it would be much different if the money had gone to the region, and then there would be a negotiation about -- how much will we pay the doctors? In this case [a potential FCC example based on joint venturing], the doctors actually bring in funding, and have an ability to take it out. So in negotiation terms they have an alternative. They could actually turn off that agreement.

Another issue related to power levels within the health care system was identified from the interview and archival data. Both government and physician informants and documents indicated that general practitioners (GPs) had become increasingly dissatisfied with their role in the health system and level of remuneration (*Alberta Medical Association*, 1995a; *Alberta Health*, 1997). GPs were categorized as being forced to practice a type of "treadmill" medicine, where they needed to see large numbers of patients in their office per day in order to make a reasonable income. Some informants suggested that GPs were threatening to separate from the AMA and negotiate directly with the provincial government in order to develop a remuneration system that allowed more time per patient and better use of medical skills. Since a splintered group of physicians would hold far less bargaining capacity and power within the health care system than a unified AMA, the FCC proposal can be seen as an attempt to satisfy the needs of GPs for an alternative payment system, while maintaining the established and relatively satisfactory FFS system for specialists.

So far there has been acknowledgment that issues of power within organizational fields exist, but little research has been done to investigate how power issues impact upon the field. Power imbalances have been identified as a way of life in organizational fields (Clegg, 1989; Fligstein, 1991), where in well-established, mature fields, power differentials

between key actors and the way in which power is used becomes institutionalized. This suggests that actors develop expectations about themselves and other actors within the field over time, developing power differentials that are recognized and accepted when they interact. As these power levels become taken-for-granted, who collaborates with whom, and under which circumstances, also becomes established and taken-for-granted. But it is important to consider how these power differentials become taken-for-granted, or how they might be purposefully used to accomplish particular goals. The effort that is put into establishing reputations of power has received little study, especially in the context of organizational fields, but recent work by Wageman and Mannix (1998) investigates this issue at an inter-group level within organizations. They analyzed the use of power in teams in order to establish a relationship with other teams and their external environment. They found that in teams with effective performance, the most powerful team members use their individual power and group generated power to establish external reputations. These reputations can be considered similar to the field level scenario, where over time, actors develop a level of power as part of their reputation that is accepted and respected by other actors. A focus on power and politics is currently missing in established organizational field theory but is consistent with DiMaggio's (1991) proposition that fields are defined by intentional, directive and conflict-laden processes, DiMaggio and Powell's (1983) conception of organizational fields as being defined by the nature of the interorganizational structures of domination and patterns of coalition, and Fligstein's (1991) statement that organizational fields are set up to benefit their most powerful members. The theoretical model proposed here suggests that when field level actors interact frequently and fatefully

(Scott, 1994), power differentials will impact upon the nature of the interactions and the patterns of collaboration that are established.

The factors of identity and power differentials also likely influence each other. This is consistent with conceptions of identity presented by Castells (1997) and Calhoun (1994) where identity and power are seen to be closely connected so that actions are tied to actors' beliefs about who they are. As well, this connection between identity and power is also consistent with professional control over a body of knowledge (e.g. Freidson, 1993). Controlling a particular knowledge base is central to the establishment and ongoing identity of a profession, and actors who perceive themselves to hold relatively high levels of power within an organizational field are likely to develop an identity that incorporates their ability to influence other actors. The perception of power differentials is an important concept in examining the relationship between identity and power differentials for field level actors, since taken-for-granted assumptions may never be put to the test if all actors simply accept established power differentials. Ashforth and Mael (1998) argue that within organizations, some groups are able to combine their sense of social identity with whatever power they hold to resist change. Moving these ideas to the level of the organizational field, suggests that actors who believe their identity to be threatened, may react by interacting with other actors in a way that maximizes the use of their power base and protects or restores their sense of identity. Thus, it seems that field level actor identity is influenced and reliant upon power differentials within the field, and the nature of field actor relationships will be affected by both power differentials and the identity and image of field level actors.

In building a theoretical model to explain the importance of interactions between field level actors, the portion of this research relating to the background and proposal of FCC seems to indicate that key actors are likely to initiate a major change only when they believe significant issues will be addressed through that process. The AMA brought forward the FCC proposal in response to government restructuring that threatened physicians' identity as critical health care leaders. As well, the FCC proposal addressed potential threats to physicians' level of power within the health care system by establishing a payment mechanism that allowed physicians to work with RHAs but protect their access to an independent funding source. Similarly, FCC was designed to address the needs of a number of dissatisfied AMA members (GPs), thereby preserving the unitary negotiating rights of the AMA and the associated level of power within the system.

I believe that this explanation of the genesis of FCC provides a useful example to consider interactions in organizational fields in general. As indicated in Figure 2.2, the portion of my theoretical framework associated with the issues leading up to the FCC proposal, is shown by the relationship between identity (and the associated concepts of image and reputation) and level of power as significant factors that may push field level actors to attempt to alter established ways of interacting. During times of stability, I propose that actors interact with each other in established ways that are based upon a consistent and taken-for-granted acceptance of each actor's identity and level of power within the organizational field. When something happens to threaten the identity or power level of a key actor, the actor is likely to take action to address that threat. Any such action will impact upon the established pattern of interactions within the field. This view

is consistent with Scott's (1995) frequent and fateful interactions since actors believe that the way in which they relate to each other is critical to their future. I have examined potential reasons for attempting to change the nature of such interactions from their established patterns, which serves to provide a stronger foundation for the importance of these relationships to each key actor involved. In the next section I focus on the nature of the interactions themselves in order to continue the theory building process.

Nature of FCC discussions

Both government and physician informants characterized FCC discussions as quiet and relatively peaceful. They also described them as being structurally modeled on regular fee negotiations. That is, government and physicians designated formal representatives who agreed to meet -- first to establish terms of reference and then to formally discuss the proposal on an item by item basis. For example, in describing the nature of the discussions, a government representative stated:

> Although it [FCC discussions] was kind of separate, and it was one of the things that people were keen to keep working on, I think that compared to some of the other venues with the AMA, FCC was a pretty calm place. FCC was a place where people could sit down and say, 'you know we're really working together to try and do something neat here, so let's do that.'

However, at the same time as acknowledging the calmness of these interactions, physician informants commented upon the wariness which they believed existed on both sides.

> The AMA was basically the one who was saying, 'look, we'll jump in the pool, but these are the terms.' And I think there has been a wariness on the part of many of the other players to get talking about the terms.
>
> There were certainly individuals at various times with different degrees of

> wariness, and all those kinds of things. ... We needed a broader understanding of how we work together. And we were trying to put something in which fundamentally affected that, and then started taking those directions.

FCC discussions appeared to be relatively low key and entered into cautiously by both physicians and government, but all informants reported a continuous belief that they were involved in a worthwhile effort that held the potential to significantly improve the delivery of health services.

Although one of the driving forces for physicians in proposing FCC, was the desire to establish a formalized relationship with the newly created RHAs, representatives of these health authorities did not participate in a meaningful way. In early FCC discussions, RHA representatives attended as observers, but later, they did not even attend. Physician informants explained the situation in the following ways:

> ... we then had a working group where the regions were asked to participate, and they basically sent observers

> When we first started FCC with Alberta Health and AMA we had two regional people saying, 'why are we here? why are we here?' and then when they got down to the nitty gritty, they go, 'oh, yes we want this and we want this' and they happen to be from region [x] and region whatever, and then they wanted to be involved because they had potential benefit to them. So that is why we realized that everything then became a local issue and that was not how you would negotiate a service agreement with the budget because it had nothing to do with those operations.

> Unfortunately at that level they had no body to speak for the regions as a whole, so there was never any agreement from that third party. So now we are negotiating without them. So we have taken the regional flavour out of an FCC which is what they wanted. They wanted a regional FCC, we have taken it out -- otherwise we are going to have to go and negotiate 17 of them.

These quotations show the importance of a designated actor at the field level. Both the

government and physicians (through the AMA) were able to interact at the field level, but RHAs had no mechanism to have their views collectively represented. Although the Provincial Health Authorities Association (PHAA) and the Council of Chairs (chairpersons of each RHA) were established at the field level, the PHAA has focused almost exclusively on labour relations from the employer perspective, and the Council of Chairs appears to have focused primarily on communication among RHAs. Either the PHAA or the Council of Chairs could have facilitated action at the field level for RHAs, but so far this has not occurred. Instead, each RHA appears to be focused on providing health care services within their geographic boundaries, and has been more interested in meeting its own individual needs than in developing any over-arching relationships with other actors.

Both physician and government informants provided insights into the relationship between printed documents and newspaper articles, and the closed door FCC discussions. They commented on the constraining nature of published documents that set out both government and physician overall goals, beliefs and perspectives. For example, government business plans focussed on the cost-saving nature of all initiatives, and government representatives in FCC negotiations were restricted to actions that would reduce (or at least keep constant) short term expenditures. As well, at one point in the FCC discussions, an elected government member with no formal FCC role provided a number of statements to the local media concerning the imminent agreement and implementation of FCC, when the committee members had no knowledge of his/ her story until they read it in the paper. Interview informants generally made light of the MLA's

comments, and explained them as 'overly eager' in anticipating an agreement, but this example illustrates how formal FCC discussions occurred somewhat in isolation, but were continually influenced by outside activities.

In developing categorical themes from the data to understand the nature of these interactions, the key emergent points appear to be the taken-for-granted assumption that discussions would follow the format of fee negotiations; the ongoing belief that FCC discussions could potentially result in significant system-wide change; the importance of a structure to allow field level interaction; and the way in which FCC discussions were influenced by other interactions within the health care field. In order to use this information to understand organizational field level interactions more generally, and since relationships between key actors of an organizational field have so far received little attention, I propose that concepts from an inter-organizational level of analysis may be a helpful starting point.

Patterns of Collaboration

At the organizational level, the concept of collaboration consists of the same relationship characteristics as Scott's (1994) description of frequent and fateful interactions suggests. That is, inter-organizational collaboration is characterized by organizations working together but maintaining separate control, entering into agreements in order to benefit both organizations, and expecting that the outcome will improve future outcomes. Clegg and Hardy (1996) identified collaboration as a critical component of organization level theory, and I propose that at the field level, collaboration between field

level actors may best conceptualize field level actors' relationships and their important role in organizational fields. Collaboration between organizations has become a specific strategy of mutual cooperation to accomplish particular goals, but a broader consideration evokes two distinct meanings of the word – working with one another; and to cooperate, especially willingly, with an enemy of one's country (Mintzberg, Jorgensen, Dougherty & Westley, 1996). It is in this second meaning of collaboration that underlying conflict can be incorporated into field level interactions. By thinking of the relationship between organizational field level actors as one of collaboration, actors maintain their own identity but interact purposefully with each other for varying reasons. Sometimes they act because it is in their best interests, sometimes because they believe they have no other choice, and sometimes because of manifest or latent conflict that exists between them. It is through this view of field level interactions as collaborations that I have based my investigations into a potential link between actors' relationships and field level change or stability.

Over time as a field matures, how actors relate to each other becomes established into patterns. This can occur through both formal and informal mechanisms in ways similar to explanations of institutionalization (Zucker, 1988), but it appears that key actors interact more carefully and purposefully than most institutional arguments suggest. Jepperson (1991) proposed that an institution represented a social pattern that maintained itself through established rewards or sanctions. For patterns of collaboration at the organizational field level, I propose that while controls may exist to limit the way in which actors collaborate, the patterns also allow significant diversity to exist in these relationships without affecting the overall field level stability. However, when significant

changes impact upon either the identity or level of influence held by key field level actors, there may be a disruption in the pattern of collaboration within the field, and the result may be instability and change for the field as a whole. By describing their interactions as patterns of collaboration, it is possible to recognize both the institutionalized nature of a regularized and taken-for-granted pattern to relationships, as well as the importance to each key actor of maintaining their identity and power level within the field. Thus, patterns of collaboration allow for purposeful (perhaps even deceptive) actions at the field level that fit in with taken-for-granted ideas of how interactions occur. In the Alberta case, the patterned interactions between physicians and the government are based on their use of formalized procedures, including the development of written agreements, but beyond the format, physicians and government planned purposeful actions to accomplish goals that would protect their identity and power levels.

In this case study, the FCC proposal served as a potential mechanism for field level change. Field level actors agreed to participate in discussions that could have resulted in a new arrangement between them to address important issues on each side. In terms of the categories that represent physicians' interest in the proposal (i.e. addressing the threat to their identity; maintaining a united front at the field level; and developing a relationship with the newly created RHAs that protected physicians' independent funding), FCC discussions had the potential to accomplish all three objectives. From the government perspective, FCC could have provided one mechanism to increase the health system focus on wellness and prevention of injury, with an associated long term reduction in overall costs. Both physicians and government entered into an established pattern of collaboration

that occurred in conjunction with published statements. This was similar to the style of communication established for regular fee negotiations, although with less intensity. Interestingly, the RHAs had no established structure for interacting at the field level, and therefore were eventually excluded from discussions. For physicians and government, the nature of FCC discussions allowed each side to investigate possible changes but protect their own identity by avoiding any obligation to agree to any particular initiative.

In terms of developing a theoretical framework at the field level, the nature of the FCC relationships illustrate Scott's (1994) description of frequent and fateful interactions in an organizational field. Key actors interact for one or more purposes, and the way in which they interact has the potential to affect the field in the future. The experience of FCC negotiations in Alberta indicate the importance of patterns of interaction, which allow actors to achieve their own goals and protect their identity as they view it within the field. As well, the FCC case shows how key actors can act in ways that recognize underlying conflicts between them, but serve to maintain stability at the overall field level. Thus, by describing interactions between key actors as patterns of collaboration, it is possible to recognize both the importance of established ways of interacting as well as the existence of separate (and sometimes hidden) goals of each actor involved.

Ongoing progress of FCC interactions

Four years after the public release of the proposal, FCC has yet to be implemented. This is in spite of the stated support and agreement by both sides that the proposal was a positive initiative and likely to result in favourable changes to the system as a whole.

Proponents of FCC list the following advantages: increased incentives for physicians to practice the style of patient-based, rather than treatment-based medicine they are trained to provide; encouraging an emphasis on wellness rather than illness; and the possibility of increasing the overall effectiveness of physicians by allowing them to delegate some duties to other professionals without reducing their income. Almost all interview informants commented that FCC could have resulted in a situation where both sides won. They explained the very slow movement in implementing FCC by statements that fit in the following four categories:

1. FCC had to be taken up and formalized through official negotiations in order to be implemented, and this is a very slow process. Every potential consequence of implementing FCC had to be formally agreed to and signed off.

2. There were so many other things going on -- health reform; fee negotiations -- that there were no left-over resources to devote to FCC.

3. Although the proposal was designed to address potential threats to physician identity, it held the potential to redistribute money from specialists to general practitioners, which threatened the unity of physicians at the field level.

4. The government was unwilling to restrict patients from changing physicians. The initial proposal called for patient commitment of at least 3 months with one doctor, or else patients would be required to pay for services received. This was seen as antithetical to consumer freedom of choice, a critical component of making government more business-like. Instead, government proposed a system where physicians on FCC would lose income for patients visiting other doctors. Agreement has not been reached on this issue.

5. Although the proposal was designed to address ways of formally determining the power differential relationships, including newcomer RHAs, no agreement could be reached.

Referring to the theoretical model in Figure 2.2, the FCC proposal moved into the established patterns of collaboration, and then seemed to virtually disappear in the

buffering nature of those patterns. That is, the patterns of collaboration appeared to absorb and counteract the tendency to change, much like a buffer in the chemistry sense, that provides a range where the effect of chemical reactions are limited. In order to explain the absence of change in this case study, I expand upon each of the above five general reasons why FCC has moved forward so slowly. I examine the data collected in relationship to the theoretical model in order to highlight characteristics about the way in which the government and physicians interacted that allowed or perhaps dictated the resulting lack of change. It is clear that the key actors interacted frequently, and the way in which they interacted and how that relates to the field as a whole is addressed below, according to each of the themes identified.

First, every informant referred to fee negotiations between physicians and the government in some part of their response to questions about FCC. Similar to management/ union relationships, Alberta physicians and the government have established formal negotiations as the primary method to set reimbursement standards and resolve conflicts. During the time period studied, there were two sets of formal fee negotiations with resulting agreements signed in 1995 and 1998. Both physician and government informants used negotiations as markers of time. For example, one government interviewee trying to remember the sequence of events, stated, "So, they had the round of negotiations -- I think the one that ended in '94, and that was where a lot of the prerequisite work on fee for comprehensive care came from, and even through the next round of talks ..." As well, negotiations were used by physician informants to track events, as shown in the following: "... and we were in a beginning stage of attempting to see how

that would play out, when we got into negotiations -- a couple of negotiations ago."

Even though FCC discussions between physician and government representatives were separate from formal fee negotiations, meetings held were characterized as similar to negotiations in that written or computer disk documents were passed back and forth between the two sides, but individuals on the committees were generally of lesser stature, and the emotional level was generally lower than that of negotiations. Consistent with a negotiation model of interactions, both government and physician informants described an attitude of wariness on both sides. They also indicated that verbal agreement on various issues was sometimes reached, but written agreement, signed by people with the proper authority did not occur. Some interviewees stated that at times they believed the committee had reached an agreement, only to find several weeks later, that things had changed and more discussion was necessary. One government informant suggested that in order to move ahead, FCC had to be taken up and formalized in the first round of negotiations (1995) following its release. Instead, there was only minimal inclusion of the proposal in the resulting formal agreement, allowing for the FCC option to be "established to provide physicians with a populations based alternative payment option for primary care services." (Letter of Understanding, 1995). A structure and timetable for implementation were to be developed and agreed to, but by the time of the next negotiations in 1998, the resulting agreement contained no reference to FCC. Instead it stated, "Where the Department and Association have agreed to funding flows respecting Alternate Payment Plans, physicians shall have a choice in the method of compensation for the provision of Insured Services." (Agreement, 1998).

In summary, formal negotiations appear to be the established model of interaction between physicians and government. Discussions between physicians and government on the FCC proposal were modeled on the negotiation process but lacked stature, formality and legitimacy. The fact that FCC was not specifically defined and agreed to in writing as a result of formal fee negotiations, meant that its chances of implementation became low. The more these actors discussed the issues, the more problems appeared to arise. As illustrated below, some informants were frustrated by the lack of change:

> I think that both the AMA and Alberta Health are interested in doing things differently. They're interested in looking at health reforms, they're excited when you talk to them about the possibilities, but as far as the actual implementation, they're afraid to change. Or if they're not afraid to change, they want to make sure that it's perfect before they change, and that's a very difficult scenario to work under.

FCC moved into the patterns of collaboration and became bogged down in the established ways of interacting. Merely agreeing to move forward with issues at a future time, turned out to be insufficient formal commitment for change to occur at the field level.

The second theme identified by both physician and government informants indicates a possible explanation for the lack of change -- that neither side held sufficient resources to pursue meaningful discussions concerning FCC. For example:

> ... there wasn't really anything going on except downsizing. Financial downsizing. And their [government's] attention was really caught up with the problems and issues related to that. (Physician informant)

> So, you know, there was huge downsizing going on, there was great loss of institutional history, which was a real detriment to the department. (Government informant)

> And all they had was me. There was no secretary, or anything. And so ... I was a one man army, and so the whole thing faltered, even though there

> was good will and commitment and a process established, just to continue moving it ahead, between both the AMA and Alberta Health. (Government informant)
>
> [The lack of progress comes from] two places -- Alberta Health's under staffing, and inability to get data out of the computer. There's one lady in Edmonton who does everything. There was another lady there last year, but she left. (Physician informant)
>
> There may have been reform fatigue. [Alberta Health people were saying things like] -- 'We just dealt with this. We need to take a bit of a rest. We need to take a breather. ... Let's not implement a major change in how we pay doctors. We have got enough going. Let's just have them [physicians] make their best efforts to find savings.' (Government informant)

With regard to the theoretical model in Figure 2.2, the patterns of collaboration may have been filled to capacity with interactions related to the ongoing health reform initiatives and recurrent fee negotiations. Such an explanation is consistent with social problem theory (Hilgartner & Bosk, 1988) which suggests that systems of communication, and in particular those including public opinion, can reach a point where new ideas or innovations simply can't be recognized because too much else is going on. But in this particular case, the government had proven its ability to simultaneously make changes on many different fronts during the restructuring process. It seems that the issue of FCC was not assigned high priority, since resources directed to it were very limited, but whether or not the government really wanted the proposal to move forward is questionable. One government informant stated that although FCC was officially part of his/her responsibility, he/ she was told by superiors "not to worry about it." Another government informant made the following comment:

> So it was a really difficult line to walk. You know, I'm being told on the one hand, this is really important, and I'm being told on another hand --

you know, well don't push Fee for Comprehensive Care forward too quickly while the next round of negotiations is going on.

Similarly it is not clear whether the physicians were dedicated to moving FCC forward. Although they did initiate the proposal formally, they did so at a time when they may have known that resources to move it through to implementation were limited. Some government informants suggest that this may be the case, but physician interviewees point to the shortage of financial resources in terms of physician services funding as a limiting factor in moving FCC forward. Since all physicians are remunerated out of a capped overall budget, a new method of payment must cost exactly the same or less than the FFS remuneration it replaced or else other physicians (in this case, specialists) would be forced to reduce their income level. Such a constraint required careful, predictable projections and safeguards on which it was difficult to find agreement. From this perspective of limited resources delaying the implementation of FCC, the patterns of collaboration were both stressed to the limit and constrained by previous financial agreements, leading to non-implementation and no change to the field as a whole.

From the interview data, the third category of reasons why FCC has not been implemented relates to the financial cap on the physician services budget. In 1992, the government negotiated a fixed, hard cap on total FFS billings to the government plan by all Alberta physicians. Both physician and government informants stressed the point that although a fee schedule for each service provided is pre-determined, if the total annual billings appear to be surpassing the value of the negotiated cap, it is the responsibility of the AMA to reduce the amount per service reimbursed, and thus per physician,

appropriately. It is this constraint which the AMA may not have foreseen being applied, that appears to have threatened the unity of physicians at the field actor level.

The AMA represents all physicians in the bargaining process, and I have previously identified the objective of maintaining a united front as one driving force for physicians in proposing FCC. It appears that an unintended consequence of implementing FCC, was the development of a potential split between general practitioners and specialists, because specialists were concerned their income might drop as a direct result. For example, a physician informant stated:

> It is my understanding that the proposal was made, and the government said fine, but it has to fit under the same financial cap. That means it would pull money away from specialists to increase the funding for FCC. The specialists would leave the province.

And consistent with this view, are two statements from government informants indicating the perception of a split within physicians as an actor group:

> Where some of the controversy started to occur, I think, is that if you look at the fee schedule, it's really skewed in favour of so-called specialties, and general practice in this province has always felt that its role has been undervalued.

> Specialists had a lot to lose, and I think that, from my opinion, all of the limitations that have been put on FCC over the past three years are probably there more because of a few specialists who have a lot of political acumen, than because general practitioners were saying no.

Some government informants suggested that the AMA may have continued with FCC discussions in order to placate the part of their membership interested in moving ahead, but moved slowly in order to keep specialists on side. For example:

> They couldn't just reject it outright. And that's why I think it was kept alive on the table, 'but you know, its got all these complications, and on

> and on and on. So we're not going to do it right now -- we're not going to say no to it.' It's kind of an appeasement strategy with part of your membership to keep it there.

With respect to the theoretical model in Figure 2.2, the AMA may have been able to use the patterns of collaboration as a way to keep both sub-groups within their organization content, presenting a single united front to the field as a whole and protecting their level of power in the organizational field. One way of dealing with this potentially divisive issue was to shift the focus to implementing FCC through pilot projects, which seemed to arise after the 1995 agreement. The pilot project route may have been a satisfactory outcome since extra funding for such initiatives reduced the financial risk for physicians remaining on FFS. As a sophisticated actor in the health care organizational field, one of the AMA's goals in proposing FCC was to address the concerns of family physicians who were dissatisfied with current arrangements. It is interesting that as discussions progressed, it appeared that FCC as originally proposed and in conjunction with the overall cap for physician services served to widen, rather than close the gap between family physicians and specialists. Thus, a modified plan to start with pilot projects seemed to provide a potentially satisfactory compromise, but even this approach has yet to be implemented.

The fourth category relates to government concerns with the original FCC proposal developed by the AMA. Part of FCC included a requirement that patients enroll with a designated physician or group of physicians, and agree to an exclusive contract for a specified period (three months suggested). If patients chose to visit another physician during that time, patients would be required to pay for those services outside the

provincial health insurance plan (AMA, 1995a). That is, physician visits outside the contract would not be covered, placing disincentives directly on patients for physician-shopping or seeking unnecessary second or third opinions. Interview informants suggested that the provincial government, which was committed to making the provision of health care more business-like, refused to adopt a system where patients (consumers) were restricted in choice. Such a change would have been inconsistent with the government's identity as a system manager devoted to bringing accountability through the adoption of market principles. Proposals currently under consideration include financial penalties for physicians if patients seek treatment or advice outside the contracted relationship. Physicians will be "negated" (have the costs of outside physician visits deducted from their billings) if their patients see other physicians while they are enrolled in a FCC plan. Discussions remain ongoing about how and when these negations will be calculated, and no agreement has yet been reached, but this example shows the government acting to revise FCC in a way that would be consistent with its identity as a protector of consumer rights.

The final category of reasons why FCC has not moved ahead, relates to the inability of physicians and government to come to an agreement on how RHAs formally fit in the system. In particular, they have not been able to agree upon which actors hold the financial authority in specific scenarios, and while FCC was proposed by the AMA as one way to address this, their suggestion seems to have received little support. Instead, every pilot project involving the cooperation of an RHA, requires separate negotiations to determine the specific arrangements. One pilot project has been the subject of continual

discussions and negotiations since 1997 (Walker, 1998) and interview informants familiar with the project report ongoing talks that seem close to implementation at times and then agreement disappears. The formal establishment of an overall power relationship is seen as critical to all discussions about FCC, and is evident in the following comments from physician informants:

> This is what we had recommended back in '96 -- that we need an agreement between the three parties, in terms of how we work together; what are the responsibilities in terms of the different budgets and so on; core services; quality standards; licensing, and all those issues. We don't have that kind of agreement. And again, I think that was one of the big issues.

> ... we've always taken the position that the profession wants to remain independent, that economic independence was important to them, and therefore we were faced with a situation where we did not want physicians' budgets going to the regions, and yet we felt the need to encourage and to play our part in encouraging greater relationships between physicians and regions.

And from a government informant:

> First of all, they [physicians] wanted to maintain their independence and they wanted to deal with the government and not the RHAs. But then they wanted some influence in what the RHA does -- because they're kind of always talking two lines. On the one hand, they don't want to be paid by the RHAs, they want to keep their relationship with government, but then they know that RHAs can make decisions about hospitals, about procedures, about the kind of care that has a dramatic impact, and the number and kind of physicians that you're going to require. So, they wanted to keep being paid by the government, but they wanted to be involved very, very much at the level of the [RHA] board.

Referring to Figure 2.2, the preservation of established identities and power differentials appears to have been a critical issue for physicians, but there is very little evidence any real consideration of change was ever taken up in the patterns of

collaboration. The hard line position of physicians with respect to their funding continuing to come directly from government, rather than through the RHAs, is illustrated by a physician informant who adamantly stated, "That is a line in the sand. A hill to die on." In this case, the government may have used its power to deal with contentious issues through the patterns of collaboration, preventing a change allowing physicians to control a portion of funding for projects with RHAs. It appears from interview data that Alberta Health staff were "under the direction of the government to be real tough with the physicians," but the ways in which this was played out are not clear. What is evident is that no change to the field in terms of funding mechanisms has occurred, in spite of continuing discussions. The patterns of collaboration that are based on ongoing discussions, culminated by formal, written, signed agreements for change to take place, seem to allow physicians and the government to remain virtually at an impasse in terms of funding control. Physicians appear to be protecting a part of their identity that is critical – their autonomy through independent funding. It seems that physicians have been able to use their power to prevent a change from direct government reimbursement for their services, and the government has been able to use its power to prevent physicians developing some financial control over RHA based services through a joint venture arrangement. It is in this regard that agreement appears to be a remote possibility.

Conclusions

The ongoing and active processes around the potential implementation of FCC that became part of the field's patterns of collaboration has resulted in no change to the system

as a whole, to this point in time. How that occurred is of interest and importance to the concept of an organizational field, because it helps in understanding the relationship between field level interactions and change or stability in the field. First, it suggests that interactions within a field's patterns of collaboration may result in a type of equilibrium that we view as stability. For change to occur at the field level, it appears that the established patterns may need to be altered, and key actors may be motivated to initiate such changes when they believe their identity or level of power within the field to be threatened. Alternatively, for a field level change to be implemented and sustained, patterns of collaboration within the field must support that change through consistent alterations of key actors' identities and power levels. This relationship is depicted in Figure 2.2.

Second, the FCC example illustrates the purposeful nature of key actor interactions. It seems that actors interact with each other for specific reasons that are significant to them. In the FCC case, physicians proposed changes in order to address specific concerns and government agreed to enter into discussions because they believed they could achieve their own goals. When it became apparent during the course of negotiations that physician unity could be at risk, and that the government's identity as an advocate of consumer choice could be sullied, each of the actors held sufficient power to resist implementing change. At this point, or perhaps even earlier in the FCC process, key actors were able to use the established patterns in order to give the appearance of making progress while possibly choosing to maintain the status quo. That is, although FCC discussions were ongoing, it seems that resources committed were insufficient, higher

level officials with the authority to make firm decisions were not involved, and increasingly minor issues became cause for delay.

This explanation of field level interaction provides room for active decision-making by knowledgeable key actors, and both supports and provides a stronger basis for DiMaggio's (1991) claim that "organizational fields are not simply investigators' aggregative constructs, but are meaningful to participants" (1991: 267-268). Fields are meaningful because key actors interact in a purposeful way designed to meet their own goals. The repertoire of actions available are directly related to the level of power held, and in some cases, actors may best meet their own needs by making use of institutionalized approaches (e.g. negotiating committees) to resist change.

This case study also provides richer detail to support DiMaggio's (1991) statement that organizational fields are defined by intentional, directive and conflict-laden processes, as well as his earlier conceptualization of a field as "both common purpose and an arena of strategy and conflict" (DiMaggio, 1983: 149). DiMaggio (1983) built upon Bourdieu's (1975) dual meaning of the French word "*champ*" to explain his idea of a co-existing sense of unity between actors as well as a battlefield mentality. The FCC case illustrates such a contrast in its picture of physicians and government working together to assure a quality health care system, while at the same time dealing with underlying conflict between them. The idea of an organizational field as a battlefield, may provide an interesting basis for future studies, particularly in light of this case which could be portrayed as a skirmish that has so far served to maintain the status quo.

Overall, the FCC case study is also consistent with the concept of frequent and

fateful interactions between key actors as the basis for an organizational field (Scott, 1994), since interactions may be frequent and fateful because actors choose to make them so. That is, interactions between key actors are not chance encounters. Rather than a deterministic meaning of the word "fateful," field level actors have the ability to create their own destiny. Their interactions are purposeful and usually carefully considered, and the result of such interactions in bringing change or stability to the field as a whole may be dependent upon the ability of other key actors to resist change. In the FCC case, there appears to be evidence that either or both of the two key actors used the established patterns of collaboration to maintain the status quo. In collaboration, the motive for working together may not be clear, and actors may have reasons for appearing to cooperate when in fact underlying conflict guides their actions. In the case of physicians and Alberta Health, both actors appear to suspect ulterior motives of the other, characterizing their relationship as one built on wariness. In this case, the result of ongoing interactions appears to be an unchanged remuneration system for physicians, located within an overall health care system that has undergone major restructuring.

Conclusions from this analysis indicate that research into the relationship between actor interactions and a stable or changing organizational field has the potential to make a significant contribution to organizational field theory. In particular, this research shows the importance of including intentional and political actions on the part of field level actors in theoretical organizational field models. Such an analysis fits well with Selznick's (1949) early work in institutional theory, where TVA interest groups engaged in various activities in an attempt to control the decision-making process. Similarly, this study of the Alberta

health care field offers little indication of a passive system where key actors are at the mercy of institutionalized forces. Instead, the data shows highly organized, motivated actors who interact with each other, striving to accomplish desired goals, and determined to maintain their own identity and power level within the field.

This research also shows how high levels of activity between organizational field level actors can be transformed into field level stability. The theoretical model presented here, as developed through analysis of the case study, develops and expands upon Scott's (1994) concept of frequent and fateful interactions between actors as a basis for understanding the field as a whole. It is the pattern of ongoing purposeful activity between actors that holds a field together, and helps to create the stability that is generally desirable in areas such as health care. In this study, physicians and the government have developed a pattern of interactions based on maintaining their individual identities, protecting their own self-interest, and accomplishing their separate goals. They collaborate with each other in a style which has become ingrained, and which supports diverse points of view. Through these patterns of collaboration that act as buffers for the system as a whole, high levels of activity can be consistent with and support field level stability. Although this example shows a lack of change at the field level, it does raise interesting issues about when such a field might move toward change. According to the model presented here, in order for field level change to take place, one or both of two conditions is required. First, if change is actually desired, meets the goals, and protects the identity of all actors concerned, they should be able to agree on changes either through the established patterns of collaboration, or through changes to the patterns themselves. Second, if the power

differentials between actors are large enough, one actor may be able to push change through the patterns of collaboration, even without support from other actors. This type of change would eventually require a supporting adjustment in the identity and perceived power level of those key actors who do not originally agree with the change, in order to be sustainable. Further research that compares the results of this case with other initiatives resulting in field level change may help to clarify the relationship or necessary requirements at the actor level most likely to support such change.

The identity of field level actors, particularly as it relates to the organizational field as a whole, is an important issue that emerged as part of the data analysis process. Identity is receiving increasing research attention at the organizational level, but the issue has received little attention as it applies to organizational field actors. This research indicates a strong connection between protecting an established identity and purposeful action. In addition, in this case study there is evidence of a relationship between identity, image and reputation for field level actors. The relationship between identity and image at the organizational level of analysis has received some attention (e.g. Dutton & Dukerich, 1991; Dutton, et al., 1994; Gioia & Thomas, 1996) but remains an under-developed area of research in organizational identity. Moving the issue to the field level, and considering the connection between identity, image and reputation holds intuitive appeal. If interactions are the key to understanding organizational fields, then a study of consistency or disparity between the three connected concepts (identity, image and reputation) may provide valuable information about field level actors and the relationships between them. From my research, it appears critical to consider the relationship of identity, image and

reputation at the field level because of the tight connections between key actors within an organizational field where opinions about other actors are likely to influence actions undertaken.

In general, it appears that established patterns of collaboration within an organizational field develop over time in a way that tends to convert underlying conflict into overall stability, particularly within areas such as health care where hasty changes may result in undesirable consequences. This helps to explain how ongoing interactions between key actors can easily lead to little or no overall change at the field level. Since actors seem to hold clearly established goals before entering into discussions such as in the FCC example, they are unlikely to adopt changes unless these goals appear to be achievable. Through the process of lengthy discussions, which characterize the pattern of collaboration in the Alberta health care field, ongoing consideration of issues seems to result in more reasons to avoid change. Similar to findings by Ashforth and Mael (1998) at the organizational level, powerful actors may be able to resist changes that impact negatively on their identity through this discussion process. In order for changes to occur at the field level, the established patterns of collaboration may need to be circumvented since they are so closely connected with stability, but research outside this case study will be required to test such concepts in other types of organizational fields.

By conceptualizing field level interactions as patterns of collaboration, I propose that the theoretical framework developed here provides a way of understanding purposeful action by organizational field actors within established and taken-for-granted methods of interacting. That is, it responds to concerns that attention to purposeful action has been

neglected in institutional approaches (Greenwood & Hinings, 1996; Hirsch & Lounsbury, 1997). Field level actors do not simply play out assigned roles within a system where destiny is preordained. Instead, actors develop strategies and action plans to suit their own particular purposes and implement them within established patterns of interacting with each other. In some cases, they may use the patterns of interactions in ways that best suit their overall goals.

I have also shown that key actors may be prevented from acting at the field level because the field's structure provides no mechanism for collective action. This points out the importance of considering the ability of actors to take action as well as observing particular actions. Powerful field level actors may be able to exclude others from acting at the field level, as was evident in the FCC case where physicians benefitted from the inability of RHAs to negotiate on a province-wide basis. By keeping discussions at a provincial level, physicians were able to exclude RHAs from meaningful participation on FCC. This issue of ability to act at the field level requires further investigation in different organizational fields in order to more fully develop concepts about how field level actors take action or are prevented from acting in particular cases.

Theory about organizational fields has emphasized the importance of tight connections between key actors, but this paper begins to identify how connections influence actions within the field. Since actors take action in a purposeful and carefully designed way, understanding the process by which their interactions impact the organizational field is critical to the field concept. In order to deal with issues of change at the field level, an understanding of how actors interact with each other is required. In this

research I have identified the importance of actor identity, level of power and established patterns of collaboration as key factors influencing change initiatives at the field level. Further research in other settings may help to develop concepts related to these or other factors.

Scott's (1994) description of interactions between key actors as frequent and fateful, was a starting point for my research, and it has continued to hold up as a conceptually helpful way to understand change or stability in an organizational field. Purposeful, planned interactions that are both designed by and hold meaning for key actors will impact upon the field as a whole. In this sense, interactions are fateful because actors act purposefully in their own interests in order to create their own destiny. These interactions may be based upon underlying issues of conflict, but serve to establish and maintain stability when key actors' identity and power levels support it. Alternatively, threats to either of these factors may trigger actors to attempt a change, or to resist changes initiated by others. This view of field level interactions as purposeful within established patterns that may themselves be used for particular purposes, allows for the recognition of political and other types of action within an institutional approach. It may lead to more detailed and rich analyses that will contribute to our so far limited understanding of organizational fields.

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Table 2.1: Data relating to research questions

3 general research questions:	Interview data	Archival data
How did FCC originate?	• AMA formal proposal prepared through usual working committee route • Response to reports criticizing FFS • Response to government pressure to move away from FFS • Response to requests from some family practitioners • Provide method for physicians to formally work with RHAs	• Formal proposal brought forward by AMA • Response to a "spate" of reports on primary health care reform • Physician view focuses on maintaining positive elements of current system • Government view focusses on changing to wellness based system; using least cost providers; paying doctors differently
How has it happened that FCC has yet to be implemented?	• FCC needed to be recognized and formalized in negotiations • There were too many other things going on; Lack of resources • FCC created identity problems for physicians as a unified group • The two sides couldn't agree on how to re-establish power relationships including RHAs	• No explanation. • Gradual reduction in mention of FCC • FCC replaced with broader term -- Alternative Payment Plan
What future do you see for FCC?	• FCC would be a positive initiative for the health system • FCC could increase the effectiveness of the health system • FCC could increase physician satisfaction • FCC can only progress now if pilot projects are successful	• Physician view is based on choice: financial mechanisms can assist in providing greater flexibility; physicians can choose method of remuneration • Physician view: Physicians remain key service provider; undertake joint ventures with RHAs • Government view: achieve increased effectiveness through substitution of other health professionals for doctors

Table 2.2: Data Analysis

	Background and Genesis of FCC Why was FCC proposed by physicians?	Nature of FCC Discussions How did FCC address issues?	Ongoing Progress of FCC Interactions How did FCC discussions progress? What was outcome?
Summary from the data	• Newly elected government determined to reduce overall costs identified physicians as cost-drivers who needed to be managed. • Physicians saw themselves as important and valuable leaders in the health care system – not as an expensive problem to be excluded from a leadership role. • Family physicians were dissatisfied with FFS remuneration, and seeking alternative methods. • United voice of physicians at the field level was critical to maintaining negotiating position. • Newly created RHAs had no formalized relationship with physicians, and potential existed for physician services budgets to move to RHA control.	• Discussions between physician and government representatives were characterized as calm compared to fee negotiations. • FCC discussions were modelled on fee negotiations, but given less importance. • Each actor entered discussions with some sense of wariness. • RHA representatives had difficulty in speaking collectively, and were eventually excluded from discussions. • Discussions were influenced by external activities such as system reform; fee negotiations; newspaper articles; etc.	• Discussions were lengthy with stated agreement on various aspects from time to time, but no written agreement signed by appropriate authorities. More discussions seemed to lead to consideration of more potential effects, and more concerns. • Because there were many other things going on, there were few resources left over for FCC. • Physician unity threatened because funding for physicians may have been redistributed from specialists to family physicians. • Government was opposed to reduction in patient (consumer) choice. • Physicians desired formalized relationship with RHA but they and government could not agree.
Categories emerging through data analysis	• Need to address identity threat in a pro-active way • Need to achieve acceptable relationship between identity, image and reputation. • Desire to maintain physician unity (and thus level of power) by responding to concerns of family practitioners • Desire to develop formalized financial relationship with newly established RHAs that preserved independent physician funding	• Taken-for-granted assumptions that discussion would follow format of fee negotiations. • Ongoing belief that FCC discussions could result in significant and positive system-wide changes. • Structural ability to act at field level (designation of a body for collective representation) was critical. • FCC discussions were continually influenced by other interactions in the system.	• Ongoing interactions may result in no change to the status quo. • Reasons for not progressing from discussion to implementation were associated with protection of actor identity or power level: -Government unwilling to prevent patients (consumers) from changing doctors since it conflicted with their view of individual consumer choice and business-like values. [identity] -Redistribution of funds through FCC for some physicians threatened established distribution of funds, and physician unity. [power level] -Physicians insist on control over own funding when interacting with RHAs. Government unwilling to formalize such control. [power levels]
Theoretical framework at organizational field level	• Significant issues for key actors precede change initiatives. • Different actors may enter discussions aimed at change for different reasons. • Examples of significant issues that may motivate actors in initiate change include: -Identity & power differentials -Threats to unity, and therefore ability to act at field level -Entrance of new actor to field with potential to disrupt power relationships	• Field actions follow established patterns. • Consistent with Scott's (1994) ideas of frequent and fateful interactions, potential results of actions are seen as important. • Key actors protect their identity and power level during the course of interactions. • Actors must have structural capacity to act at organizational field level. • Stability at field level may persist because underlying conflict between actors is buffered by patterns of collaboration.	• Interactions within patterns of collaboration must be consistent with key actors' identity and power levels. • Key actors may purposefully use the established patterns of collaboration to meet own goals -- goal may be to resist change. • Key actors act for specific reasons that are significant to them. Acceptable changes resulting from these interactions need to address the reasons for acting. • For change to occur at the field level, change must be consistent with key actors' identities and power levels.

Figure 2.1: A priori theoretical framework

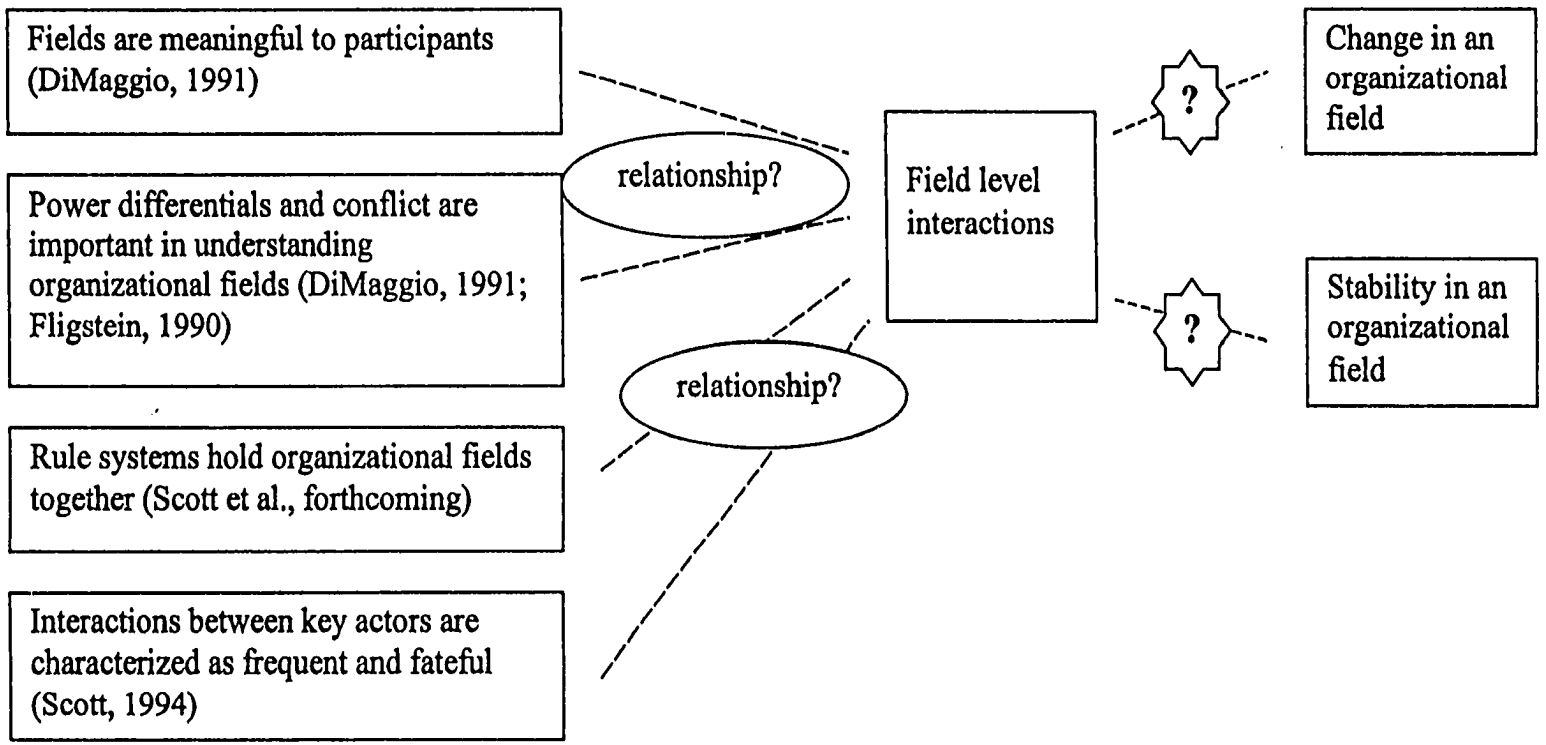
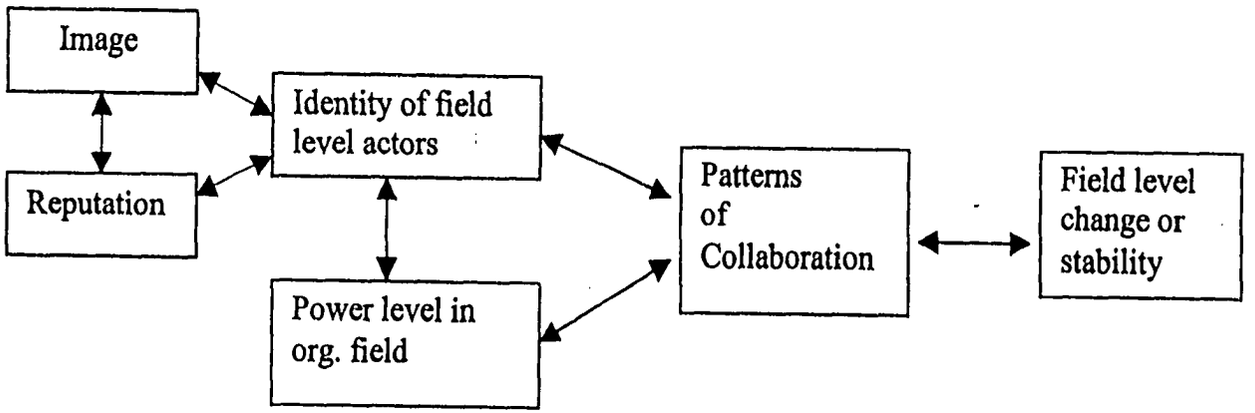


Figure 2.2: Theoretical framework



Chapter 3

Paper 3

Public Policy Change Initiatives: Managing an Organizational Field

In 1994, the Alberta provincial government announced a major restructuring plan for the publicly managed health care system. This plan was fully implemented on schedule by 1995, but four years later, in 1999, continuing unrest within the system prevents the return of stability. Physicians in particular have continued to voice opposition to the restructured system, and have rallied public opinion to back their concerns on several occasions. The Alberta government's health restructuring plan was carefully outlined in a series of three-year business plans and focused on "keeping Albertans healthy", encouraging "individual responsibility for health", and developing "a consumer driven system based on community priorities to form the cornerstone of future health service delivery" (Alberta Health, 1994: 5). Consistent with a more business-like approach to the provision of all government services that is currently popular throughout the western world, strategies for health reform appeared to be based upon developing and evaluating objective measures of health system efficiency and effectiveness. In a climate of public support for cost-cutting initiatives and efficient use of public resources, the government's strategy appeared to be consistent with public expectations and economically sound. Why, then, has the Alberta health care system yet to return to a stable position where key actors work together in the provision of appropriate services?

Health reform initiatives in Alberta have been part of a larger government reform process designed to improve government productivity, reduce expenditures and balance the budget, thus providing citizens with the best possible value for their tax dollars (Government of Alberta, 1994a). Since the rising cost of health care had been an ongoing concern in all Canadian provinces (Angus, Auer, Cloutier, & Albert, 1995), and since health expenditures made up 29% of the total Alberta government budget (Government of Alberta, 1994b), reducing total government expenditures on health services in order to improve efficiency and effectiveness became a high priority within overall reforms. However, health reform was also based upon a desire to refocus the system away from an institutionally based illness model, and instead reorganize to focus on the health needs of Albertans in a system based on wellness. The overall approach to health reform is summed up in the following statement from the government's first business plan for health:

> The current fiscal situation challenges us to identify new ways of doing business that improve the health and well-being of Albertans and, at the same time, are less costly. (Alberta Health, 1994: 3)

The strategic approach underlying these dual reform objectives of refocusing on wellness and reducing overall costs, appears to have been guided by economic principles. That is, principles upon which initial health reform was introduced included many statements based on an economic approach. Examples of such statements are listed below:

> co-operation of health providers and organizations through a consumer driven system based on community priorities will form the cornerstone of future health service delivery;

> health services will be publicly funded subject to what society can afford;
>
> the Department of Health will encourage the use of appropriate services at the least cost by a range of qualified providers;
>
> Funding mechanisms will reward desired behavior of providers and discourage inappropriate, inefficient and ineffective practices;
>
> Disincentives to providing the lowest cost appropriate care will be removed. (Alberta Health, 1994: 5)

These principles, together with others focusing on individual responsibility for health and keeping Albertans healthy, provided general guidelines for reforming the system but have proved difficult to achieve. Cost savings were initially realized since the provincial government simply reduced the overall budget for health services, but achieving sustainable system wide change based on both wellness and consumer need driving the provision of services has been much more difficult.

By focusing on citizens as customers, and by shaping public policy to reward and encourage efficient use of resources, the provision of health services was expected to simulate a free market situation where demand and supply establish an equilibrium point where efficiency is maximized. In the Alberta health reform experience, the system has yet to reach such an equilibrium point. Health care economists (e.g. Evans, 1984) tend to point out market imperfections to explain such problems, and the suggested course of remedial actions is usually based on finding ways to model competition with the public sector.

I suggest that a different approach is required. Although an economics based approach to public policy holds intuitive value and garners a high degree of public

support, I propose that it is only through the use of knowledge from organizational theory that such strategies can be successfully implemented. Public policy makers must recognize the context in which such economics based strategies will be applied, and that their implementation will be done through organizations. Public policies are normally designed to govern the actions of a number of connected organizations. This setting is described in theoretical terms by the concept of an organizational field within institutional theory, and recent research into the process of change in organizational fields may provide useful information for policy makers. By understanding these concepts of change in organizational fields, policy makers may be able to improve their ability to implement economics based change initiatives.

In this paper, I draw on previous research examining the Alberta government's strategic planning process and the way in which change initiatives were implemented in the provincial health system. In particular, I apply theoretical insights gained from my two previous thesis papers, *The Recomposition of an Organizational Field: Health Care in Alberta*, (paper 1) and *Patterns of Collaboration: Interacting Frequently and Fatefully in an Organizational Field* (paper 2), to propose practical implications from my studies that may benefit policy-making in the future. By considering the Alberta health care field as an excellent example of a mature organizational field, I apply theoretical knowledge developed previously (paper 1; paper 2) to the practice of public policy making by viewing the role of policy makers as one of managing an organizational field. Consistent with ideas proposed by Zukin & DiMaggio (1990), I suggest that economic approaches to public policy tend to avoid sufficient consideration of the cultural, structural and political

embeddedness of economic behavior. That is, public policy that relies upon market forces to achieve efficiency and effectiveness may be missing important factors involved in a change process. Particularly in public settings it is critical to incorporate ideas concerning the role of shared collective understandings, social networks and struggles for power in shaping the operation of economic markets (Zukin & DiMaggio, 1990). These concepts of cultural and structural embeddedness are inherently part of organizational field theory. I propose that by considering public policy making as managing a field, economics-based change initiatives can incorporate ideas from field level theory that will improve the ability to achieve sustainable changes and allow a smoother transition from the old to the new.

Therefore, my research question for this paper is: How can organizational field theory, particularly as it applies to the field of health care, assist policy makers in the development and implementation of economics-based public policy strategies? In answering this, I first provide theoretical background concerning the need to incorporate organizational field theories into the development of economics-based public policies. Next I explain my theoretical framework for analysis in this paper, and follow with the case analysis and recommendations for policy makers designing future government led change initiatives. Finally, I provide concluding comments.

Theoretical Background

Current trends in the development of public policy tend to involve a business-like approach where citizens are considered to be customers and central to the provision of services (Pegnato, 1997). Proponents of such an approach argue that by simulating a

private market setting, efficiency in government can be increased and the needs of the electorate best met. But switching to a consumer driven system and implementing incentives to encourage supportive behavior are not easily achieved. Health care economists point to market imperfections such as the inability of health care consumers to accurately evaluate the quality of services provided (Evans, 1984), and thus propose corrective approaches such as attempting to incorporate a sense of competition between various government departments, or educating citizens to make better consumer decisions about health care service consumption. I propose that a different approach is required. Similar to Oliver's (1996) explanations of institutional impediments to market efficiency, I suggest that what is needed to understand difficulties in implementing economics-based public policy is more careful consideration of the key components of the delivery and consumption pattern of services. That is, by recognizing that in many settings, government services are provided by a tightly-connected group of organizations who must work together to accomplish overall goals, policy makers could recognize and address difficulties associated with applying business and market principles to the public service arena. Knowledge that has been gained in the study of organizational fields within organizational theory could be valuable to policy makers in understanding how best to accomplish the provision of high quality services in the most effective way possible.

Organizational fields are a relatively new way of looking at "communities of organizations" that interact closely with each other (Scott, 1994: 207-208). They have also been defined as "those organizations that, in the aggregate, constitute a recognized area of institutional life: key suppliers, resource and product consumers, regulatory

agencies, and other organizations that produce similar services or products" (DiMaggio & Powell, 1983: 63-64). The concept of an organizational field is similar to the idea of an industrial sector, but goes further by including regulatory agencies and consumers, and by focusing on the cognitive connections between actors at the field level. For example, a health care organizational field consists of all providers such as hospitals, home care agencies, physicians, nurses, other health professionals, etc.; consumers of health services (patients and potential patients); government and other regulatory bodies such as professional licensing associations; and competitors of the providers under consideration, including alternative medicine practitioners. In order to understand the implications of attempting to change the focus of such a field to one based on economic principles, it is critical to consider the effect of the tight inter-connections between field level actors that develop over time, become deeply ingrained and taken-for-granted, and are extremely resistant to change.

In general, the value of applying organizational theory to public policy development has been discussed by researchers such as Hall and Quinn (1983) but seldom accomplished. Some have suggested that organizational theory and public policy implementation are parts of such separate worlds that neither can help to inform the other (Ilchman & Uphoff, 1983), but others proposed that both areas may be improved by attempting to understand the effects of public policy through an organizational theory lens as well as examining the effects of particular public policies with a view to advancing organizational theory (McCaffrey, 1983; DiMaggio, 1983). In particular, the increased focus on interorganizational activities and relationships within an institutional approach to

organizational theory appears to be an appropriate connection between the two worlds, since public policy is inherently reliant upon organizations working together to accomplish particular objectives. Consistent with the observation by Baum and Dutton (1996) that "we can learn much about how strategic processes work by taking context more seriously" (1996:1), I propose that by applying concepts related to the organizational field as developed within institutional theory to a particular public policy initiative, it may be possible to increase our understanding of both public policy and institutional theory.

Amburgey, Dacin & Singh (1996) have pointed out the necessity of understanding field level processes in order to evaluate and analyze interfirm activities. Similarly in public sector settings, policies need to be developed with an understanding of how other key actors relate to each other, how they are likely to respond to government initiatives, and the probable impact of this on the field as a whole. It is apparent from previous research in Alberta health reform that government driven structural changes relied upon cognitive changes in other field level actors to accomplish the recomposition of the field and a return to stability (paper 1). Theory derived from studying this recomposition process, as well as lessons learned from the Alberta health care experience, are important in understanding change initiatives within organizational fields. I examine these issues by investigating both the successful portions of the Alberta economics-based change initiative as well as potential reasons for the continuing instability of the field and connect the experiences with organizational field theory. Through this analysis I suggest that it is possible to provide advice to policy makers that will be helpful in future change initiatives.

Theoretical Framework for Analysis

In order to improve public policy makers' ability to plan for and implement change initiatives, an understanding of organizational field theory as previously developed in papers 1 and 2 provides a useful basis. In this section I set out my theoretical framework regarding change at the field level. In particular, I explain the importance of both cognitive and structural change in creating sustainable overall change, and also present concepts concerning the interactions between key field level actors and the effect of these relationships on the field as a whole. That is, I explain how concepts developed in paper 2 concerning the role of actor identity, perceived power level in the field and the nature of the interactions themselves, can impact upon attempts to implement field level change.

First, as developed in paper 1 and indicated in Figure 3.1, my framework for analysis is based upon the need for cognitive changes in key field level actors to support structural changes. Although structural changes may be accomplished relatively easily by powerful actors with significant control over resources, it is much more difficult and time consuming to develop the supporting cognitive changes in key actors. In order for an organizational field to recompose in a newly established state of equilibrium following a major change initiative, key actors must re-establish an understanding that they are involved in a common enterprise. This idea stems directly from DiMaggio's (1983) proposition that as a field undergoes the initial formation or structuration process, it is critical that key actors develop a sense of common endeavour. Similarly in the recomposition of a field, actors must cognitively connect with new field level goals in order for the field to re-establish. In paper 1, I showed how one key actor could

encourage such cognitive change in other actors by maintaining an ongoing sense of interest dissatisfaction with previous field level cognitive views, and by steadfastly proving a capacity for action. These concepts build upon and support ideas proposed by Greenwood and Hinings (1996) concerning change at the organizational level, and contribute to the overall argument concerning the critical nature of cognitive change in the recomposition of a field. When these cognitive changes do not occur in one or more key actors, the field is likely to be characterized by ongoing unrest and instability, which depending upon the nature of the field may be an undesirable result.

[Figure 3.1 about here]

My theoretical framework also includes concepts concerning interactions between key actors within a field, and the role these interactions play in promoting or preventing cognitive changes. Figure 3.2 shows these theoretical relationships as developed in paper 2. I built upon actors' cognitive views and the importance of frequent and fateful interactions between key actors in an organizational field (Scott, 1994), to develop a theoretical framework connecting the identity of key actors together with their perceived power level within the field as a way of explaining how their inter-relationships affect the field as a whole. This relationship, indicated in Figure 3.2, shows that in order for an organizational field to return to stability following a change initiative, key actors' sense of identity and power level within the field must be consistent with the overall field arrangement. The adjustment process may be played out through the established patterns of collaboration. Alternatively, and consistent with a view of field level actors as

purposeful (and possibly subversive), actors may use the patterns of collaboration to resist changes that threaten identity or power level.

[Figure 3.2 about here]

Identity is one important factor related to cognitive change in field level actors. By building upon ideas of organizational identity (Albert & Whetten, 1985), I proposed that the identity of key actors (how they view themselves) must be consistent with field level changes. Otherwise dissension is likely to persist. Since identity is considered to be central, distinctive and enduring, it is an important component to consider in cognitive change for a field level actor. If an actor's sense of identity is inconsistent with proposed field level changes, such an actor is likely to be motivated to resist change. Alternatively, when proposed changes are aligned with actors' established identities, they will more easily alter their cognitive views to support overall changes.

I also proposed that at the field level, actors are likely to be strongly influenced by the views of other actors. Therefore, their sense of identity (how they view themselves) must be seen as a part of an equilibrium that balances with their reputation (how others in the field view them) and their image (how they perceive others view them). Identity, reputation and image may not be equivalent, since a poor reputation may co-exist with one actor's exalted sense of identity. But some relationship between these concepts must be established over time, and changes in reputation or image are likely to result in a changing identity or action to preserve that threatened identity. My framework builds on ideas about identity and image from the organizational level (Dutton & Dukerich, 1991; Dutton, Dukerich & Harquail, 1994; Gioia & Thomas, 1996) and I proposed that identity and

image, together with reputation, exist in an established equilibrium during times of stability, but are easily disrupted during a change initiative. Field level actors are likely to take action to preserve their identity but from a change strategy perspective, the disruption associated with change may also serve as an opportunity to encourage actors to alter their identity in line with a desired field level change initiative.

In addition, but also related to actors' identity, my theoretical framework for analysis emphasizes the importance of power relationships within a field and their effect on field level change initiatives. Power and identity are often closely related, especially in settings where professionals are key actors. A professional sense of identity includes the ability to self-regulate and take control over a particular portion of a field (Freidson, 1993), and may also incorporate the power to control changes at the field level. In terms of taking action at the field level to resist or encourage change, not all actors will be equally able to do so. Actors holding high levels of power will be most successful in resisting change, and when such actors are motivated to oppose field level changes, their actions may result in ongoing disruptions that prevent a return to field level stability. Power levels in a field may be correlated with actors' control over financial resources, but particularly in public sector settings, may also relate to actors' ability to gain public support for their position. Thus the support of powerful actors within a field will likely be critical to the implementation of a sustainable change initiative.

The nature of interactions between key actors in a field becomes established and taken-for-granted over time, but it also appears to be consistent with Scott's (1994) characterization of interactions as frequent and fateful. Therefore, although the way in

which actors interact may be taken-for-granted, the patterns of interaction tend to result in field level events that are important and meaningful. I proposed in paper 2 that the way of interacting could best be described as collaboration (Mintzberg, Jorgensen, Dougherty & Westley, 1996), since actors may appear to be working together toward common field level goals, but at the same time be actively involved in protecting or improving their own field level position. These established patterns of collaboration tend to support the status quo and allow underlying conflict between actors to be played out without resulting in overall change. (See Figure 3.2.) It appears that when field level change is desired, new ways of interacting may need to be developed in order to achieve a sustainable change.

The implications of this theoretical framework for public policy makers can be seen in the following way. Economic theory suggests that market forces will provide the necessary guidance in implementing change. But my research suggests that managing a public policy driven change process is difficult, complicated and time-consuming, and in order to be effective in establishing sustainable changes, public policy must address strategic planning and implementation issues within the context of an organizational field. By thinking of the process of making public policy as one of managing an organizational field, policy makers may be able to improve on an economics-based approach's ability to achieve desired changes. Theory about fields shows that a number of key actors must work together to accomplish particular goals, and that in order to manage a proposed change initiative, one key actor must garner the support of others. In fields where the state plays a major role, it is likely (although not imperative) that the state will be the key actor attempting to manage change. In such situations, developing strategies to accomplish

major change initiatives must take into account the necessity of achieving supporting cognitive changes in other key actors. I propose that by thinking of their role as one of managing an organizational field undergoing a change process, public policy makers will be more successful in achieving the development of supporting cognitive changes that are necessary to achieve sustainable overall change.

In the remainder of the paper I apply this theoretical framework to an analysis of the Alberta government's health reform strategies. I then propose a series of recommendations that integrate knowledge about change in organizational fields. I suggest that by following these recommendations, policy makers could improve their ability to plan and implement a change strategy that includes the return of a stable and reliable health system. The study of this change initiative may improve the ability of others to avoid the lengthy and disruptive instability that characterizes the Alberta experience.

Case Study

In the Canadian health care system, provincial governments hold the responsibility for providing all medically necessary services for all citizens. In 1994, the Alberta government introduced a major public policy initiative designed to fundamentally restructure the health care system as part of overall government restructuring to become more effective and efficient. The motto, "Doing More With Less," was prominent in both health department and overall government documents (Alberta Health, 1994; Government of Alberta, 1994a). Elected government members and top level bureaucrats were supplied with, and expected to read, *Unfinished Business* (Douglas, 1993), an economics based,

business-like approach to public policy based on experiences in New Zealand and centring on deficit reduction.[1] This public policy initiative could be classified as an example of a New Public Management approach as popularized by Osborne and Gaebler (1992). In general, the underlying ideas of such reform are based on finding ways to make government more business-like, and relying upon concepts of consumer demand and measurable outputs to create an increasingly efficient and effective public sector (Aucoin, 1995; Ferlie, Ashburner, Fitzgerald & Pettigrew, 1996).

The Alberta government's approach to public policy reform was implemented in the provincial health department and all other departments through the development of three-year business plans. As well, the health system was restructured through a regionalization process that introduced new field level actors – Regional Health Authorities (RHAs) (paper 1; Philippon & Wasylyshyn, 1996). The *Regional Health Authorities Act*, introduced in March 1994, structurally changed the health care system from one where more than 200 hospital, nursing home and public health boards were responsible for providing services through individual facilities, to one where 17 geographically determined RHAs took over responsibility for almost all services provided within their boundaries. In addition, two health authorities with provincial responsibility for cancer and mental health services, respectively, were established. The first priority for each health authority was to develop a three-year business plan (Alberta Health News

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Government records show the expenditure of $7,184 on a presentation by Sir Roger Douglas and purchase of his book "Unfinished Business" (Legislative Assembly of Alberta, 1996). Conversations with government officials of the time provided information concerning expectations that MLAs and higher level bureaucrats read the book.

Release, 1994), confirming the business-like approach and focus on a consumer driven system that was critical to the government's overall policy.

An important part of the government's strategy for implementing system-wide change hinged upon the direct, forceful, and consistent commitment to change presented by government officials. The newly elected Alberta government in June 1993, held public discussions on health reform in the summer and fall of 1993, issued reports on their interpretation of public opinion in November 1993 (Alberta Health, 1993a), and introduced legislation to restructure the delivery of health care services in March 1994. The legislation was passed by June 1994, and the first members of the newly formed RHAs were announced later the same month. Initial timelines called for RHAs to be fully functioning by March 31, 1995. These targets were met in every instance. Elected government members and Alberta Health officials were unrelenting in their adherence to established dates, and pushed through changes to restructure the system on a regionalized basis (paper 1).

Unlike almost all other parts of the health delivery system, physician services were not brought under the financial control of health authorities. Instead, physicians continued (and still continue) to negotiate a fee schedule directly with the provincial government. They are also directly reimbursed for all medically necessary services provided on a fee-for-service basis. Physicians continue to resist having the budget for their services come under RHA control, and have recently suggested that they will never allow that to occur (AMA, 1999). This separation of physicians from the regionalization process has been a

critical factor in the implementation of the Alberta health change process, and will be discussed in greater detail in the *Case Analysis* section of this paper.

Although the Alberta government followed a strategy of making changes quickly, all at once, and never backing down, the expected result of creating a restructured system focused on a new vision and overall health goals (Alberta Health, 1993b; 1994) has yet to occur. In previous research (paper 1), I have shown how supporting cognitive changes for physicians in particular are not apparent. Instead, physicians continue to raise objections to various aspects of the way in which health services are provided, and through their direct connections to the public, continue their resistance to a health care system based on meeting consumer needs as determined through RHAs – rather than on the advice of physicians. Physicians continue to argue for a system-wide focus on the physician-patient relationship, and instigated a public campaign calling for Albertans to "Tell Us Where It Hurts" (AMA, 1995) so that physicians could represent those concerns to government. As well, the AMA commissioned a survey of physicians to show the difference between their opinion of appropriate waiting times for various medical procedures compared to actual waiting times experienced (Burke & Assoc, 1998). Through these activities and a series of documents sent to the general public (AMA 1998a; 1998b; 1999), physicians continue to indicate their dissatisfaction and also contribute to the ongoing unrest characterizing the health care system.

Case Analysis and Recommendations:

In many ways the overall Alberta health reform initiative can be described as successful in that the system has been restructured, some measures of efficiency have been improved, citizens have been given more control over the provision of health services through local RHAs, and most required medical services are available for Albertans immediately or within a reasonable waiting period. A government survey indicated that 86% of Albertans were satisfied or very satisfied with health care in the province (Alberta Health, 1998). But, the Alberta experience four years after structural changes were made is one of recurrent bouts of discord primarily orchestrated by physicians (e.g. AMA, 1999). This physician dissatisfaction is particularly problematic in a system where it is important to assure continuity of services. Stability in the provision of health services is a critical aspect since people desire assurances that services will be available if and when they need them, and in Alberta it is government's inability to gain physician support for the reform process that has prevented a return to stability.

In implementing change, the Alberta government appeared to follow Douglas' (1993) advice to make changes quickly, make them all at once, and stick steadfastly to the plan. This strategy was designed to minimize organized resistance to change by keeping all stakeholders occupied in dealing with their own situation. That is, with many changes all at once, there was little opportunity for united resistance. Douglas' advice was to ignore any resistance that did occur, and the Alberta government successfully ignored several major public demonstrations against hospital closures. As predicted, the public grew tired of demonstrations, and resistance to restructuring diminished except from physicians.

By considering the Alberta health system as an excellent example of an organizational field, it is possible to examine the government's strategy in a new light. In terms of the theoretical model developed in previous research about change in a field (Figure 3.1), the government was able to steadfastly adhere to proposed timelines, thus developing a recognition of their capacity for action. This appeared to be a significant factor in minimizing the effect of resistance to change. As well, the government consistently reminded the public and other key actors that the old system was not sustainable -- that continually increasing costs could not be sustained in the long run, and that restructuring was the only hope for maintaining a publicly funded health system. This strategy, which I classified as maintaining interest dissatisfaction, is also indicated in Figure 3.1 as an important precursor to developing cognitive changes in key actors that support structural change in an organizational field, and encourage a return to stability.

Maintaining interest dissatisfaction and continually reinforcing their capacity for action appeared to be government strategies designed to overpower other field level actors, giving them no choice but to accept restructuring initiatives. But there is little indication that government strategies were designed with an understanding of how change in a tightly connected organizational field is likely to occur. Some field level actors appear to have undergone cognitive changes that support the government's view of health care and the structural changes, but others (notably physicians) have not. An understanding of the importance of supporting cognitive changes may have helped policy makers to recognize and plan for the difficulty of physicians in accepting field level changes that were contrary to their view of the health system. Other than excluding physician services

budgets from RHA control, there was no apparent plan for gaining physician support. Doctors were initially excluded from RHA board membership[2] and in spite of their lobbying efforts, were unsuccessful in negotiating voting positions (Walker, 1994). They believed their voices fell on deaf ears (Mullen, 1994). In general, the government appeared to stick to the restructuring plan and ignore physician resistance.

This strategy does not appear to have incorporated knowledge concerning the importance of inter-connections between key actors in an organizational field. In particular, the significance of excluding physicians from a leadership role in health reform and the effect of this action in relationship to physicians' sense of identity, does not appear to have been given sufficient attention. As well, physicians' level of power within the field may have been underestimated, especially with regard to their ability to gain public support for their position. Thus, the government strategy appeared to be one of ignoring and excluding the protestations of one particular key field level actor whose strong identity and high level of power within the field should have been given special consideration. By gaining physician support for health reform, much of the ongoing turmoil at the field level may have been avoided.

In addition, the Alberta government did not appear to understand the importance of changing the way in which key actors interact in order to alter the field as a whole. Although key actors other than physicians were required to change their method of interacting through the implementation of RHA boards, physicians continued to interact

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2 All Albertans receiving income from the public health system were ineligible to sit on RHA boards, but physicians are the only group to publicly complain about their exclusion.

directly with the provincial government as they had done in the past. It is not clear how this decision came about. No rationale is given in printed documents by either the government or physicians, but interview data collected for previous research (paper 2) provides varying explanations. Both government and physician interviewees stated that serious consideration was given to including physician funding within RHA budgets, but this idea was abandoned early in the planning process. Some informants suggested that the Alberta Medical Association (AMA) flatly refused to agree to such a change, while others suggested that RHAs were resistant to taking on that responsibility. Whatever the reasoning, physicians continued to interact with other key actors in much the same way as they had previously done, and they have been most resistant to change. Organizational field theory suggests that changing the way in which actors interact is important to achieving a sustainable overall change. Altering the pattern of interaction between physicians and the government may have provided a better opportunity to allow change to occur.

In the remainder of this section, I present and explain five recommendations for policy makers that may serve to reduce the period of unrest during a major change initiative and encourage a return to a dynamic equilibrium for the organizational field. This return to a sense of stability where key actors re-establish a similar cognitive view of the field as a whole is an important stage of a major change strategy. By considering the role of policy makers as one of managing an organizational field, I provide recommendations that are based upon the Alberta health reform experience and field level theory about

change. These recommendations may provide helpful information for policy makers involved in planning for and implementing major economics-based change initiatives.

Recommendations:

Recommendation 1.

In order to return to stability following a change initiative, key field level actor(s) must develop cognitive changes to support the overall change initiatives. Public policies should be designed to encourage the alignment of cognitive changes with structural changes.

In terms of Figure 3.1, the Alberta government approach to reforming health care was to quickly alter the structural components of the field, and then wait for supporting cognitive changes to occur. This strategy appears to have gained at least grudging support from most key actors. Field level actors, except for physicians, appeared to adapt to the government's view of the health care system where wellness became a focus, and patients became more like consumers. The underlying drive toward efficiency and effectiveness through market based principles as presented in yearly government business plans (Alberta Health, 1994; 1995; 1996) has received little criticism from key actors other than physicians. But a return to stability for the system has yet to be achieved, and physicians' recurring public statements of disapproval (e.g. AMA, 1995; 1998a; 1998b; 1999) appear to be key factors in the persisting unrest.

A better understanding of change in organizational fields may have helped policy makers develop a strategy that identified key actors holding a critical position within the

field through their interconnections with other actors, but whose cognitive view of the system was incompatible with intended changes. Once identified, specific policies should be developed to encourage supportive change in those actors. For example, there is no evidence that the Alberta government provided any special encouragement for physicians to adapt their view to one aligned with the new health system goals. Instead, in opposition to physicians' view of a health care system where physicians were leaders, they were allowed very little input into health reform. This government strategy appeared to create a sense of antagonism (Arnold, 1995; Mullen, 1994; Walker, 1994) that continues to persist. Possibly in response to ongoing physician criticisms, later strategies (Alberta Health, 1997; 1998) appear to place more value on health providers' opinions and knowledge in determining the appropriate level and type of services provided. This more recent approach seems to recognize that physicians are a critical actor in the health care field, and that gaining their support is important to achieving sustainable field level changes.

Policies should have been designed to gain at least partial physician support early in the change initiative and then built toward more complete support over time. That is, by allowing physicians to maintain a leadership role in the initial health reform process, they may have been more willing to alter their cognitive view to align with a restructured system based on the maintenance of health rather than the treatment of illness. Such an approach earlier in the reform process may have reduced physician animosity and helped to garner at least their partial support, thus encouraging rather than preventing a return to stability. In other settings, it is important to identify actors least likely to alter their

cognitive view to align with the desired changes. Then, by determining which portions of their established view can be accommodated, and also which portions are most critical for those actors, policies can be designed to incorporate parts of their cognitive view while working toward change in other parts. While a purely economics-based approach to implementation is to make changes and allow the system to adjust through market forces, by incorporating knowledge about the need for key actor cognitive change in organizational fields, policy makers may help to reduce the level and duration of unrest during a major change initiative.

The theoretical framework developed in paper 2 (Figure 3.2), helps to point out factors that may be driving physician actions to resist change in the organizational field. It suggests that the identity and perceived power level of field level actors must support proposed changes in order to support the goal of a changed, stable field. In the Alberta case, physicians did not believe that a changed health care field driven by consumers was consistent with their well established identity. Instead, their identity was based on a sense of leadership and authority for the system as a whole, making the introduction of RHAs who were to take significant control, unacceptable. Physicians foresaw a significant loss of power within the reformed system, and had little incentive to support government restructuring. Following this theoretical framework (figure 3.2), in order to gain physician support, government actions needed to address the inconsistencies between physicians' identity and perceived power level, and the restructured system.

Recommendation 2.

Actor(s) with strong identities require special attention to ensure that the changed nature of the field is consistent with established identity, or that actors alter their identity to fit with the changed field. Public policies should incorporate strategies to either alter the identity of key actor(s) to fit with desired overall changes, or design the changes so that they are compatible with such actor(s)' established identity.

Previous organizational research has pointed out the strong connection between identity, strategy and action of identifiable groups (Ashforth & Mael, 1996). Field level actors are likely to take action in order to protect their established identity (paper 2). Recognition of the importance of identity at the field level provides a rationale for giving special attention to particular actors in a field level change initiative, rather than relying on market forces to re-establish an equilibrium position. For some actors, their identity within the field is of utmost importance, and this appears to be evident in the actions of Alberta physicians. Doctors' sense of identity appears to focus on their designation as critical leaders in the provision of health care services. A shift to focus on wellness rather than illness, and to establish citizens (through RHA boards) rather than physicians as designers of the system, held the potential to drastically change physicians' roles. If a field level actor chooses to withdraw from a field rather than face a forced identity change, the consequences may be great. In the Alberta health case, a number of physicians chose to leave the province and many more threatened similar action. Although the government publicly minimized the effect of doctors leaving (Alberta Health, 1997), a significant exodus could seriously affect the provision of health services.

In order to address inconsistencies between physicians' identity and the restructured system, government strategies need to recognize the strength of identity in motivating action. Ashforth and Mael (1996) proposed this connection, and expanded upon it to provide an understanding of resistance to change based on threats to identity (Ashforth & Mael, 1998). In order to manage identities within a change process, several researchers have provided insights into strategies designed to alter the identity of specific groups within organizations. Gioia and Thomas (1996) showed how the identity of an academic group was changed by undertaking initiatives to first change the group's image, leading to an identity change. Fiol (1999) proposed a strategic intervention for groups within an organization who were essential to the organization's core business, but whose identity no longer matched with the overall mission and vision. She suggested that management implement a process over time whereby the group's current identity is first destroyed, followed immediately by efforts to develop a new identity consistent with the organization's desired future.

Although these examples are both at the organizational level, similar strategies may be effective at the field level, and government may be able to implement policies designed to alter the identity of a particular actor that will then support the overall change initiative. Such strategies may involve the intentional creation of a future image for that actor that is consistent with proposed changes, and that leads to an identity change (Gioia & Thomas, 1996). This could be done through government statements designed to establish a new reputation for an actor (how government views that actor), that the actor will then incorporate into their sense of image (how others view them), and finally develop

consistent changes in identity (how they view themselves). An additional step in this process, similar to the strategic approach proposed by Fiol (1999), is to first make clear through government statements that the actor's current identity is without value under a changed system. That is, government policies could attack and belittle the actor's current identity. In the Alberta case, this would have meant government strategies to devalue physicians' current identity, followed by the creation of an image that aligned with the government's proposed changes.

One caveat of such a strategy is that the government's desired future image must also be attractive to the actor in question. As well, the success of a strategy designed to alter a field level actor's identity is likely to be dependent upon the nature of that actor. In the Alberta health case (and as shown in paper 1), some actors (e.g. registered nurses) saw themselves as advocates for patients in maintaining their health. Government changes required a relatively small change in identity for nurses, since their approach was already very close to one focused on consumers. On the other hand, Alberta physicians may be outside boundaries where identity change is achievable. Under a consumer-driven health care system, physicians may believe that their role would be so significantly changed that the meaning of the profession would also have to change. It is likely that many would choose to leave the system rather than change their identity, and the result of significant numbers of physicians leaving would make the implementation of government change initiatives impossible. Therefore, in a field where key actors with strong identities are critical to the functioning of the field, change strategies must be compatible with those identities in order to achieve sustainable change.

Recommendation 3.

Powerful actors(s) in the field require special attention to ensure that their ability to resist change does not prevent the field from returning to stability after a change initiative. Public policies should be designed to either overpower these actor(s), or else to gain their support.

The overall government strategy in the Alberta experience appears to have been to overpower other key actors by remaining steadfastly committed to announced changes and by designing funding mechanisms to reward desired behavior (Alberta Health, 1994: 5). Actors with relatively low levels of power within the system appeared to accept changes quickly. For example, although there was initial outcry, physiotherapists either left the system or rapidly adjusted to the new remuneration scheme and consumer focus through RHA boards. But physicians have yet to adjust. The Alberta government appeared to understand that physicians were too powerful an adversary to treat the same as all other field level actors, but beyond excluding them from some initiatives, there was little apparent strategy to manage physician resistance to change.

From an organizational field perspective, the government's strategy appeared to rely upon controlling funding relationships between key actors, and seemed to minimize the importance of other connections between them. That is, the government attempted to use its control over financial resources to gain support for change initiatives. But this approach fails to recognize the variability in strength and importance between different actor connections. Not all actors have the ability to influence the actions of others, and

some may be virtually immune to control by others. For example, Alberta physicians appeared to hold sufficient levels of power within the organizational field that they were able to keep their funding source separate from that of RHAs. Doctors were then able to use their tight connection with the public to resist particular initiatives. In the Alberta example, physicians launched a highly successful public campaign designed to garner support for their position from the electorate (AMA, 1995; Arnold, 1995).

Therefore, in cases where particular actors hold levels of power that challenge that of the government, public policy designed to implement change must take this factor into account. Since organizational field level theory suggests that future stability requires supporting changes in the perceived levels of power within the field, actors holding and exercising power levels incommensurate with the reformed system must be given serious consideration. Such powerful actors cannot likely be overpowered, and in cases such as health care where physician services are critical to the provision of services they cannot be eliminated.

The only option remaining is to find a way to gain at least partial support from such actors. This strategy might be achieved by gaining support for some of the change initiatives, while continuing to work toward agreement on others. For example, after initially taking a very hard line approach to controlling physicians, it appears that the Alberta government may have found it necessary to give in on certain issues. The outcome of two separate fee negotiations has been successful for physicians (Arnold, 1995; Agreement, 1998), but the government has steadfastly refused to allow physicians to sit as voting RHA board members, and continues to push ahead with other restructuring

initiatives (Alberta Health, 1997; 1998). In this way, public policy can be seen as designed to gain physician support for some parts of the change process, while accepting physician resistance on other issues. The goal of such policies may be to gradually increase the number of physician supported initiatives while reducing resistance, but the danger of such an overall strategy is that physicians may increase their ability to control overall changes while causing lengthy delays in a system-wide return to stability.

An alternative method of gaining partial support may be public policies designed to gain the support of identifiable groups of physicians, who may benefit from proposed system wide changes. Field level theory points out the importance of being structurally able to act at the field level in order to accomplish strategies (paper 2). If the AMA was unable to represent all physicians at the field level, physicians as actors would hold a much lower level of power within the system. Thus, a strategy on the part of government to gain the support of general practitioners, for example, might weaken physicians as field level actors, and with support from some physicians increase the probability of success for government change initiatives.

Recommendation 4.

Field level actor(s) with both strong identities and high levels of power require specific strategies designed to gain their support for proposed changes. Public policies should be designed with specific strategies for gaining at least partial support from actor(s) with both strong identities and high levels of power.

Although it may be possible for public policy to overcome field level actors with either a strong identity or high levels of power, it is highly unlikely to do so when actors are both powerful and hold a strong identity within the field. This is consistent with organizational field level theory suggesting the strong tie between identity and power levels and the ability to use established patterns of interacting to prevent change (paper 2). This recommendation also arises from the Alberta experience where restructuring changes threatened both the identity and power level of physicians. In moving toward a reformed health care system where objective measures determined the course of action, the Alberta government first attempted to deal with physicians similarly to all other field level actors. It appears to have been recognized early in the planning process that physician remuneration could not be immediately brought under RHA control without creating a very unstable situation. However, having kept physicians financially separated from the rest of the system, there is little evidence that other strategies were designed to gain physician support for system-wide changes.

The Premier of Alberta acknowledged the mistake of antagonizing physicians early in the reform process (Arnold, 1995), but rectifying this appears to be difficult. A better understanding of organizational field theory in designing government strategies for change might have provided impetus to build in special consideration for encouraging physicians to cooperate in restructuring. Strategies about change in health care settings have stressed the importance of involving physicians in all stages of planning and implementation (e.g. Andrews, Cook, Davidson, Schurman, Taylor & Wensel, 1994; Shortell, Gillies, Anderson, Erickson & Mitchell, 1996). An understanding of the relationship between

perceived identity and power levels of field level actors, and the use of collaboration patterns to protect against threats, may help to explain why physician cooperation is critical to success.

Where full cooperation proves to be impossible, partial support for change strategies may enable movement toward overall goals. If identity change is possible, it will require a lengthy period of time, and may occur in professionalized settings only with the ascendency of individuals trained in a different way. Medical schools are currently more focused on prevention of injury and illness and maintenance of health than has previously been the case, and over time, the government's initiatives may become more supportable by physicians in general. In order to gain this partial support, government may need to seek out physicians such as family physicians or those involved in public health, whose identities are more easily adapted to fit with overall government goals. At the same time, since physicians are important to the future of health care in Alberta, the government needs to find a way to restore a sense of leadership and ability to influence the future course of events. Otherwise, the government may continue with its strategy to rely on an economic, consumer based approach to the provision of health services, but create ongoing instability for the entire system.

Recommendation 5.

In order to implement change in an organizational field, established patterns of collaboration may need to be altered. Public policies should attempt to alter the way in which actors interact in order to achieve sustainable field level changes.

Figure 3.2 shows that established patterns of collaboration are closely linked with the maintenance of stability within an organizational field. Field level actors develop taken-for-granted ways of interacting with each other that are developed over time and take into account each actor's sense of identity and level of power within the field. These patterns of collaboration allow minor changes to occur without disrupting the stability of the field as a whole, but they also may prevent change through a public policy initiative to occur. In paper 2, I have shown how field level actors may use established patterns of collaboration to resist change. Since established patterns of collaboration are closely linked with particular outcomes at the field level, unless the patterns can be changed, there is little likelihood of attaining field level change.

The Alberta government created new mechanisms of interacting with all other key actors except physicians. By introducing RHAs as the field level actor controlling the provision of services within their region, the government effectively altered the established patterns of interacting, and it is those actors who appear to have accepted system changes. But by separating out physicians and allowing them to interact with government in the same established way, it has been much more difficult to gain physician support for change. Theory about organizational fields developed earlier (paper 2) and shown in Figure 3.2, places strong emphasis on the interactions between key actors and suggests that by altering the nature of the interactions, the potential for successfully implementing a lasting change initiative will be improved.

The Alberta government should have altered the way in which it interacted with physicians in order to encourage physicians to change. From a change perspective, the

best strategy would have been to move physician funding arrangements to a regional level in order to alter the pattern of fee negotiations and discussions so that the mechanisms of interacting would be different from the established pattern of direct physician-government formal talks. It may not have been possible to give RHAs direct control over funding for physician services since doctors reacted strongly against that, but government could have created a new body at the regional level through which government-physician interactions could occur. This strategy would require the establishment of a new coordinating body at the provincial level to provide continuity between regions, but any alteration of the existing patterns of interaction would encourage more change to occur. By changing the established pattern of interaction between physicians and government to a regional level, physicians would have been incorporated more strongly into the regionalized system and would have been more likely to alter their established cognitive views, and thus encourage a more rapid return to stability in the health system.

Conclusions:

In this paper, I have shown that an understanding of concepts from organizational field studies can provide an improved approach to implementing economics based approaches to public policy. That is, consistent with an overall emphasis on the need to consider the context or embeddedness in which strategical approaches are planned and applied (Amburgey et al., 1996; Baum & Dutton, 1996; Oliver, 1996; 1997; Zukin & DiMaggio, 1990), this paper points out the dangers of following an economics based strategy without making modifications to suit the actors involved. It also provides

recommendations that may help to avoid such problems. By framing the overall approach to change through public policy initiatives as one of managing an organizational field, it is possible to consider the implementation consequences before they occur, include knowledge about the role of particular actors, and develop appropriate strategies. In particular, by focusing on the importance of inter-connections between key actors in an organizational field, it may be possible to initiate field level changes and achieve a relatively speedy return to stability. This focus on relationships between key actors is reliant upon a view of organizational fields where powerful actors have the ability to act purposefully (Fligstein, 1990; Greenwood & Hinings, 1996; Hirsch & Lounsbury, 1997) and where actors are primarily connected through their interest and cognitive view of a particular set of issues (Hoffman, 1999). In this paper, I have attempted to build upon concepts of change in these types of organizational fields to improve public policy makers' ability to manage large scale change processes.

Based on current theoretical ideas about organizational fields, I believe that recommendations developed in this paper are applicable to other tightly-coupled fields where a rapid return to stability following change initiatives is important. This is likely to be the case in public sector areas, particularly where government provides some type of ongoing services for citizens. But so far there has been very little research into change initiatives within organizational fields, and more studies in other settings are needed to improve our understanding. Powell (1996) has cautioned against the use of theoretical concepts without sufficient understanding, and consistent with this warning, it is important

to gather reports of various case studies in order to improve the potential for successful initiatives.

The Alberta experience in health reform shows the importance of the initial approach in setting the stage for a change initiative. In this case study, the government's initial strategy was based on restructuring the system quickly, steadfastly adhering to the changes, and relying upon market forces of supply and demand to refocus health care on the consumer (citizen) resulting in an efficient and cost-effective system. As part of the strategy, physicians were financially excluded from restructuring and not allowed to take a leadership role in health reform. I have shown in this paper how a better understanding of change in organizational fields may have helped to point out the need to give special attention to some actors -- particularly those with both a strong identity that is inconsistent with strategic goals, and a high level of power within the field. Physicians were this type of actor in the Alberta case. Although the government appears to be changing its approach slightly by acknowledging that health system evaluations from providers (physicians as well as other health professionals) may be valuable (Alberta Health, 1997: 13), more efforts to gain their support at the beginning of restructuring may have alleviated some of the instability that continues to characterize the system. Once antagonized, the physicians remain leery of supporting the reform process.

The Alberta government adhered to strict timelines in implementing changes, and the way in which time was incorporated into strategic planning may be an interesting issue for further research. Since governments are always concerned with the election cycle, public policy is almost always constrained by a three or four year planning timeline. One

of the strengths of the Alberta health reform process has been the development of strategic plans with short term goals connecting to longer term goals that extend beyond the electoral cycle. In this way, the government has been able to plan beyond the normal life span of an elected body, while keeping the electorate satisfied between elections. More research in organizational theory that is developed with specific attention to issues of time and timing may be of increasing value to public policy makers. As well, it may help to develop a more central role for organizational theory in strategic planning, and begin to counteract criticisms that reflect the difficulty in presenting such research in a useful format (Vaughan & Buss, 1998). This paper was designed to provide practical applications from organizational theory for public policy makers. More efforts in this regard may help to implement sustainable change initiatives in complex public sector settings.

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Figure 3.1: Theoretical framework (Paper 1)

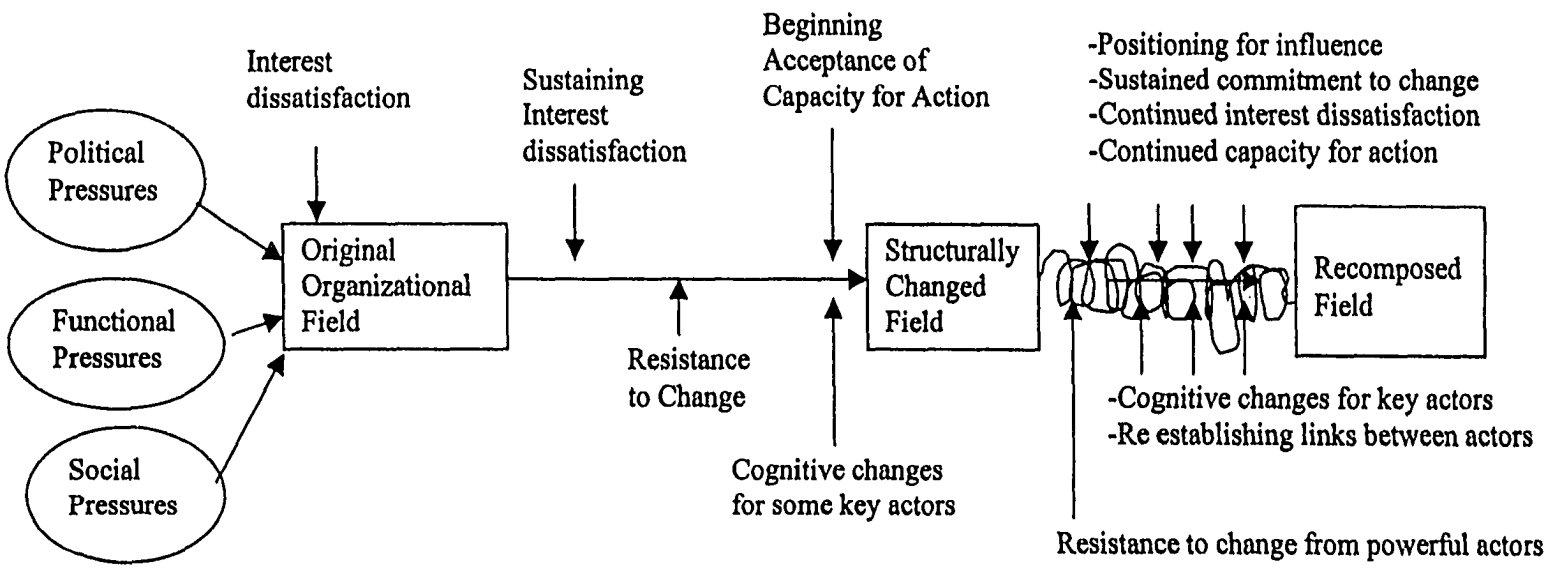
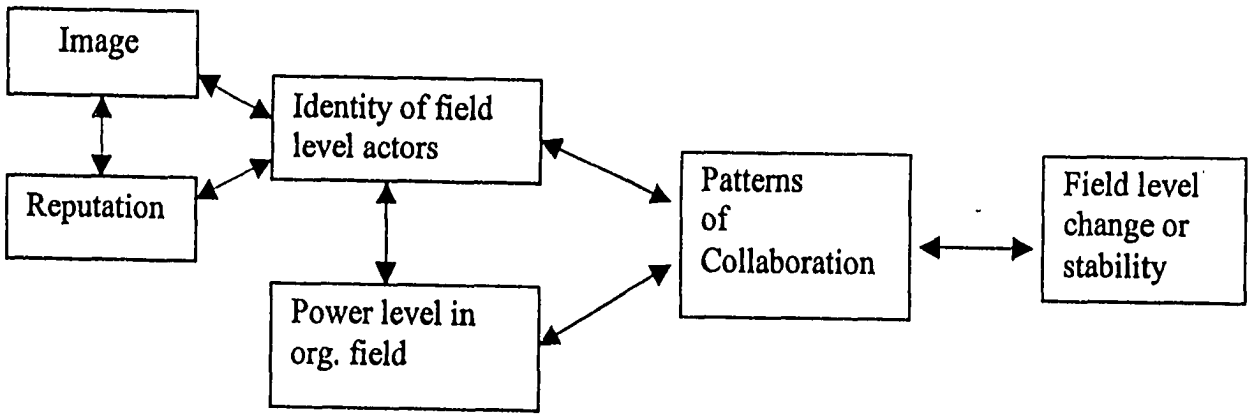


Figure 3.2: Theoretical framework (Paper 2)



Conclusions

In this thesis, I have used a case study of health reform in Alberta to develop two theoretical frameworks concerning change in organizational fields, and then translated these theoretical findings to the development of recommendations for policy makers involved in planning and implementing major change initiatives. Each of the three papers is aimed at increasing our understanding of change in an organizational field, and relies upon the analysis of qualitative longitudinal data concerning the process of health care restructuring in Alberta. In particular, by focusing these analyses at the level of field actor interactions, I have taken a new approach to understanding how change occurs by bringing in issues that have been missing from organizational field theory -- actor interest, action and politics.

Considered together, these three papers that constitute my dissertation contribute to increasing our overall knowledge about organizational fields because they build upon established theory in an attempt to better understand change at the field level. That is, where the past literature has focused on stability of organizational fields and the process by which fields become established over time, I sought to understand how change can occur in a mature, established field. The theoretical frameworks developed in each of papers 1 and 2 work toward a better understanding of such change. In paper 1, I developed a framework to explain change from a macro, field level perspective and found that for a field to recompose in a new, relatively stable form, field level actors must develop supporting cognitive changes. While powerful actors may be able to implement

structural changes in the field, these will be insufficient to develop an overall sustainable recomposition of a field because the lack of support from other key actors can create sufficient unrest to prevent the return to stability.

In paper 2, I focused on these cognitive changes in key actors in order to investigate how such changes did or did not occur during a major change initiative. Through this analytical process, important characteristics about key actors emerged as critical issues in the development of cognitive changes. I propose in the theoretical framework from paper 2, that key actors' sense of identity and perceived level of power within the organizational field are critical factors in understanding cognitive change, and that both of these factors will provide rationale for field level actors in interacting with each other. The way in which actors interact becomes taken-for-granted and institutionalized within a field over time, and actors may choose to use these patterns to suit their own purposes. This theoretical basis of understanding field level change has so far been missing from the organizational literature. By delving deeper into the underpinnings of an organizational field, and in particular by focusing on the connections between field level actors, there appears to be a wealth of information that may increase our general understanding of the field itself.

In my study of organizational field level change, implications for policy makers involved in major change initiatives became apparent, and I have expanded upon those ideas of applicability in my third thesis paper. By thinking of policy making as attempting to manage an organizational field, I showed how the theoretical frameworks from papers 1 and 2 provided recommendations for planning and implementing field level changes. The

current policy planning focus on economics-based initiatives has moved away from consideration of individual stakeholders and toward market based solutions. The consequences of such economics-based approaches begin to show up in difficulties experienced in achieving a return to equilibrium following a change initiative, and organizational field theory provides some insights into why this occurs. Therefore, in the third paper I move from theoretical ideas about change in organizational fields to recommendations that policy makers may be able to incorporate into their strategies. I suggest that in order to encourage the return of equilibrium or stability, policy makers should identify key actors who are critical to the field but whose cognitive views of the system are least likely to change in accordance with desired changes, and develop specific strategies to gain at least their partial support. In general, actors must be either overpowered or convinced to support system-wide change initiatives if a return to field level stability is desired. Particularly for actors with strong identities and high levels of power, policy makers should engage in strategies designed to gain at least partial support -- possibly by identifying some segment more likely to change and encouraging that support.

I have attempted to present both theory and applications together within this thesis in order to point out the importance of connecting the two. Hall and Quinn (1983) elaborated upon the potential advantages of connecting organizational theory with public policy. They stated:

> organizational theory has been scarcely utilized by policy makers and implementers. It would probably be fair to say that policy makers and implementers are unaware that a field of organizational theory even exists.

> There may be some indirect awareness through exposure to undergraduate and graduate-level courses or popular treatises on the subject, but by and large, organizational theorists have been talking to themselves. (1983: 18)

There is still little evidence of organizational theorists attempting to talk to policy makers, and it is my goal in the third paper to attempt that process. Responding to concerns by Vaughn and Buss (1998), I have tried to present theoretical findings in a potentially useful format for policy makers, and hope to establish a basis for conversation between organizational field theorists and policy makers. It is my belief that if such a conversation gets started, it may be possible to improve not only the planning and implementation of public policy, but also through the feedback process to increase the depth of understanding at a theoretical level. That is, by finding ways for theory and practice to inform one another in the area of public policy, both may be substantially improved.

Both theoretical frameworks developed in this thesis are based on the analysis of longitudinal qualitative data. This research approach was critical to gaining an understanding of a change process that transpired over a relatively lengthy period of time, involved many identifiable actors, and where the context in which change occurred was important to the overall research questions. I was interested in how change occurred, and it was only through the collection and analysis of qualitative data that I was able to develop theoretical frameworks to help explain the process. The health care setting that I studied is one characterized by a wealth of publicly available information representing the perspectives of most actors, and this collection of archival data formed the foundation of my research. As well as providing an accurate record of events occurring during Alberta health reform, this archival data also gave insight into field level actors' interpretations and

cognitive views of the change process over time. Both Hodder (1996) and Forster (1994) have discussed the value of using archival data in qualitative research, but so far there are few examples in the literature. This research shows the value in using such documentation and may help to establish a recognized model for qualitative researchers interested in longitudinal studies.

Each of my three thesis papers contributes to increasing our overall knowledge of change in organizational fields. In the following paragraphs I give a short description of the more specific contribution I believe each of the papers make.

In paper 1, *The Recomposition of an Organizational Field: Health Reform in Alberta*, I showed the importance of cognitive changes in key actors to support structural changes in the recomposition of an organizational field. By using the health reform process in Alberta as an example of a major change initiative in an organizational field, I drew upon established theory about fields combined with an analysis of Alberta health reforms to better understand field level change. Previous literature concerning organizational fields tended to present them as tightly connected groups of organizations that became more closely entwined over time and developed increasing stability through institutional processes (DiMaggio & Powell, 1983; DiMaggio, 1991; Scott, 1994). Only a few studies have previously examined field level change in a mature, established organizational field, and those have tended to focus on structural changes (e.g. Leblebici, Salancik, Copay & King, 1991) or cognitive changes (e.g. Hoffman, 1997), but have not considered both. In paper 1, I showed the importance of considering both types of change, and from a change management approach that although structural changes may be

imposed upon actors within a field, they must develop appropriate and supporting cognitive changes for the field to recompose in a new form of stability. More investigations into field level changes in different settings are needed to increase our understanding of both cognitive and structural changes in various contexts. This study provides a starting point, and comparisons of it with other examples will likely provide greater insights into the process of field level change.

In my second paper I investigate the idea of cognitive changes in key actors in more depth. Based on a view that connections between key actors within a field are critical to the field itself, I focused on the way in which field level actors interact. That is, since I had identified the need for cognitive changes in the recomposition of a field, I wanted to examine how such cognitive changes did or did not occur. I analyzed qualitative data from both archival and interview sources in order to gain an understanding of this process over time, and since there is no previous research that investigates field level interactions, developed a theoretical framework based on organizational level studies. I began with Scott's idea of frequent and fateful interactions between key actors in an organizational field and incorporated concepts of organizational identity, image, reputation and perceived level of power within the field (Dutton & Dukerich, 1991; Dutton, Dukerich & Harquail, 1994; Gioia & Thomas, 1996) with concepts concerning organizational collaboration (Mintzberg, Jorgensen, Dougherty & Westley, 1996) to help understand the relationships between field level actors. I developed a theoretical framework that helps to understand how actors' perceptions of their identity (in relationship to image and reputation) and power level within an organizational field impact

through their patterns of collaboration with other actors to support or resist field level change. In this model, identity of key actors (how they view themselves) is a defining characteristic and highly resistant to change. Thus, it will be very difficult for actors to alter their identity in order to develop cognitive changes supporting a major field level change initiative. Instead, it is most likely that key actors with strong identities and relatively high levels of power within the field, will be motivated and able to resist change initiatives, and may even be able to delay the field returning to a state of stability.

The framework developed in paper 2 also points out the importance of patterns of interaction between field level actors that develop over time. I proposed that these are best thought of as patterns of collaboration, since actors interact with each other in ways that meet their own interests but also fit with overall field level goals. This conceptualization of interactions provides a basis for understanding how latent (or obvious) conflict between actors may co-exist with field level stability. That is, patterns of collaboration that develop over time serve as a type of buffer for the field as a whole, allowing varying levels of conflict between actors to exist and then become dissipated through institutionalized methods of interacting. This conceptual approach to reconciling underlying conflict with field level stability may provide one way of incorporating politics and action in institutional approaches to organizational studies, and helps to address calls for more consideration of action in institutional theory (Greenwood & Hinings, 1996; Hirsch & Lounsbury, 1997).

The contribution of paper 3 is its development of recommendations for policy makers based on theoretical frameworks from the first two papers. It provides suggestions

based on policy makers considering their task as one of managing an organizational field, and by thinking of themselves as managers in this sense, policy makers can develop strategies that will anticipate and prevent at least some resistance to change by key actors. I propose that in some circumstances, particularly when powerful field level actors hold strong identities that conflict with overall desired changes, that policy makers develop ways to gain at least partial support from those actors. By looking at the development of public policy in this way, it becomes important to evaluate the potential of key actors within the field to develop appropriate cognitive changes, and then develop policy to either overpower them or gain their support. This paper helps to bring a new perspective to public policy development by showing how strategy based on organizational field theories could be developed to improve the potential for success in government led change initiatives.

Several issues for further research arose through the writing of these three papers. First, the concepts of identity, image and reputation for field level actors appeared to be important in the Alberta health example and hold promise as a basis for understanding actors' actions. However, these ideas need to be developed in more depth through the analysis of other organizational fields. Since actors are tightly connected within a field, how they view themselves (identity) is likely influenced by how others view them (reputation), and by how they perceive that others view them (image). Based on my research, I have suggested that a type of equilibrium exists between identity, reputation and image, and further investigations in other settings may provide additional information that contributes to our overall understanding. In particular, I proposed that the equilibrium

between identity, reputation and image may be easily disrupted during change initiatives because, for example, changes in one actor may influence the reputation and image of another. Therefore, future studies that investigate identity, reputation and image during times of change may provide both interesting and valuable information.

Second, I have applied organizational field theory to public policy development, but I believe that more efforts in this regard are required. The bulk of research in organizational fields has been in public or quasi-public settings (e.g. DiMaggio, 1991; Oakes, Townley & Cooper, 1998) where governance mechanisms by the state are a critical characteristic. It seems logical that research into such settings should result in useful information available to policy makers, but so far that has not been the case. The concept of an organizational field makes particular sense in the public sector where governments provide services to citizens through organizations. Sometimes service provision is contracted out, and sometimes government departments provide services directly, but in either situation, public policy makers are faced with the same task of developing legislative controls that govern the methods of provision. Already developed theory about organizational fields could be valuable to policy makers, but needs to be translated in a way that makes it understandable and useful. As policy makers implement these applications, knowledge gained will help to improve our theoretical understanding of fields, and the cycle can be continued to inform future strategies.

And finally, further research is needed that incorporates politics, action and interest into studies based on an institutional theory approach. I have shown how actors may interact with each other in order to achieve their own goals, and that politics between

actors may be consistent with field level stability. More studies in other settings that focus on field level interactions may help to increase our understanding of political action and its relationship to field level change or stability.

Change in organizational fields is an important issue for organizational researchers to understand. As organizations interact more frequently with one another, and as they increasingly work together in communities pursuing common goals, the concept of an organizational field becomes more critical in understanding organizations. Issues of change are also increasingly prevalent in today's organizational world, and therefore research into how change occurs in organizational fields holds great relevance for organizational theory and practice. It is in this area that I hope my dissertation research can contribute.

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