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Institutional logic relationships and sustainable change in healthcare: a systematic review of the literature

Nicola Mountford[a] and Yuzhuo Cai[b,c]

[a]School of Business, Maynooth University, Maynooth, Ireland; [b]Department of Education Policy and Leadership & Global Research Institute for Finnish, European, and Global South Education (GRIFE), The Education University of Hong Kong, Hong Kong, SAR China; [c]Faculty of Management and Business, Tampere University, Tampere, Finland

ABSTRACT

Institutional logics are an important conceptual tool when designing and navigating public sector change. Our systematic review discovers how institutional logics clash or combine during healthcare change efforts. We identify logics that are more, or less compatible with each other and offer a framework that map logic relationships. We offer a typology of relationships between institutional logics: independent (constellations, loose coupling), interdependent (rebalancing, hybridization) and co-dependent (dominance, co-optation). We go beyond previous conceptions of logic relationships to characterize these relationship types, identify associated risks, and suggest that successful logic relationships includes clear boundaries, reciprocity, and a balance of power and control.

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Introduction

Public administration has been buffeted by the introduction of new institutional orders – from the welfare state to marketization; New Public Management to citizen co-production (Torfing et al. 2020). The logics that underpin these institutional orders bound how public servants, policymakers, and citizens think and act. They set out a perception of what is valued under that regime. Where invading market or corporate logics fail to co-exist with preceding incumbent logics such as those of state, profession or community, public sector change efforts are likely to be characterized by

CONTACT Nicola Mountford nicola.mountford@mu.ie
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conflict, failure, or unsustainability (see for example, Reay and Hinings 2005; Thornton 2002; Townley 2002). These institutional logics are, therefore, vital to the success of change efforts within the public sector and offer a valuable conceptual tool for those who seek to study such contexts. A sustainable system is balanced and resilient with the capacity to endure and thrive over the long term while maintaining the well-being of current and future generations (Giovannoni and Fabietti 2013). If we do not understand the relationships between the institutional logics underpinning a particular change effort, then we are unlikely to foster and manage the pluralism of logics necessary for sustainable modern public services.

Given institutional logics' role as the 'material practices and symbolic constructions' of major societal institutional orders (Friedland and Robert Alford 1991), they have become an accepted theoretical tool in the arsenal of those who study often institutionalized public sector contexts. Owen-Smith and Powell (2008) describe logics as 'the constellation of beliefs and associated practices (the schemas and scripts) that a field's participants hold in common' constituting both organizing principles and recipes for action (pp. 600). These logics affect the relationship between collective and private interests, between the state and its citizens. They therefore go right to the heart of the nature and organization of public administration (Wood and Wright 2015).

While the literature clearly articulates the importance of institutional logics and their ability to make or break public sector change efforts, notable research gaps remain. First, public administration research using an institutional logics lens has tended to focus on how professionals or policymakers navigate institutional change (Vivier et al. 2024). This focus on the actor level may fail to appreciate that it is often how logics relate at field level that shapes the context in which actors must operate. Second, although organization studies literature has outlined various types of relationships between institutional logics such as constellations (Goodrick and Reay 2011), hybrid logics (Battilana and Dorado 2010), dominant logics (Rao, Monin, and Durand 2003), loose coupling (Pache and Santos 2013), and rebalancing (Dunn and Jones 2010), there is no systematization of these types of relationships that allows us to typify how particular logics might relate in particular contexts. Finally, we lack an integration of these two elements, navigating institutional change in the context of inter-logic relationships, across public administration and organization studies literatures.

To address this, we conducted a systematic review of research on institutional logics within the healthcare field. Healthcare was chosen as it is a field that has widely used institutional logics approaches in the study of change (Cai and Mountford 2022; Mountford and Cai 2023). Healthcare is also acknowledged to be institutionally complex, having 'experienced tremendous changes in its institutional structure in recent decades, incorporating

new and varied organizational actors and responding to different rules and logics' (Galvin 2002, 674). This complexity stems from the constant destabilization wrought by regulatory complexity, the pluralistic nature of many healthcare organizations, and the 'intricate relationships between professionals and other actors with various backgrounds, institutional logics, needs and views of the future' (Alalääkkölä et al. 2025, 1). Multi-faceted pressures including globalization and financialization, changing demographics, budget constraints, and rising health tourism all add to the pressure-cooker nature of the healthcare institutional environment (Currie and Seddon 2022). Indeed, Gibeau et al. (2020) find the context of health care to be 'an ideal setting to study the presence of competing institutional logics' (pp. 466). Most importantly, healthcare change affects large populations while posing formidable challenges for public administration (Liu and Duarte 2023).

Accordingly, the research questions of this review were finalized as follows:

(1) What institutional logics feature in empirical studies of healthcare contexts?
(2) What types of relationships are there between institutional logics in such contexts?
(3) How can a typology of logic relationships help us to achieve sustainable change in healthcare?

By synthesizing the institutional logics found in the healthcare studies, we identified institutional logics that mapped directly onto the seven classic logics, as well as new and hybrid logics. We then mapped these different types of institutional logics in healthcare – identifying those logics that are more and less compatible with each other across the healthcare field. We go on to offer a typology of relationships between institutional logics: independent (constellations, loose coupling), interdependent (rebalancing, hybridization) and co-dependent (dominance, co-optation). We highlight the risks and benefits of each type. We extend the institutional logics literature by moving beyond the centrality – compatibility matrix proposed by Besharov and Smith (2014). While their framework offers a foundational understanding of when institutional complexity becomes problematic, it does not explicitly categorize the *types of relationships* logics may have in practice. Our typology complements this by introducing a relational dimension that characterizes *how* logics interact – symbolically, functionally, and politically – across healthcare contexts.

Our paper takes a global approach. We understand that, across the globe, different countries are building their healthcare systems on different institutional foundations. We do not, therefore, claim to map

correctly any one geographically-bound healthcare field. Rather, we aim to develop a generalizable framework for theorizing institutional logic relationships and offer a prescription for successful logic relationships that can create an environment for sustainable field-level change in healthcare. While our framework is grounded in global empirical evidence, its application requires local contextualization, acknowledging the historically and institutionally embedded nature of healthcare systems. Specifically, the prescription we offer should therefore be understood as heuristic tools to support locally grounded sensemaking, rather than as universally applicable solutions.

Theoretical background

Definition of institutional logics

Institutional logics are linked to each of the major societal institutional orders, where logics act as both 'material practices and symbolic constructions', and a 'set of organizing principles' that are 'symbolically grounded, organizationally structured, politically defended, and technically and materially constrained' (Friedland and Robert Alford 1991, 248). Institutional orders are cornerstone subsystems that are both the cultural symbols and material practices that govern recognized areas of social life. They precondition how actors make sense of their environment (Thornton, Ocasio, and Lounsbury 2012).

This set of organizing principles is referred to as institutional logics. So, for example, the accumulation and commodification of human activity as the logic of capitalism, or rationalization and regulation of human activity by legal and bureaucratic hierarchies as the logic of state. Thornton and colleagues applied institutional logics to account for the complexity of institutional changes in an institutional system (Thornton and Ocasio 1999; Thornton, Ocasio, and Lounsbury 2012). They defined institutional logics as 'the socially constructed, historical patterns of material practices, assumptions, values, beliefs, and rules by which individuals produce and reproduce their material subsistence, organize time and space, and provide meaning to their social reality' (Thornton and Ocasio 1999, 804). In other words, 'institutional logics are the shared conceptual and normative frameworks that provide guidelines for the behaviour of field participants' (Scott et al. 2017, 8). Thornton (2004) extended Friedland and Robert Alford (1991)'s five logics to six institutional logics, adding two and dropping 'democracy' – the state, the market, the family, religion, the professions and the corporation. Thornton, Ocasio, and Lounsbury (2012) added one more logic – community. These seven institutional logics embody the classic formulation of

logics, each of which is tightly coupled to a small number of clearly identified societal institutions.

The impact of a prevailing logic becomes clear as we realize that any community's stance on an issue is informed by its own broader worldview (Haas 1992). Power and institutional logics are inextricably linked as logics define the rules of the game by which executive power is gained, maintained, and lost (Thornton and Ocasio 1999). Institutional logics can therefore help to explain how political struggles affect meaning systems and socio-economic processes, for example, de-institutionalization or industry emergence (Lounsbury, Ventresca, and Hirsch 2003).

While our use of the term logics is grounded in the institutional logics tradition (Friedland and Alford, 1991; Thornton, Ocasio, and Lounsbury 2012), we recognize that public management research has also hosted an influential stream of work, e.g. on value creation in public services, particularly the development from a public service – dominant logic to a public service logic (Osborne 2018; Osborne, Radnor, and Nasi 2013). These contributions conceptualize normative models of how value is created and co-created in public service systems and ecosystems, typically at organizational or inter-organizational level. Institutional logics, in contrast, refer to broader, historically embedded belief systems and material practices that structure fields and shape what actors consider legitimate, desirable and possible. The two conversations are therefore analytically distinct but overlapping: value creation arrangements in public services can be interpreted as particular configurations or expressions of underlying institutional logics (for example, specific combinations of state, market, profession and community logics). In this paper, we use institutional logics strictly in this latter sense, while acknowledging these related debates and their shared concern with value creation in public services.

Institutional logics in the healthcare system

While religion and family logics make limited appearances in the healthcare literature, profession, state, market, corporation, and community logics all appear with relative regularity (Mountford and Cai 2023). Healthcare is an arena 'long noted for the dominance of professionals' (Dacin, Goodstein, and Richard Scott 2002). Indeed, healthcare has its own instantiation of a *professional* logic in the form of a 'medical professionalism logic' that prioritizes care and clinical judgement (Batista et al. 2016) and draws heavily on identity-based associations (Galvin 2002). The turn of the 20th century saw a move in healthcare (Christensen and Gregory 2008), as in wider public administration (Weber 2019), towards bureaucratic and professionalized healthcare provision. To a greater or lesser extent, each of these paradigms also involved the institutionalization of a *state* logic in healthcare.

Bureaucratic paradigms involved national and local governments putting in place rules and hierarchies of authority within the healthcare field of that territory (see, for example, Christensen and Gregory's (2008) description of Bismarck's implementation of Germany's Health Insurance Act of 1883). Often, the securing of hierarchies of authority in healthcare also involved government putting the healthcare profession's status on a formal footing where states directly regulate (and often employ) the profession (see, for example, Abbott's (1988) discussion of France's organization and employ of the healthcare profession). Bureaucracy was accompanied by a 'welfare orientation' as healthcare professionals believed, and acted on the belief, that treatment trumped cost per-case and the health of the patient was more important than the financial health of the providing organization (Bode, Lange, and Märker 2017).

Increasingly, however, healthcare represents a complex institutional system containing plural and contesting institutional logics (Bastedo 2009). 'New statism' saw the State logic somewhat diluted in many territories as states delegated 'key state functions to private players but retaining active financial support' (Wood and Wright 2015). *Market* logics emphasized 'rational economic motives' (den Broek, Judith, and Paauwe 2014, 11) and patient-centred organizing (Oygarden et al. 2019). New regulatory modes such as contractual arrangements, standards, rankings and monitoring frames shaped by market logics diffused market principles (Djelic and Sahlin-Andersson 2006). Indeed, since the late 1970s, a 'culture of markets' has been fostered – with markets seen as more efficient in allocating most, if not all, goods and resources (Djelic 2012). The market became a taken-for-granted solution to a large set of problems from a great variety of domains (Ahrne, Aspers, and Brunsson 2015), leading providers to focus on "'micro-economic fitness' even as service users are invited to behave like 'consumers'" (Bode, Lange, and Märker 2017, 503). New Public Management layered these market and *corporation* institutional logics onto healthcare's pre-existing state and profession logics – sometimes less successfully than others. The corporation logic took the form of 'business-like' healthcare (Kitchener 2002) and ushered in 'practices traditionally found in the corporate sector' (den Broek, Judith, and Paauwe 2014, 11).

More recently, however, a new paradigm of 'Digital Era Governance' merges a market-type focus on efficiency with the belief that digital technologies 'may also help to reintegrate fragmented public and private service-delivery agencies, provide more holistic service to citizens and enhance democratic participation and public deliberation' (Torfing et al. 2020, pp. 14). The Internet, digitalization, AI, big data, and algorithms are all influencing healthcare professionals' work 'for example, when medical decisions are supported by algorithms or when medical doctors are replaced by computers and robots' (Noordegraaf 2020, 209). The market logics that accompany digital health

interventions (based on the belief that markets will more efficiently allocate scarce resources) therefore compete with a professional logic that defends healthcare professionals' decision-making and gate-keeping role (Mountford 2019). Digital Era governance also opens the door to a *community* logic, supported by technology, that seeks democratic participation in the design and delivery of healthcare (Moses and Sharma 2020; Mountford and Geiger 2024). This builds on the state logic that underpins principles of universality manifest in what Forbes (2012) terms an NHS logic.

A more recent swing towards an emphasis on patient welfare within healthcare introduces yet further institutional complexity into the healthcare field (Waldorff and Madsen 2023) as this community logic is in the ascendancy, sitting ever more equally alongside profession, state and market logics. This reflects a New Public Governance paradigm (Osborne 2010) that relies on collaborative approaches that require greater empowerment of patients and citizens, as well as increased transparency and trust amongst public and professional actors (Torfing et al. 2020). Citizen involvement in healthcare is rooted in an ideology of democracy but a logic of community, and sometimes the (labour) market, where citizens with lived experience as service users are paid for their perspectives (Andreassen 2018).

From the classic institutional dominance of public governance paradigms such as bureaucracy and the profession; we have, therefore, moved through New Public Management to a current contestation or constellation of paradigms such as Digital Era Governance and New Public Governance amongst others (Torfing et al. 2020). The result is a layering of institutional logics over time as illustrated in Figure 1 . This is illustrated by Bode, Lange, and Märker (2017) in German hospitals where traditional 'welfare' (or state universalism)

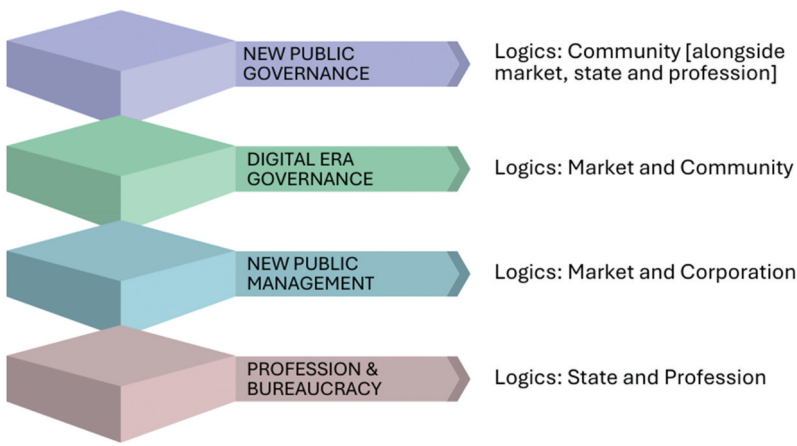


Figure 1. Institutional logic layers in healthcare mapped to public governance paradigms.

and profession logics are joined by a market logic that condemns major decision-makers to complexity and associated ambivalence. We do not suggest, therefore, that one era replaces previous logics with its own, but rather that the logics build over time with some becoming stronger through repetition whiles others become somewhat muted or diluted beneath additional layers.

Healthcare professionals now must draw on multiple facets of their identity to meet the requirements imposed by professional, community, managerial, market, bureaucratic and democratic logics (Ewert 2020). Identity not only shapes internal group dynamics (as seen in Fiol, Pratt and O'Connor (2009, 37) notion of 'decoupled intergroup identities') but also mediates external tensions arising from competing governance frameworks – a core concern in institutional theory. Ewert (2020)'s concept of multifaceted identities highlights how professionals embody multiple, nested logics and Noordegraaf (2020) furthers this by emphasizing identity's role in legitimizing professional action through dynamic relationships with clients and stakeholders. Collectively, these works show how identity can reconcile ambiguity, mediate external pressures, and integrate cultural, strategic, and structural perspectives, reinforcing its value as a rich conceptual lens for understanding organizational continuity and change.

The importance of institutional logics in change is well established, and the proliferation of institutional logics in public administration areas such as healthcare is widely acknowledged. Indeed, previous systematic reviews have focused in on *particular aspects of healthcare*, such as Akmal et al'.s (2020) review of logics in lean implementation in healthcare or Roth's (2025) eight-paper review of institutional logics in integrated care that finds 5 pre-eminent logics (managerial, professional, patient-centric, market, and state). Others have focused on *specific logics within healthcare*, such as Noordegraaf's (2020) discussion on how the protective shield that traditionally surrounded the 'profession' is giving way to a more connective professionalism, aided by financial-economic pressures, socio-cultural pressures, public and political turmoil, and technological pressures. To our knowledge, however, there has not yet been any successful attempt to identify, map and inter-relate all logics at the field level across the healthcare field.

Methodology

We chose a systematic literature review approach to generate a reliable, and reproducible body of knowledge as to the relationships between institutional logics in healthcare. Our review followed five key steps including: question formulation, locating studies, study selection and evaluation, analysis and synthesis, and reporting and using the results (Denyer and Tony 2009). We describe the question formulation in our introduction and theoretical background to this paper. Below we describe the process followed in the remaining four steps.

Locating studies

We searched the dominant and most generally accepted databases in social scientific research, the web of science core collection databases (including Science Citation Index – expanded, Social Sciences Citation Index, Arts & Humanities Citation Index, Conference Proceedings Citation Index-Science, Conference Proceedings Citation Index- Social Science & Humanities, Book Citation Index – Science, Book Citation Index – Social Sciences & Humanities, Emerging Sources Citation Index, Current Chemical Reactions, and Index Chemicus). Our searches covered the subject areas of 'business', 'management' and 'public administration' as our goal was ultimately to relate our findings back to public management of the healthcare field. Our search string combined 'institutional logic' and 'health*'. We conducted a topic search and used the Boolean operator 'AND' to connect the field identifier to the area of research interest – institutional logics. Three searches were conducted. The first, on 30 September 2020 returned 76 potential articles for inclusion; the second on 17 February 2024 returned a further 57 potential articles; finally a third search in June 2025 focused on public administration papers added 61 papers giving a total of 194 articles for consideration.

Study selection and evaluation

The inclusion and exclusion criteria are set out in Table 1 below:

The search end date was 29th February 2024. We did not set a start date as we wished to capture the entirety of the literature on the topic. We then used a manual title and abstract screening of every article to decide whether each article should be included or excluded. The two authors met and discussed the process which was implemented by the first author. After two rounds of such discussions, each followed by a return to the databases to make any adjustments necessary, we felt that we had reached a common understanding of our selection processes. A subset of the papers (the public management dataset) was separately screened by both authors to assess inter-screener reliability. At abstract screening, coding agreement levels were at 68% and rose to 84% at full paper screening. Of the eight papers on which the authors disagreed, after discussion five of these were excluded as four were not set within healthcare delivery and one was a non-empirical literature review.

In total, we excluded 105 articles that were not empirical in nature, were not situated in the healthcare field, did not identify any institutional logics, or were not peer-reviewed journal articles. Of these, 4 articles did not have a year of publication as they were published online and had not yet been added to the print journals. In these cases, while we reviewed the content and let it inform our analysis, we have not included them within the more

Table 1. Inclusion and exclusion criteria for the study.

Inclusion	Exclusion	Rationale
Empirical works	Review articles, conceptual articles, essays, other non-empirical works	Map to the research questions.
Published in English	Studies in languages other than English	Practical considerations and an indicator of impact given the prevalence of English as a language of academia.
Published in peer-reviewed journals	Book chapters, technical reports and other non peer reviewed journal publications	The peer review process was deemed an indicator of quality
Set in healthcare contexts (i.e. hospitals, primary care settings, and community healthcare settings)	Non healthcare studies (e.g. policy-making studies, welfare studies, occupational health studies)	Institutional logics are historically inscribed and so the history of the public administration sector needed to be kept constant to truly ascertain the relationships between logics.
An institutional logics lens was used to examine change within the healthcare context.	Studies that mentioned institutional logics in passing or as an outcome	Ensuring that studies were focused on institutional logics.

quantitative analysis below as they would potentially skew any findings that were timeline related given that they do not incorporate the usual publishing lag.

As a result, we have selected 83 health articles that fall within the scope of our literature review (see Figure 2, PRISMA diagram).

Analysis and synthesis

The full text of each article was loaded into NVivo qualitative analysis software where it was coded by the first author. Coding was conducted in two rounds – the first was inductive, allowing themes (such as logic conflict, or the processes involved in bridging logics) to emerge organically from within and across the literature. The second was deductive in nature, drawing from Thornton et al'.s (2012) ideal-type logics; and Reay and Jones' (2016) approaches to identifying institutional logics; to actively seek references to institutional logics within the articles – what types of logics were identified, how these logics were described, how these logics connected to existing organizational theory, and how the researchers had identified the existence of such logics. While this process was led by the first author, it involved multiple rounds of discussion and calibration to ensure inter-coder agreement.

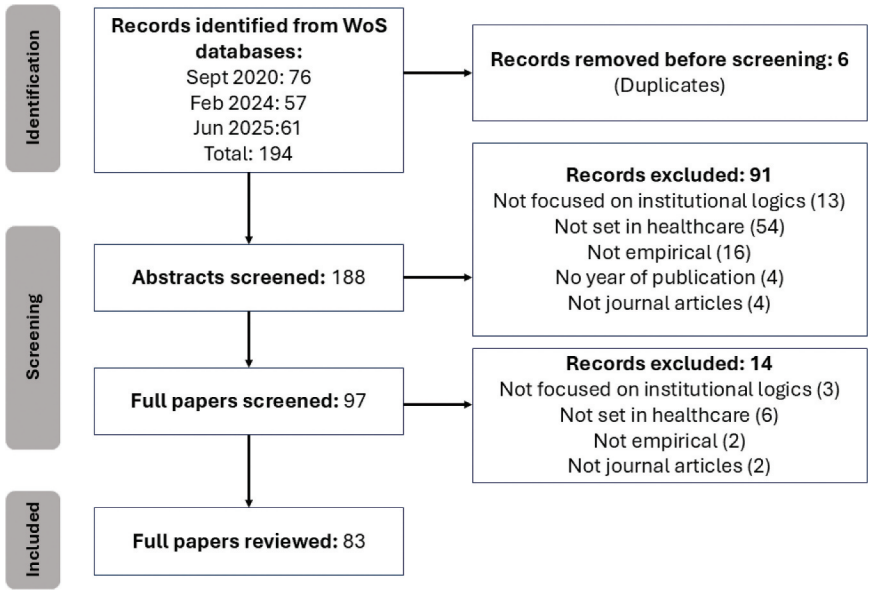


Figure 2. PRISMA diagram outlining the search and selection process.

Reporting and using the results

In the first instance we analysed the selected papers for descriptive statistics that would identify the general characteristics of the papers included, following similar public management studies (such as Boselie, Van Harten, and Veld 2019; Liu and Duarte 2023). We then used our NVivo coding of the full texts to theorize the relationships between logics within the included articles.

Findings

General characteristics of the data

The number of health-related institutional logics articles has increased over time – in particular over the last decade (see Figure 3). Healthcare articles began employing an institutional logics lens in 2002, peaking in 2019 with a high of 13 articles.

Geographically, over half of the studies (57%) focused on European countries, with North American countries accounting for 20% and Asian countries for 7% of the studies. Australia and South America were each the focus of two studies, while Africa and Turkey hosted one study each. Three studies spanned continents while four studies failed to specify a specific country context. See Table 2.

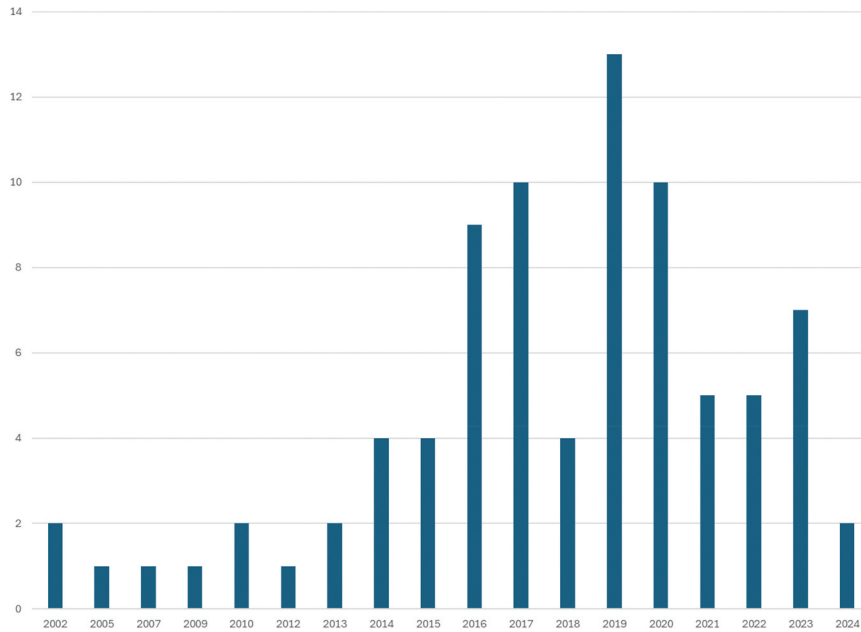


Figure 3. Numbers of health-related institutional logics articles by year.

What institutional logics feature in healthcare research?

Our statistical analysis also included a count of the presence of individual institutional logics across the studies. While all seven of the classic institutional logics appear across the dataset (see grey shaded entries in Table 3), the dataset shows evidence of an increasing number of logics used over time. While the classic logics appear often (profession, market, corporation, and state) (see Table 3), these account for just over half of the mentions of logics identified within the studies (107 out of 202 logic mentions) and just under 9% of the total logics identified (5 out of 59).

To map major logic shifts across the healthcare field, we grouped individual logics into buckets of 'meta-logics', using Thornton et al'.s (2012) ideal types where suitable. For example, we merged society and community into one community logic; we grouped different types of care logic into one 'care' logic, we merged organization and corporation into one corporation logic and we merged commercial into market logic (Table 4 below).

We then mapped the top six meta logics by number of occurrences (all of which appeared more than 10 times over the course of the data), using a three-year moving average trend (Figure 4). These were Profession, Market, State, Care, Managerial, and Community. Figure 4 adds more detail to the institutional 'layering' of healthcare as set out in our theoretical background. The professional logic climbs and

Table 2. Papers by country and region.

Region	Country	# Papers	% Papers
Africa	South Africa	1	1%
	Total	**1**	**1%**
Asia	China	3	4%
	India	2	2%
	Israel	1	1%
	Total	**6**	**7%**
Australia	Australia	2	2%
	Total	**2**	**2%**
Europe	Denmark	5	6%
	Finland	1	1%
	France	2	2%
	Germany	1	1%
	Hungary	1	1%
	Italy	4	5%
	Nordic[1]	3	4%
	Poland	1	1%
	Portugal	2	2%
	Spain	1	1%
	Sweden	8	10%
	The Netherlands	4	5%
	UK	10	12%
	Pan European	4	5%
	Total	**47**	**57%**
N America	Canada	6	7%
	USA	11	13%
	Total	**17**	**20%**
S America	Brazil	2	2%
	Total	**2**	**2%**
Cross Continent	Turkey	1	1%
	UK & Singapore	1	1%
	US & Germany	1	1%
	US & UK	1	1%
	Unknown	4	5%

remains strong throughout all eras of governance, with the market following close behind. Managerial and care logics peak in the last decade, likely aligned with the height of New Public Management approaches. Community logics make a late entry, just over a decade ago but climb steadily alongside a revival of state logics, perhaps reflecting community and state roles in the more distributed forms of governance characterized by new public governance and digital governance eras. It should be noted that the year in this analysis refers to the year of publication of the paper rather than the year of the study which was not consistently available data. There is, therefore, likely a lag of a number of years.

Relationships between the logics across the studies

Across the reviewed articles we identified institutional logics that mapped directly onto the seven classic logics, those that combined two

Table 3. Counts of logics identified across the articles based on authors' original wording.

Logics Identified	Count
Profession	42
Market	24
State	15
Business	13
Managerial	12
Care	11
Society	8
Bureaucracy	7
Corporation	6
Science	6
Community	4
Technology	4
Health	3
Integration	3
Organization	3
Democracy	2
Innovation	2
Market-managerial	2
Medical	2
Regulation	2
Service dominant	2
Welfare	2
All other logics mentioned only once	27

Table 4. Occurrences of meta-logics across the literature.

Rank	Meta Logic	# Mentions	Rank	Meta Logic	# Mentions
1	Profession	43	7	Corporation	9
2	Market	40	8	Bureaucracy	7
3	State	15	9	Science	6
4	Care	13	10	Technology	4
=5	Managerial	12	=11	Health	3
=5	Community	12	=11	Integration	3

*28 other meta logics were identified equating to 35 individual mentions.

of these classic logics, and those that constituted new logics. Two of the classic institutional logics, religion and family, were largely unrepresented.

Combined logics

Some of the combined logics are named such that it is clear that they are combining two pre-established classic logics. Market-managerialism, for example is defined by Kitchener (2002) as containing two key elements: 1) a resurgent ideology of the market where competition and efficiency justify state expenditure; and 2) ideologies of individualism, neo-conservativism, and self-help that justify reduction or total removal of state expenditure. This acknowledges that rival institutional logics may co-exist within an

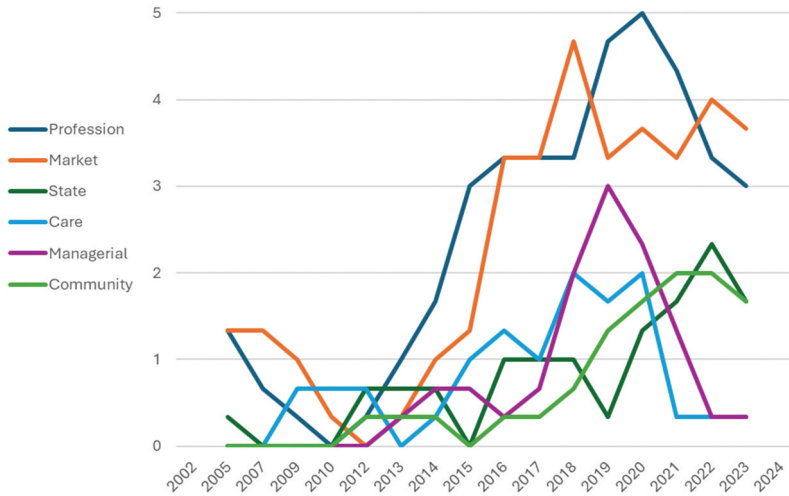


Figure 4. The prevalence of meta-logics over time.

organizational field and that an institutional system may cut across several organizational fields (Reay and Hinings 2009).

There are also, however, less obvious 'new' logics that eschew the classic institutional logics nomenclature but that, in their description, appear to span two of these classic logics. These new terms group pre-existing logics into field-accepted buckets of logics such as a logic of 'managed care', described by Nigam and Ocasio (2010): 'The field-level logic of managed care was a hybrid logic, merging societal- level logics of the market, bureaucracy, and to a lesser extent, the profession'. (pp. 825). Other hybrid logics identified include:

- 'society/democracy' incorporates elements of state and community logic. For example, Vickers et al. (2017) refer to 'the logic of civil society (or the social sector) [as] explored in the literature on social enterprise (SE) and hybrid form' (Vickers et al. 2017, 1756).
- 'care', balances profession and community logics in the healthcare setting. Dunn and Jones define a care logic as present where "quality healthcare is seen as physicians who provide compassionate, preventive care to patients and treat them as whole people rather than simply diseases … a care logic highlights physicians' clinical skills used to treat patients and improve the health of the community". (Dunn and Jones 2010, 116).
- 'bureaucracy' spans state and corporation logics. According to Waldorff (2013) the state relies upon bureaucracy for its authority, while the corporation or organization relies upon it for its identity.

- 'business' straddles corporation and market logics in an echo of the hybrid market-managerial logic. Reay and Hinings identify 'a new dominant institutional logic – one based on efficiency and effectiveness, customer service and business-like processes … replacing the word "patient" with "consumer"' (Reay and Hinings 2005, 360).

New logics

'New' logics across the healthcare articles include a patient-care logic that 'involves a focus on the patient, patient care, patient safety, quality of care, and public trust' (Verleye et al. 2017), a 'lean practices logic' that is contrasted with professional logic in that it espoused team-based problem solving, standardization, flow efficiency, and continuous improvement (Hultin and Mähring 2014) and a casemix logic: a commercial logic where funding followed implementation and results rather than politics (Kern, Laguecir, and Leca 2018) amongst others.

The logic of 'science' warrants particular discussion as it has no roots in the previous institutional literature. The science logic introduces a struggle between the traditional professional skills of the clinician and the innovative research that offers new evidence and treatment: 'a science logic focuses on knowledge of diseases built through research and innovative treatments, whereas a care logic highlights physicians' clinical skills used to treat patients and improve the health of the community'. (Dunn and Jones 2010, 116). Dunn and Jones are key to the establishment of 'science' as a credible institutional logic within the healthcare literature: 'Thus for a science logic, quality health care involves innovative diagnostic and therapeutic procedures to ameliorate human suffering and help eradicate disease' (116). Essén and Värlander (2019) build on Dunn and Jones to distinguish a logic of science (generating evidence) from logics of care (delegating decision-making power to patients) and logics of management (increasing clinical resource efficiency).

A typology of relationships between institutional logics

Authors across the studies have combined logics, and in some cases ideologies such as democracy or civil society (society being similar to Mountford and Cai's (2023) conception of a public good ideology), to bridge the classic institutional logics (see Figure 5 above). In our reporting of general characteristics, when counting and reporting logics we used the original authors' definition of a logic or ideology. If they have, for example, called democracy or public good a logic then we count it as such. Here, however, where we conceptualize and discuss, we distinguish an ideology as 'a value-laden and relatively rigid doctrine' from the relatively abstract and symbolic nature of

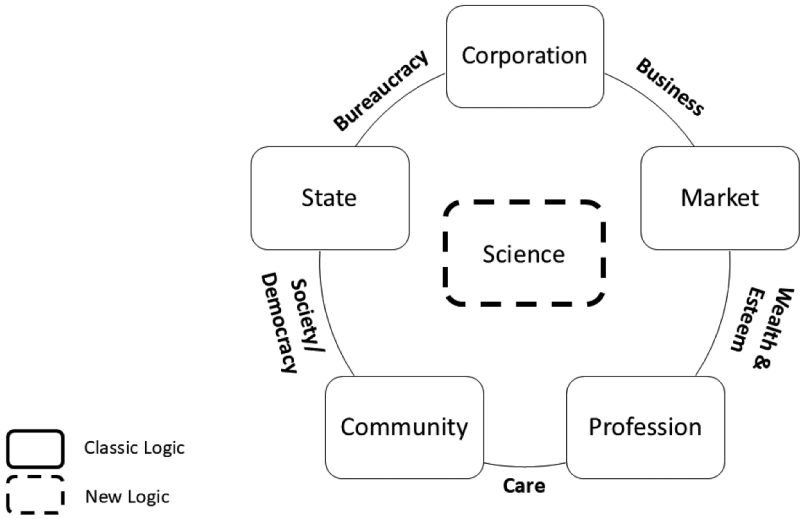


Figure 5. Conceptualizing the relationships between common institutional logics in healthcare.

an institutional logic (Mountford and Cai 2023). Waldorff (2013) links the State to Corporation in his definition of 'Bureaucracy' which says that bureaucracy is the source of authority in a State institutional logic but the source of identity in a Corporation logic (Waldorff 2013). Similarly, Styhre, Roth, and Roth (2016) articulate a link between Corporation and Market in their definition of a 'Business' logic which they describe as being focused on organized and managed activities and processes (a corporation logic) that have an economic end goal (a market logic). Vickers et al. (2017) connect a Community logic to a State logic in their development of a hybrid logic of 'Civil society' which speaks to both an ideology of citizen-sponsored government through democratic engagement and societal values that are rooted in Community logics as well as public good ideologies. Community is also, however, linked to Profession through the hybrid logic of Care as previously described by Dunn and Jones (2010) incorporating professional excellence with a duty of care to a patient community. Conceptualizations of 'wealth' and 'esteem' link the logics of profession and market (Gürses and Danışman 2021; Vivier et al. 2024). While many studies situate these logics as natural enemies, it is a market logic that measures professional excellence by material wealth. Wealth and esteem are, however, neither logic nor ideology but more in the nature of personal goals or objectives. Figure 5 helps us to understand where institutional work (Lawrence, Suddaby, and Leca 2009) has already been carried out within the healthcare field to successfully bridge logics and forge sustainable inter-logic relationships. The relative proximity of certain logics, such as care and profession, or business and market, suggests a history

of institutional maintenance, adaptation, or bridging efforts at the field level. This visual synthesis extends existing typologies, such as Besharov and Smith (2014), by identifying not only the nature of logic relationships but also where foundational relational work has taken place and where further institutional work may be required to address persistent divides between logics.

We now describe contexts where multiple logics feature in the studies with a view to examining how they inter-relate as well as the potential risks and benefits of each type (Table 5). We offer a novel perspective on logic relationships – our typology delves into the nature of different logic relationships rather than stopping at their structure as previous conceptions of hybrid, constellations, dominance and others.

We suggest that the relationships between logics fall into three different categories: 1) Independent: situations in which the two logics co-exist within a particular healthcare context but take little or no account of each other; 2) Inter-dependent: situations where logics mutually adapt so that both survive; and 3) Co-dependent: situations where one logic thrives at the expense of another. We go on to discuss each type of relationship illustrating with examples from the literature. We highlight the types of contexts where each relationship is likely to be found, as well as the risks that should be monitored.

Independent logics

The literature indicates two categories of relationships in which institutional logics are largely independent of each other. The first, *Constellations of Logics*, captures situations where strong institutional influences emanate from diverse sources on an ongoing basis (Blomgren and Waks 2015). The second, *Loose Coupling of Logics*, refers to situations where healthcare organizations conform to one logic through 'front stage' symbolic displays, but to another logic in 'backstage' activities (Bishop and Waring 2016). In such contexts one institutional logic is symbolically endorsed while another is used in actual work practices (Lander 2016).

Constellations of Logics work when actors have substantial autonomy and reward systems are not aligned to clear rule structures (Gürses and Danışman 2021). This allows individuals to appeal to multiple logics based on different facets of their work (Hansen and Baroody 2020). Leaders are able to 'combine' and/or selectively apply elements of co-existing logics through their management styles and communication of 'guiding visions' (Vickers et al. 2017). Often, practices or audiences that follow contradictory or competing logics are kept apart (Currie and Spyridonidis 2016). In constellation scenarios, actors may break the rules by incorporating 'rogue practices' into their daily work lives (Gürses and Danışman 2021, 139).

Table 5. Types of institutional logic relationship in healthcare.

Relationship Type	Core Dynamic	Mechanisms	Risks	Benefits	Example of Logics Involved
Independent	Parallel coexistence with little interaction	Constellations, loose coupling	Fragmentation, ambiguity, strategic decoupling	Flexibility, local adaptation	*Market* (external reporting) & *Profession* (internal practice) — e.g. symbolic compliance
Interdependent	Mutual adaptation or integration	Rebalancing, hybridization	Coordination complexity, identity tensions	Innovation, adaptability, resilience	*Profession* & *Care* logics — co-leadership or hybrid models such as managed care
Co-dependent	Power asymmetry with strategic domination	Dominance, co-optation	Hidden tensions, resistance, instability	Clear hierarchy, short-term control	*Market* dominates *State* logic in hospital governance; *Corporate* co-opts *Profession* logic

The existence of a plethora of available logics, without a clear hierarchy, creates room for actors to choose from among these. Such self-serving action can lead to underperformance (Sandeep and Ravishankar 2014). The ensuing inability to predict individual action means that practice outcomes become divergent and uncertain (Martin et al. 2017). The ongoing proliferation of logics may lead to cycles of balance and imbalance (Lander 2016) requiring resource-consuming ongoing institutional work to maintain a workable healthcare organization or system (Andersson and Gadolin 2020). Implementing innovative practices may become very complicated (den Broek, Judith, and Paauwe 2014) as interdependence is difficult in constellation contexts (G. Currie and Spyridonidis 2016).

Loose coupling of logics is generally found where actors must balance the institutional logics that underpin external requirements and internal demands (Roekel et al. 2020). Loose coupling allows actors to align a new idea with incumbent dominant institutional logics (Waldorff and Madsen 2023). In other words, actors embrace the ambiguity afforded by the loose coupling of logics towards their own ends (Fincham and Forbes 2015). Ostensive compliance may, however, mask underlife improvisation (Batista et al. 2016). Actors may strategically decouple to 'game' the system (Kern, Laguecir, and Leca 2018) and key intermediaries may influence the ways in which institutional logics are communicated (Hartman and Coslor 2019). Ultimately, this can give rise to transformations that are unstable (Miller and French 2016).

Interdependent logics

We identified two groups of interdependent institutional logics. Firstly, situations that demonstrated a *Re-balancing of Logics* were characterized by an evolution of the balance between the philosophies, normative understandings, and values of logics over time (Dunn and Jones 2010). Secondly, *Hybridization of Logics* identified blended responses to heterogeneous logics (Bishop and Waring 2016) which gave rise to a 'composite, distinctive, and relatively stable phenomenon' (Blomgren and Waks 2015, 83).

Re-balancing of logics is seen where counterbalancing mechanisms are introduced, such as government interventions or policy changes (Currie and Seddon 2022). This broadens actor perspectives beyond the organization (Møller and Cecchini 2023). At its best, co-leaders or boundary spanners model institutional balance for actors within the healthcare organization or system (Gibeau et al. 2020). Over time, use patterns unintentionally challenge the presumption of institutional dominance or conflict, allowing for a rebalance (Essén and Värlander 2019). Re-balancing of logics does, however, involve complex, conflicting situations and negotiation processes (Roekel et al. 2020). This may lead to periods of balance and imbalance

that result in an uneasy tension (Dunn and Jones 2010). At its worst, where actors fail to deal with competing logics, value deterioration and destruction may occur (Verleye et al. 2017).

Hybrid Logics occur where organizational structures integrate logics, for example in a social enterprise (Zollo et al. 2022). Actors have expertise, competence, and experience in several fields and are considered legitimate by a broad range of people (Blomgren and Waks 2015). At its best, the micro-level processes within the organization involve interaction between actors who are accustomed to divergent forms of work organization, and professional groups who may shape the resultant organizational form (Bishop and Waring 2016). Tensions may arise, however, in terms of values and goals, work processes, hierarchy, and the material and technological aspects of work (Bishop and Waring 2016). Groups may find themselves unable to detach from existing logics as they lack the new vocabularies and cultural resources to form the required new attachments (Fincham and Forbes 2015). Hybridization efforts may change organizations in asymmetric ways, as different elements within the organization become more or less well aligned with the mission and vision that hybridizers articulate (Miller & French, 2016). For some, hybridization may change the meaning of professionalism and call professional identity into question (Sartirana, Currie, and Noordegraaf 2019).

Co-dependent logics

Co-dependence between institutional logics manifests in two different formats. Firstly, the *Co-optation of Logics*, where actors 'hijack' logics, using the home logics of others as a control strategy (Andersson and Liff 2018; Holm-Petersen, Møller, and Salling Buch 2021). Secondly, *Logic Dominance*, where multiple institutional logics co-exist but some are subordinate to others, leading to a hierarchization of logics (Andersson and Gadolin 2020; Arman, Liff, and Wikström 2014).

Co-optation of logics occurs where creative strategies, such as boundary-disturbing devices, are used to hijack home logic (Holm-Petersen, Møller, and Salling Buch 2021). Co-opted logics are in effect cannibalized, where one logic adopts a strategic element from another logic that retains the most important elements of its own logic (Andersson and Liff 2018). Co-optation of logics can legitimate unequal power structures (Andersson and Liff 2018). While it may appear to solve conflicting logics, often the initial underlying tensions remain unresolved (Gibeau et al. 2020).

Logic Dominance occurs when new practices are aligned with one powerful logic and can manifest in a portrayal of 'deference' to incumbent logics (Cappellaro, Tracey, and Greenwood 2020). Structural differentiation can allow different logics to dominate different phases of change so that

dominance shifts over time (Blomgren and Waks 2015). Despite the seeming deference of the non-dominant logic, pockets of resistance may remain (Gibeau et al. 2020) populated or led by renegade actors (Reay et al. 2017). The power imbalance inherent in the logic dominance model of institutional logic relationships (Reay and Hinings 2005) may lead to the rise of coalitions and cartels (Ryngelblum, Giglio, and Corrêa 2019).

Discussion

Measures of success in healthcare typically include patient outcomes, efficiency, safety, patient experience, and access to care. What, however, is success in the context of institutional relationships in the healthcare field? While a successful logic relationship should, long-term, create an environment that facilitates the above success measures, there are many mediators between cause and effect. We therefore focus on the success of the logic *relationship*. For us success can be measured on two continuums. The first is the stability of the relationship. How prone is the field to institutional warfare, logic cycles, or peaks and troughs of logic dominance. Such institutional environments make it virtually impossible for actors and organizations to achieve outcome measures as the goalposts are in constant flux. The second measure is the ability of the institutional environment to accommodate change. The concept of punctuated equilibrium says that fields are naturally stable due to institutional structuring punctuated by bursts of radical and fundamental change (Gersick 1991; Romanelli and Tushman 1994; Tushman and Romanelli 1985). Logic relationships that cannot accommodate change leave fields open, therefore, to unexpected and destabilizing 'fieldquakes' that again make the achievement of desirable health outcomes ever more difficult.

Scholars highlight the challenge of aligning various stakeholder perspectives and institutional logics, such as market-driven healthcare versus medical professionalism. This tension is exacerbated by differing priorities regarding the role of technology, patient autonomy, and cost containment. For instance, while policymakers may advocate for market-driven approaches, medical professionals often prioritize patient care over managerial efficiency, leading to clashes in values and priorities. These conflicts underscore the complexity of healthcare governance and the need for nuanced approaches to policy implementation. Conceptualizing the relationship between logics as dependent, independent, and co-dependent allows us to consider the balance between dependence and independence when it comes to those values, norms, and cognitive processes that constrain and enable action within the healthcare field.

Healthy logic relationships, like those between individuals, require a balance of independence and dependence, with each maintaining identity

and autonomy while still feeling connected, cared for, and supported by the other. In our typology, interdependent relationships are the most likely to demonstrate these characteristics and therefore, to result in sustainable change. At the level of practice, interdependent logic compatibility implies 'constant and reinforcing organizational actions' (Besharov and Smith 2014, 367). At the meaning level, it requires the forging of conceptual connections that bridge the co-existing logics for individual actors (Roekel et al. 2020). Those authors give the example of the organizing professional in the form of nurses who manage to align both organizational and nursing professional aims. Structures such as hybridization and rebalancing, serve to bridge logics while creating an institutional environment that allows, and may even welcome, change. The inevitable conflict and complexity can be managed at the individual actor level as their identity and autonomy is legitimized by coexisting logics (Waldorff and Madsen 2023). Put differently, affected actors can distinguish between meaning and the practice in how they adhere to, and employ, interdependent institutional logics. Such relationships manage to harness the best of multiple institutional worlds. This facilitates real change but in a sustainable way. It is sustainable because the system is underpinned and futureproofed by a rebalanced or hybridized logic relationship. It is this relative stability (Blomgren and Waks 2015) that leads to sustainability and it is this balance that delivers productivity.

The most dysfunctional of our relationships are co-dependent logics. Here, the balance tips towards dependence leading to an unhealthy dynamic within the field. Co-dependent logic relationships are characterized by a lack of clear boundaries that threatens identity and autonomy within the field. Blomgren and Waks (2015) show how, even within one organization, different logics may dominate different phases of a process. Co-dependence is symptomatic of a need for control where actors hijack logics to manipulate the behaviour of others. The process of one institutional logic gaining precedence over another may lead to power structures that mean one group of actors is institutionally victorious and another defeated. The inequality of these structures may force tensions underground for a time. These are, however, likely to ferment in hiding and eventually erupt to destabilize the organization. Without boundaries and balance, codependent logic relationships are likely to lead to short run, volatile, and highly costly change.

Our third type of logic relationship is independent logic relationships. While this may well be a sustainable type of relationship it is unlikely to lead to real change. Structures such as logic constellations and loosely coupled logics may allow the classic logics and new logics such as science to co-exist relatively peacefully, but they lack the shared goals necessary for real logic compatibility (Besharov and Smith 2014). The constellations of logic and loose coupling of logics that underpin independent logic relationship types

are sustainable in that one logic really does not impact on or get in the way of another. Such relationships between logic are however unlikely to forge the types of real connections necessary for cognitive and normative change amongst the actors embedded in such fields.

Implications for policy-makers and healthcare managers

Our framework identifies where and how different logic relationships may require distinct forms of institutional work or governance mechanisms. We offer a draft prescription for more 'successful' logic relationships that will create the environment for sustainable change. We hope to outline for those who shape fields – governments, professional bodies, patient representative organizations, healthcare standards authorities and others – how to influence institutional logic relationships that will sustain the changes they desire. We suggest three steps that might lead to healthier logic relationships and more productive healthcare fields.

Step1: Identify the logics in your decision-making context

Review guidance and policy documents, conduct interviews with representatives from all stakeholder groups, and attend meetings – both inter- and intra-group. Seek to see beneath the surface positions articulated and focus on identifying the root metaphors that underpin this position. For example, is the delivery of care seen as a transaction (market logic); a relationship between patient and doctor (Profession logic) or a democratic right (state logic). In the same way, consider the sources that legitimise and give authority to the actors (and their positions) – it is their professional qualifications; their position in the organisation, or their status as a citizen? Repeat this process with regards to identity, norms and the basis of attention (Thornton et al. 2012). On completion of this exercise you should have a sense of the different logics at play in your decision-making context. Now map the logics onto our conceptualisation in Figure 5 above. Did you identify any linking logics or ideologies?

Step 2: Characterise the relationships between those logics

Use our typology described above (and Table 5) to characterise the core dynamic between the different logics:

Where the logics run parallel to each other with little interaction this indicates an Independent relationship between the logics. This might manifest as etcher constellations of disconnected logics, or a very loose coupling of logics. An example here might be where a market logic might advocate one set of criteria for external reporting purposes while a medical professional logic has a completely different set of criteria for internal practice.

Where you find evidence of mutual adaptation or integration of logics you are likely dealing with interdependent logic relationships. Typical manifestations will include a noticeable rebalancing or hybridization that can give rise

to coordination complexity and identity tensions. An example of such a relationship might include co-leadership or hybrid role that bridge management and clinical expertise (bridging corporate and profession logics).

Where your research reveals a notable imbalance of power and one logic dominates another, or co-opts another to achieve its own ends, you are encountering a codependent logic relationship. An example of this is where resource allocation trumps patient care in hospital management decision-making – a market dominates profession or community logics.

Step 3: Adopt a strategy that fits the logic relationship

Independent logic relationships: Define clear boundaries and facilitate boundary-spanning

In contexts characterized by independent logics, policy actors may need to develop boundary objects or shared performance frameworks to promote alignment. Where there is no linking logic or ideology combination (for example, between market and profession within the healthcare field) logic links may rely on relatively individualistic conceptions of wealth and esteem, rather than the societal level conceptual, normative and regulatory frameworks provided by an institutional logic or the active, groundswell of an ideology. Boundary spanning objects, roles, or networks may mitigate this absence and serve to connect independent logics without threatening role identities. Leotta and Ruggeri (2022) describe, for example, how a boundary object in the form of a performance management system facilitated both communication and value coherence across logics. We suggest that the use of boundary objects to encourage a focus on ends, rather than means, can begin to move codependent or independent market and profession logics more towards an interdependent relationship that can deliver both efficient and effective healthcare. The establishment of government-sponsored multi-stakeholder networks (as outlined by Mountford, 2019 in the area of eHealth) can force a coming together of logics espoused by different types of stakeholder.

Interdependent logic relationships: Encourage logic reciprocity

Healthy logic relationship relationships involve give and take. Stakeholders, including physicians, healthcare operators, administrators, and consumers, each carry distinct logics shaped by their professional roles, organizational affiliations, and societal expectations. This meeting of logics contributes to disputes over resource allocation, treatment protocols, and accountability, highlighting the multifaceted nature of healthcare decision-making. Reciprocity amongst logics will not require the destruction or dominance of one logic to the benefit of another. Rather it takes account of different logics and in some instances merge some elements of the logic towards mutually desired change goal. For example, standards setting agencies and

medical professional bodies could incorporate the needs of multiple stakeholders in their education and auditing processes including both medical and managerial competences. While managerial competence will necessarily be a much smaller training module, its incorporation will direct actor attention towards multiple logics and will require a balancing of priorities that will necessarily entail both give and take. Likewise, hospital manager inductions could include time spent 'on the floor' observing medical treatment and decision making under resource and time constraints to develop a better understanding of the medical professional logic.

Codependent logic relationships: Balance power and control

Codependent logic relationships such as co-optation of logic or logic-hijack as a control strategy will never lead to a sustainable balance of power and control across a changing field. The interplay between logics in healthcare governance extends beyond organizational boundaries to encompass broader societal values and norms. Bringing the voices of those affected into the decision making process inserts a community logic into decision making that we know bridges state and profession, but may well have the potential to also bridge to market logics where it is used to decide, for example, funding decisions. When healthcare professionals, healthcare managers, or governments get to make all the decisions it is likely that profession, managerial and state logics will exist in either codependent or independent states. Public and patient involvement in healthcare decision making at all levels – from funding allocation, to care pathway design – rebalances power across multiple stakeholders and, through this, across multiple logics. We therefore suggest that codependent logic relationships can be mitigated through decision making structures at policy and funding decision making levels that reify a role for non-professional interest holders such as patients and informal caregivers.

Conclusion

Our extensive review of the literature highlights the importance of taking institutional logic relationships into account when seeking to introduce change in a healthcare context. This is because change efforts often disturb the established relationships and hierarchies of institutional logics. We identify three categories of relationships between institutional logics and we typify types of relationships within each category. We propose our integrated framework—linking institutional logic types (e.g. care, profession, market) with patterns of interaction (independent, interdependent, co-dependent)—as a heuristic tool. This tool helps scholars and practitioners to interpret complex configurations of institutional logics in healthcare systems and to anticipate how such configurations may support or constrain

change. It also extends institutional logics theory by visualising how field-level institutional work may draw certain logics closer together while keeping others apart. Our findings suggest, however, two particular areas that would benefit from further examination.

Firstly, our review reveals a dearth of studies that consider institutional logics in the global south. Only 10% of the studies reviewed were based in Africa, Asia of South America. It is highly likely that the cultural contexts that are key to the development of institutional logics will differ in global south contexts. Market logics may, for example, be far less evident in less capitalist contexts. Future research should investigate logic relationships in these context which are key to the achievement of Sustainable Development Goal 3 which seeks to ensure healthy lives and promote wellbeing across the globe by 2030.

Secondly, our study relies secondarily on a set of studies that did not, in the first instance, set out to understand logic relationships. This means that key questions around the boundary conditions for particular type of logics; or the mechanisms by which such relationship types might be shaped or managed; were answered conceptually rather than empirically. Future research should empirically investigate these questions using, for example, experimental designs to test different responses to logic relationship management approaches. This would provide robust practical advice for practitioners and support strong theorizing. Our reviewed studies demonstrate that not only can actors strategically choose institutional logics for their own benefit, social interactions can in fact rearrange logics to guide professional role identity (Reay et al., 2017). We hope that our proposed strategies will aid agentic individuals and organizational leadership teams in balancing between competing logics or reducing the resulting tensions where logic dominance or co-optation is necessary.

Note

1. One study is set in Norway and the other in a 'Nordic' hospital as described by the authors.

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No potential conflict of interest was reported by the author(s).

Notes on contributors

Dr. Nicola Mountford is Associate Professor in management at the School of Business in Maynooth University, Ireland. In 2016 she held a Fulbright TechImpact scholarship, funded by Enterprise Ireland in the area of Digital Health.

In 2023 she was Co-PI on the award winning Future Innovator Challenge Award, funded by Science Foundation Ireland, that seeks to reduce neonatal mortality due to sepsis in Uganda. Her research into the organisation of healthcare has been published in international journals such as Organization Studies, the Journal of Business Research, International Journal of Management Reviews, PLOS One, Journal of Medical Internet Research (JMIR), and others. Nicola is a member of the editorial board of the Journal of Business Research.

Dr. Yuzhuo Cai, is Professor in the Department of Education Policy and Leadership & Co-Director of the Global Research Institute for Finnish Education at The Education University of Hong Kong. In addition to publishing impactful articles in prestigious journals such as Studies in Higher Education, Higher Education, and the International Journal of Management Reviews, he has edited special issues for international journals, including the Journal of Studies in International Education and the European Journal of Higher Education, as well as books for international publishers such as Edward Elgar and Sage. He also serves as an editor for the Journal of Studies in International Education, Triple Helix, and the Journal of the Knowledge Economy. Moreover, he is a member of the advisory board for the Master of Arts in International Higher Education and Management program at Lingnan University, Hong Kong, and a member of the Think Tank for the China Coordination Group under the SGroup university network in Europe. He has been listed in Stanford/Elsevier's Top 2% Scientist Rankings in the field of education for three consecutive years.

ORCID

Yuzhuo Cai http://orcid.org/0000-0002-7934-3828

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