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# Stakes, Positions And Logics: An Institutional Field Analysis Of Cross-Border Health IT Policy

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# STAKES, POSITIONS AND LOGICS: AN INSTITUTIONAL FIELD ANALYSIS OF CROSS-BORDER HEALTH IT POLICY

## Introduction

The intellectual antecedents of field theory are found in the generic social sciences literature (Martin, 2003). The concept provides an analytical framework that spans macro (societal) meso (organizational) and micro (individual) levels of analysis. Field (*champ*) is featured widely in the work of French social scientist Pierre Bourdieu (1984) who continued to develop the concept throughout his career. Prior to Bourdieu's work, field theory was not well articulated or understood in academic scholarship (Jenkins, 1989; Swarz, 1998, Fligstein, 1991).

A field analysis of social order and change in different industries and organizations is central to institutional theory (Greenwood and Hinings, 1996). The concept is used in the seminal work of DiMaggio and Powell (1983) to analyse the effects and processes of institutional and organizational fields (Fligstein and McAdam, 2012). In this study, field theory provides a lens for analysing supra-national policy on health information technology (HIT) in the European Union (EU)<sup>i</sup> of 27 Member States<sup>ii</sup> (nations). Supra-national HIT policy expressed by power or influence of stakeholder groups transcends national boundaries or governments to fulfil the wider objective of European integration.

The research is motivated as follows: First, we revisit the sociological work of Bourdieu (1977; 1990; 1993) for his influential contribution to field theory and to neo-institutional work (Fligstein and McAdam, 2012).

Bourdieu's sociological contribution provides a powerful set of concepts to theorize the intersection between health policy and information technology. Supra-national policy on HIT<sup>iii</sup> is a complex landscape of multiple institutions, organizations and professional groups. Stakeholders from various inter-connected fields of government, health and technology include policy makers, clinicians, technology companies, and patient advocacy groups. Bourdieu's work addresses the complex relationship between structure and agency, focusing particular attention on individual action within fields. Our interest extends this analysis by examining consensus or conflict among stakeholder groups impacted by HIT policy.

Second, field theory is a methodological approach spanning multi-levels of analysis (Esser and Vliegthart, 2017). Comparative country studies on European integration frequently use benchmarking techniques to demonstrate disparities in resources and performance. Benchmarking of Europe's health systems reveals significant variability across Member States (European Commission, 2018)<sup>iv</sup> with vastly different levels of citizens' access to, and use of, information technology (Cruz-Jesus et al, 2012). The European Commission regularly publishes health performance data focused on identifying the high performing countries (OECD/European Commission, 2020). Isolating the drivers for, and examples of, *best practice* is used as a template for improving health systems in under-performing countries. In this paper, field theory complements comparative benchmarking country studies, conceptualizing the European Union as a *health IT field*. Countries in this context are *sub-fields*. Similarly, stakeholder groups are also sub-fields. Political and professional boundaries within the health IT field produce a complex set of dynamics. The methodological challenge is thus to derive insights from multi-level influences and pressures on HIT policy development, interpretation and enactment.

Third, emerging health technologies (cloud computing, telemedicine, electronic and mobile health) are 'enablers' for cross-border health (European Commission, 2020). A primary goal of EU HIT policy is to create a level playing field for Europe's citizens. As *health consumers*, citizens are expected to play an active role in all aspects of their healthcare (diagnoses, treatments, medicines). However, cross-border health is a major societal, economic and cultural challenge for EU policy-makers and Member States, as health systems face dual pressures of globalization and convergence (Sahay et al., 2018) coupled with increased financial constraints and rationing (Stein and Sridhar, 2018). Our study draws on context-specific empirical insights to generate theoretical observations (Davidson and Chiasson, 2005, Marmor et al., 2009) on the ideological and implementation challenges of supra-national HIT policy.

## Field Theory

The literature on field theory from North America and Europe is defined by mixed theoretical and empirical approaches. The ‘field theory rule’ was applied by Lewin (1946) to organizational change and consulting to show the interdependency of people and their surroundings. Extending field theory<sup>v</sup> Bourdieu (1993) initially viewed the concept loosely (Warde, 2004). He later refined his ideas by theorizing how agents and their social positions are located within a field, and how their ‘positions’ (interpretation and action) derive from the specific *rules* of the field. Two further concepts of *habitus* and *capital* were developed to show how cultural life and production are situated within a field (Bourdieu, 1993). *Habitus*<sup>vi</sup> refers to lifestyle, values, dispositions and expectations of social groups acquired through the activities and experiences of everyday life. Capital is any resource effective in a social arena that enables an individual to appropriate the profits from their participation in a given situation (Wacquant, 2006). Fields interact with each other in differentiated structures of power and influence. Fields and subfields are viewed as subordinate to the larger field of power and class relations, with social power embedded in the structure and logic of all fields (Bourdieu, 1986).

In Bourdieu’s work, fields are not analogous to classes. Fields are autonomous independent spaces of social life. The field of power, for example, exists horizontally in all fields and the tensions within it determine the ‘exchange rate’ of the forms of cultural, symbolic, or physical capital between the fields. A field is constituted by relational differences in the position of social agents, with boundaries of fields demarcated by where their effects end. Bourdieu theorized fields as interrelated. Field analysis examines how meaning is produced relationally. Comparative stakeholder data offers a nuanced picture of the relational characteristics of fields (Benson, 1999). Differing *stakes* and *positions* result in struggles between agents, influenced by hierarchically-structured relations. The dynamics of field relationships become more complex as cross-field interactions between stakeholder groups span multiple fields, or sub-fields<sup>vii</sup>.

An example of interaction across fields is central government and health (hospitals, health professionals, and patient representative bodies). As societal complexity increases, the number of fields and the relations within and across fields expand, with agents engaged in *struggles* for scarce resources (Bourdieu, 1993). Methodologically, Bourdieu positions social science research away from variable hypothesis-testing towards a *relational* approach to study social life. Social action is conceptualized as occurring within a social space, comprising intersecting fields that condition and constrain the behaviour of individuals (Bourdieu and Wacquant, 1992).

*Habitus* depicts individuals and groups acting purposefully and practically to external sets of formal rules (Bourdieu, 1984). *Habitus* provides a conceptual frame to analyse how stakeholder groups respond either passively or actively to formal policy. An anthropological interpretation of *habitus* extends the micro analysis of individuals towards macro phenomena to include actions and behaviour of collective bodies (groups, societies and nations) (Mauss, 1934). Thus, *habitus* forms the aspirations and expectations of influential groups positioned within a social hierarchy who pursue social change by collective policy intervention.

Institutionalist theory adapts the concept of *habitus* to show how institutional processes transition from habitualization, objectification to sedimentation (Tolbert and Zucker, 1996). Others show how market incursions into previously stable fields lead to change, or deinstitutionalization of fields (Oliver, 1992; Suddaby and Greenwood, 2009). In industries of relative stability, such as healthcare, field-level analysis generates insights on institutional stability and pressures for change (Davis and Marquis, 2005). A recent study shows how health information systems implementation among low and middle income countries, lead to institutional outcomes for maintaining or deinstitutionalizing routines and practices (Bernardi et al, 2019). The findings suggest *habitus* is shaped within and across field boundaries by political and professional groups engaged in struggles and conflict with other interested parties. Some examples of tensions among stakeholder groups include, resistance of policy changes on bureaucratization, rationalization and de-professionalization (Friedson, 2001, Timmermans and Oh, 2010).

The cultural shift in healthcare over the past few decades towards a *financialized* market involves new entrants (professional managers) pursuing a reductionist agenda with health services treated as exchangeable financial instruments (Scott et al., 2000). Field agents adapt or resist change. Different fields and subfields with their specific ‘rules of the game’ offer their own economy of exchange and reward (Bourdieu, 1984). Fields are differentiated by the value of the capital therein and by their relative autonomy from each other. No field is completely autonomous or isolated from another field (Benson, 1999).

The defining features of a field are integrated around stakes and commitment to the value of those stakes, a set of structured positions, strategic and competitive orientations, and agents endowed with resources and dispositions (Bourdieu, 1984). As a structured domain or space, socially instituted fields are defined by their contingent histories and development pathways (Warde, 2004). Fields are not static as they change over time (Beckert, 2010), sometimes gradually, but also rapidly. Individuals and groups routinely engage in struggles for ‘stakes’ (Bourdieu, 1984). Tensions arise over legitimizing the stakes and establishing their value. The dynamics of a field arise from the positions, dispositions and position-taking of stakeholders. Structured positions within fields

are demonstrated by differences in the resources and dispositions held by individuals and groups. Resources and dispositions enter from other fields which unconsciously shape the habitus (Sieweke, 2012). These properties undergo further changes as fields mature. Stakeholders orient themselves towards a field and adopt their positions by considering their resources and dispositions. Participation in a field reflects shared commitment to the value of the activities of the field and of field-specific capital. A rapid influx of new entrants into the field exerts transformational or maintenance pressures. These morphological changes are mediated by ideologies and agendas of field members (Benson, 1999).

The field theory of Bourdieu (1984) encourages wider sociological analysis of societal, economic and political effects and pressures within and across fields. Neo-institutional theory offers extensive insights on the creation, maintenance and change in fields (Powell and Dimaggio, 1991). Contributions focus on institutional logics of field members, citing examples of conflicted logics within specific field contexts (Thornton and Ocasio, 1999; Thornton et al, 2012). Fields are described as 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” (Scott, 1994, 207-8).

Macro-level field analysis of social phenomena extends across national jurisdictions. Comparative, multi-country studies are common in political science, and less so in management research. Meso-level analysis interlinks macro and micro levels, including organizations in the health sector. Sociologists often refer to this as mid-range theory. Micro studies examine individuals or groups focused on a single issue, such as clinicians’ perceptions of health technology use in the workplace (Hendy et al, 2005).

Neo-institutional work contributes to organizational theories on individual and organizational behaviour. Links to wider societal or inter-institutional systems are under-explored. Fields and sub-fields, however, operate across supra-national and inter-organizational boundaries, with groups and individuals pursuing material life in time and space, and in symbolic systems infused with meaning. Failure to include societal phenomena with organizational and agency analysis is described as ‘*the order of retreat from society*’ (Friedland and Alford, 1991). In sum, societal level analysis provides deeper insights on stakeholders’ engagement with their environment, and their interaction with organizations, groups and individuals (Bourdieu’s (1977, 1984).

### Institutional and Organizational Fields

Institutional and organizational fields overlap in the wider literature (Powell and Dimaggio, 1991; Meyer, 2008). This poses theoretical and empirical problems for institutional theorists, as interchangeable concepts reduce descriptive and analytical clarity. The concept of institutional fields is used to demarcate spheres of institutionalized meaning. The focus is on ‘shared typifications’ and ‘mutual expectations’ to provide insights on how ‘institutional orders expand or contract or how institutional logics, institutionalized practices and rationalizations or legitimations differ across time and/or space.’ (Meyer, 2008: 525) Institutional fields encompass ‘actors who are expected to perform an institution but include all those who expect the institution to be performed, that is, all actors who share the frame of reference’.

By contrast, organizational fields look at agents in a field of single or multiple, dominant or competing, institutional orders or logics (Besharov, and Smith, 2014). Attention is drawn to the heterogeneity of institutionalized patterns and interpretation frames in interaction fields (Meyer, 2008). An earlier definition views organizational fields as ‘sets of organizations that, in the aggregate, constitute an area of institutional life’ (Dimaggio and Powell, 1983, 148-9). An organizational field exists where an organization defines its environment and, in turn, the environment is clearly defined. The organizational field of healthcare comprises multiple and diverse organizations, including hospitals as the focal population, and associated organizations, including state or regional health authorities, and patient forums.

Institutional and organizational fields in the extant neo-institutional theory literature are un-demarcated, theoretically or empirically (Greenwood et al., 2002). Health fields comprise a complex set of multi-faceted organizations influenced by macro and micro level pressures (Karahanna et al, 2019). In healthcare, and especially in cross border health, organizational fields are influenced by complex supra-national, national, regional and local policies that strengthen or destabilize institutional practices. Health systems are traditionally slow to change, with institutionalized patterns of behaviour and rules governing medical professional (Scott et al., 2000; Scott, 2001). Field pressures on globalization of health systems multi-faceted, characterized by changing population demographics, rationalization of national health budgets, health tourism as citizens seek treatments outside their home country.

### Health fields and subfields

Health fields offer a rich opportunity for research and investigation (Chiasson and Davidson, 2004; Adler and Kwon, 2013). Three themes emerge from the literature. First, state monopolies are increasingly regulated as a structured space of *stakes* and *positions* that impose specific controls on health professionals. A medical student wishing to become a hospital doctor is required to adopt the rules and regulations of the profession which are

enforced by the scientific milieu at a given time and place. As their career develops, the medical/professional dominance of their status and position afford them a high degree of personal autonomy in decision-making and interaction with patients and subordinates (Armstrong, 1976; Ovretveit, 1985). But over several decades, this autonomy and control has been eroded as healthcare has faced numerous structural and operational changes due to government intervention (Friedson, 1970; Kluge et al. 2018).

Second, health fields are historically characterised by tensions and struggles over the allocation of resources, and how they should be prioritized among stakeholders (Klecun et al, 2019; Kraus et al, 2021). A longitudinal study on health organizations in the San Francisco Bay Area analyses the interdependent relationships between regulatory systems and health policy at local, state and national levels (Scott et al., 2000). This study offers insightful analysis on conflicted logics among field members, showing that institutional conditions in regional health organizations are contingent upon coercive pressures from regulators, but also from local pressures from health professionals. Governments seek to introduce various programs, including health technology to change health service delivery. Tensions emerge, however, as health professionals and their powerful representative bodies resist these changes (Scott et al., 2000). This study of regional health institutions, complements country-level studies on national health IT programs (Greenhalgh and Russell, 2010, Pouloudi et al., 2016; Currie, 2012). A more complex and challenging scenario is how the EU, as a supra-national state, develops policy to encourage cross-border health engaging multiple, diverse stakeholders (Legido-Quigley et al, 2012).

Third, health fields require analysis of their relative autonomy from, or dependence upon, other fields. Fields are 'historical constellations' (Waquant, 2006) that arise, develop, change shape, and sometimes wither away over time (Swanson and Ramiller, 1997). How health systems adapt in the light of global challenges (e.g. health inequality, pandemics, ageing populations) shapes the delivery of future health services (OECD/European Commission, 2020; Mengiste and Aanestad, 2013). Longitudinal and multi-level studies on healthcare are less common. A study on healthcare in Alberta, Canada, examines how an organizational field becomes re-established following the implementation of radical structural change (Raey and Hinings, 2005). A large-scale or 'mega-change' IT program in UK public health uses a process-oriented approach to reveal conflicting institutional logics across governmental, professional and managerial field boundaries (Currie and Guah, 2007). A more recent study on the U.S health system examines complementary and conflicting logics in the implementation of electronic health records (Hansen and Baroody, 2019).

Social theory uses multiple levels of analysis. A general typology of micro/macro linkages includes situational mechanisms (from macro to micro), action formation mechanisms (from micro to micro) and transformational mechanisms (from micro-macro) (Hedstrom and Swedberg, 1998, 22-23). Fields are simultaneously material and symbolic. The above neo-institutional studies encapsulate social phenomena within the institutional and organizational field of healthcare. Extending this work, our interest is to examine HIT policy across a wider institutional field of a supra-national (EU) state.

Combining Bourdieu's concepts of field and habitus with institutional work on governance structures and logics provides a rich theoretical foundation to study HIT policy across multiple health fields and subfields. We develop two research questions: 1. *How do multiple EU stakeholders perceive supra-national policy on health information technology?* 2. *What theoretical and empirical insights emerge from primary and secondary data on stakeholder values and opinions of cross-border HIT policy?*

## Methods

The research study began in 2011 as a quantitative benchmarking study on national HIT policy in the European Union. Sponsors formed a coalition of partners including government agencies, technology vendors, management consultancies, patient advocacy groups and academic institutions. The authors began the research enquiry by reading widely on digital health policy (eHealth, mHealth, telemedicine and cloud computing) seen as 'drivers for change' in European health systems. Sponsors requested an academic study with an emphasis on HIT policy diffusion and implementation. The concept of supra-national HIT policy was not problematised by government agencies or technology vendors. Neither did sponsors discuss the difference between digital transformation and IT-enabled organizational transformation (Wessel et al, 2020) in health domains. Implementation issues were viewed as technical challenges, with less emphasis on political, cultural and social issues. However, sponsors facilitated high level access to EU and company-led workshops, enabling brainstorming and opportunities to visit different organizations/agencies (e.g. EU departments, tech companies and patient groups). Inductive methods were used by 'talking and listening' to gain a wider appreciation of sponsors' perceptions about Europe's ambitious digital agenda.

## Comparative Methods

The initial study used comparative country analysis methods to benchmark EU health systems (OECD/European Union, 2020, Currie and Seddon, 2014, Cruz-Jesus et al, 2012). Countries or nation states were seen as units of analysis, *'the features being compared can be measured, that these features are sufficiently similar, and that*

*variations in features in one country are largely independent of variables (unit independence) of the same features in other countries”* (Lor, 2011, 12). Country-comparison is made across political and social systems demarcated in relation to territorial as opposed to geographical space (Pennings et al, 2006).

Comparative methods have traditionally played a significant role in social science disciplines, particularly politics, economics and sociology (Hantrais, 1999, Ragin, 1987). The comparative method is a distinct, subfield of disciplines and a methodology (Pennings et al, 2006). Most social science, including management research examines a single country with organizations the default level of analysis. Cross-country comparison is a multi-level analysis (Cacace, et al, 2013) where knowledge about social reality is acquired by examining similarities and differences between data gathered from one or more countries. Comparative studies include: i. comparing many countries, ii. comparing few countries, and iii. single-country studies (Landman and Robinson, 2009). The distinctive approach of comparative social science is to examine large macro-social units of regions, countries, or larger political entities, such as the European economic region (Ragin and Rubinson, 2009). A fourth dimension of comparative research positions multiple countries within a supra-national economic region. The approach goes beyond a single case study that empirically examines an institutional environment (a national health system) or a professional group (medical professionals). In the context of this research, comparative analysis focuses on a single policy objective (digital health) within a supra-national region (EU) gathering primary data from diverse stakeholder groups (policy-makers, clinicians, IT vendors and patient advocacy groups) engaged in policy development and implementation.

### Field Level Analysis

The benchmarking study served as a forerunner to our research, showing that EU Member States have highly differentiated health systems compounded by a digital divide (Seddon and Currie, 2017). EU HIT policy, however, aimed to implement cross-border health across the entire region. So, the concept of a *health IT field* extended beyond a country-specific analysis. To help define the concept and empirical use of *field*, we revisited the work of Bourdieu (1977; 1984; 1993). The ‘field theory rule’ advocates researchers begin their enquiry by looking at the ‘situation as a whole’ to gain a rich picture of ‘how people relate to their environment’ (Lewin, 1946). Field theory is a set of concepts for ‘dispassionately analysing field dynamics and effects’ (Benson, 99, 475). It is relevant for policy driven research using mechanism-based theorizing and field level analysis of societal change (Davis and Marquis, 2005, 332; Alvesson and Sandberg, 2011). The approach links policy-making with practice-driven institutional change (Smets et al., 2012).

Table 1 attributes five levels of analysis to health fields moving from macro societal to micro individual levels. Institutional effects and processes permeate all five levels. Academic enquiry often isolates social phenomena within one or two levels, although emergent properties in each institutional domain or unit of analysis are relevant for research enquiry (Fligstein and Alford, 1991). The macro-meso-micro level distinctions are often treated as mutually exclusive. However, field level analysis of HIT policy attributed to the macro (societal) level, emanates from meso (institutional, organizational) and micro (group and individual) influences and pressures.

### **Table 1. Institutional Levels, Units and Contexts of Analysis in Health Fields**

#### Data Sources

Data was collected from multiple sources from 2011-2014. First, sponsors arranged several workshops and symposia in Brussels and Paris attended by policy-makers, civil servants, health professionals, academics and patient advocacy groups. At these events, participants discussed various issues relating to cross-border HIT policy. Discussions focused on EU policy formulation, the intersection of health and technology for understanding social and economic issues about the rising ageing population, demographic changes, skills shortages and youth unemployment, chronic conditions (diabetes, heart disease and cancer) the digital divide, constraints on health budgets, rationing of health services and health tourism. These events provided an opportunity to engage with stakeholder groups to gain a wider appreciation of the multifaceted challenges facing the region. An important outcome of the discussions and interaction with stakeholders was an appreciation of the fundamentals of EU HIT policy-making, coupled with shining a light on the potential obstacles and impediments for policy implementation at member state level. The research enquiry was thus re-oriented to focus specifically on stakeholder group views and opinions in the context of these challenges.

Second, thirty interviews were arranged with EU policy-makers (EU-10) clinicians (CL-10) health technology providers (TP-5) and health advocacy groups (AG-5). Policy-makers were employed by the European Commission and from across the region. The technology providers, or vendors, included multi-national companies, with offices based in Brussels. Two of the technology vendors were start-up firms from Belgium. The health advocacy groups were UK. And Brussels based. The informants were all engaged in policy discussions about pan-EU policy to roll-out cross-border health technology. The job descriptions of the respondents included: Members of the European Parliament (MEPs), EU Director General, Chairman of a tech firm (anonymous) Health of Life Sciences at a tech firm (anonymous) Head of Patient Forum, Entrepreneur

(Brussels tech start-up) Medical Consultants (UK, France, Germany and Brussels based) General Practitioners, and Software Sales Personnel and Developers (EU-wide). We retain the anonymity of the informants in this study.

Research topics included how supra-national HIT policy translates across national borders given that each member state has its own national (and in some cases regional) health IT policy, regulatory differences in patient data protection laws, data privacy and security, clinical incentives for adopting health technology (i.e. electronic health records, mobile apps), programs to encourage patients to become ‘active’ and participants in using health technology.

Interviews were recorded and lasted between 1-2 hours. Interview data was transcribed. Sponsors agreed to follow-up interviews to clarify key points and comments, and also explore additional topics. Key themes emerged from interviews about how health systems are structured and financed (i.e. Bismarck model or Beveridge model), how health technology is perceived by stakeholder groups (i.e. whether it offers immediate benefits to health systems or requires a period of adaptation and redesign), how medical professionals embrace or reject health IT policy, and how the rhetoric of ‘patient choice’ and ‘patients as consumers’ is interpreted by patient advocacy groups. Delineating the interview data into emergent themes provided an analytical framework to the research enquiry.

Third, to complement qualitative primary data, secondary source material was used in the form of European Commission reports outlining supra-national HIT policy and implementation plans. The Digital Agenda is a wide-ranging list containing 101 actions, in 7 pillars to ‘reboot the EU economy and enable Europe’s citizens and businesses to get the most out of digital technologies’. The EU is a patchwork quilt of Member States with diverse health systems and technology profiles. Benchmarking data on country level performance provided background information to the study (see OECD, WHO and Eurostat). Comparative performance indicators, ‘whether few or many, aggregate or granular’ provide a snapshot on the ‘relationship to other metrics, and likely policy relevance’ (Forde, Morgan and Klazinga, 2013, 7). Archival data sets and EU comparative country reports reveal socio-political and economic diversity between Member States, impacting EU-wide policy objectives and potential outcomes. The extent to which objectives and outcomes are shared among stakeholder groups is discussed in the following section.

## Data and Findings

The EU with a population of over 447 million citizens aims to ‘connect health systems’ across Europe. The vision is to ‘play an active role in the uptake of eHealth at European level, facilitating cross-border health services and supporting Member States’ action to roll out eHealth solutions at national level’ (European Commission, 2020:1). The European Commission over several decades has actively promoted IT in the form of general-purpose technologies (GPTs) (Cruz-Jesus et al, 2012). More specifically, the digital policy agenda has targeted Europe’s health sector. The first eHealth Action Plan in 2004 EU crafts policies to foster HIT diffusion in Europe (European Commission, 2012a). Notable policies include the eSOS project to design, build and evaluate a service infrastructure for cross-border interoperability between electronic health record systems in Europe, and the Directive on the Application of Patients’ Rights in Cross Border Healthcare and Article 14 establishing the eHealth Network. The second eHealth Action Plan in 2012 identifies barriers to access, availability, interoperability and clinical and citizen engagement with HIT. Policy aims to widen citizen participation by creating a *pan-European* vision for HIT (European Commission, 2014a). Building on the digital health agenda, a Green Paper on mobile health (mHealth) encourages wider stakeholder participation by inviting commentary and views about *unlocking the potential of mHealth* (European Commission, 2012b).

## Cross Border Health

National health systems worldwide face growing economic and social challenges (World Health Organization, 2014; OECD/European Commission, 2020). Rising health budgets, ageing populations, chronic conditions and citizen demands for affordable healthcare impose barriers on Member States participating in policies to extend health service to EU citizens. EU policy on ‘borderless healthcare’ is part of the ‘Horizon 2020’ program, with a budget of €80 billion for research and innovation to ‘build the digital economy’ (European Commission, 2014a). Pan-European digital health requires profound change in health service delivery. Cross-border health, designed to eliminate national and regional barriers, aims to give EU citizens wider access to Europe’s health services. Digital technology is an enabler in this process.

Achieving health equality across Europe is a major policy challenge. Europe’s digital divide shows significant inequalities in citizens’ access to, and use of, information technologies (Cruz-Jesus et al, 2012. Datta, 2010). The legacy of large-scale national HIT programs, however, has repeatedly ended in failure to deliver benefits to patients and health professionals (Greenhalgh and Russell, 2010; Greenhalgh and Stones, 2010). Implementing supra-national HIT policy is a much greater challenge. Commenting on technology diffusion in the EU, the Estonian President Toomas Hendrik Ilves, Chair of the Independent high-level eHealth Task Force, noted, “We



know that in healthcare we lag at least 10 years behind virtually every other area in the implementation of IT solutions. We know from a wide range of other services that information technology applications can radically revolutionise and improve the way we do things.”

One challenge is to create awareness among citizens about access to Europe’s health systems. Data sources show to facilitate cross-border health, National Contact Points (NCPs) provide information for patients and public enquiring about health services outside their home country. In 2018, 95,565 enquiries were made across 28 NCPs. The majority of Member States, however, only received fewer than 1000 requests, with Estonia, Poland and Lithuania receiving more requests totalling 27,242, 24,233 and 15,532 respectively. Coupled with modest requests to Member States, Denmark, Estonia, Romania and the UK made requests to rationalize health services for citizens outside their home country (European Commission, 2020).

### **Table 2. Empirical Themes and Data Sources on EU Health Information Technology Policy**

Against a background of political turbulence in health systems across the EU, the motivation for cross-border health is set out in various EU policy documents and reports (see Table 2). Digital technology is central to the vision, objectives, benefits and expected outcomes of cross border health. The following sections present primary interview data stakeholder groups. An observation is the mismatch between the ‘blue sky’ content in policy documents and the ‘mixed’ views and opinions of key stakeholder groups.

#### Health Systems and Markets

The transition of public health systems from state monopolies to market-driven systems is discussed in the literature (Gubb and Meller-Herbert, 2009). Studies show health systems increasingly exposed to *market forces*, with services outsourced to private sector firms (Klein, 2006). In the EU, a mix of private and public (Bismarck and Beveridge) health systems prevail. Market ideologies pursue greater efficiency by encouraging citizens to exercise their rights on health service choices (Kay, 2004). Free market healthcare designed to expand stakeholder participation rests on the premise that wider choice is given to citizens (Le Grand, 2007). State monopolies like the UK NHS are founded on the principle of giving citizens healthcare free at the point of delivery. Variations across Europe are in place. France, for example, gives citizens a health identity card (Carte Vitale). Citizens pay to see a doctor, and are reimbursed by the state. Informants offer conflicting views about the efficacy of market driven systems compared with state monopolies. An EU policy maker (EU#5) commented:

“The goal of the EU is to build a digital market for health services. Citizens and clinicians are already using technology, but the EU’s goal is to extend the market beyond country borders to create borderless healthcare, and to level the playing field in who has access to health services. Technology will be a great leveller in this process.”

An IT Vendor comments:

“I’m based in Brussels. My company is a start-up working on mobile apps for patients. In time I think patients will access healthcare across geographical regions because public health has long waiting times and is generally inefficient.” (IT#4)

Contrasting views include:

“By reducing doctor-patient exchanges to market forces, the values and ideologies for public health systems are being eroded. My job as a GP in the UK has changed so much. I now spend a great deal of

time filling in forms rather than attending to my patients. The National Program (for IT) was an example of how mega-IT systems don't work in practice. I also think cross-border health will not work as there are too many cultural and financial obstacles.” (CL#7).

“Health professionals across the EU are not against expanding the market for healthcare, but more work needs to be done about rewards and incentives, for the patient and clinician. Some people have suggested online consultations across borders using skype. The question is, who pays for this service? The EU, the state, the region, the health provider or the patient?” (CL#4).

Comments about market driven healthcare, expressed individually by clinicians, and collectively by powerful representative bodies, reflect competing personal and professional agendas. Interview data pointed to policy makers and IT vendors more commonly supporting market-driven healthcare, with clinicians and patient advocacy groups more cautious. Clinicians were concerned about market forces “*changing the rules of the game*” (CL#3) without demonstrable benefits for Europe's patients and health professionals. Public health systems, described as ‘socialized medicine’ were derided by those who supported market-driven health systems. A Brussels based Clinician comments:

“The idea of cross-border health encourages EU citizens to seek health services in other locations, not even in their home country. Information technology will help them to do this. There is some evidence this is already happening in countries like Spain who offer a holiday as an incentive. But for the average citizen, particularly the elderly, the logistics of transporting patients from one location to another are very real obstacles.” (EU#1). Patient advocacy groups expressed support for health policies to give patients more choice and affordability in healthcare, yet cautioned against inequalities in access to health services:

“We have to remember that if you're young and technology-aware, you are more likely to have the ability to seek treatments outside your home country. But many of my members serve elderly and disabled patients who may find going to another country for healthcare is not feasible or desirable.” (AG#2).

### Digital Health

EU policy rhetoric rests on the belief that digital technology is a force for good in society. Interviews with policy-makers and IT vendors show view technology as a means of improving patient care. The goal of ‘patient-centric’ health systems was attainable with the ‘proper use of IT.’ Promoting *technological-push* strategies, policy makers rarely discussed implementation challenges, preferring instead to describe digital technology as a means of ‘empowering’ citizens. An MEP based in Brussels comments:

“We know that differences exist in access to health information technology, but the digital agenda is to empower all citizens with access to digital technologies. Citizens will be able to access health services across Europe's many borders in a digital health market.” (EU#4)

Similar statements from the Vice President of the Commission and Commissioner for the Digital Agenda, Neelie Kroes (2014) states:

“Today we see the emergence of a new digital citizen. People with greater access to information, people empowered to shape the world around them. More able to both learn and participate.”

An IT vendor comments:

“Health IT has made slower progress compared with finance and manufacturing. My company is developing eHealth apps to create an environment for private and public stakeholders to share health records in the Brussels area. The technology will drive demand as people realise there are real benefits from eHealth.” (IT#5)

The above views contrast with those of other informants who perceive diffusion and implementation challenges requiring a *technological-pull* strategy, spearheaded by health professionals and citizens. HIT is highly fragmented market serving a variety of national, regional and local priorities. Cross-border health presents Member States with additional challenges, not least from competing interoperability frameworks within the region (European Commission, 2014a). A ‘one-size-fits-all’ HIT policy was viewed with scepticism as failure to align policy imperatives with the day-to-day practical needs of clinicians would undermine policy outcomes:

“Priorities for health technology begin at the local level, not at the state or EU levels. Cross-border health using the latest devices will increase, but so many more things need to be put in place first. Right now, we are only beginning to sort out IT systems between primary and secondary care...so that doctors can book appointments at local hospitals for their patients. This is a far cry from cross-border health.” (CL#5)

“In over thirty years working in different EU countries, I think health technology takes much longer to change working practices than policy-makers and technology companies predict. If you look at the number of health apps available and how many of these apps are being used by people, the evidence shows that most apps have very few regular users. In my experience, people want local health services, and have very little interest in the idea of cross-border health.” (CL#3)

Policy decisions promoting mega IT projects in national health systems were compared with supra-national HIT policy:

“Mega-projects are unsuccessful because politicians don’t do detail. IT vendors rarely understand the practical needs of clinicians, and the clinicians are not included in the policy-making process. There is plenty of evidence to show that government IT policy fails at the local level, so there is even less chance it will succeed across the whole of Europe.” (CL#7)

“The biggest IT program in Europe is the UK’s national program for IT (NPfIT). After several years of trying to make it work, the government finally abandoned the program to concentrate on specific localised systems.

Choose & Book was rebranded as a patient booking system. I think this program provides a lesson to policy-makers that technology in healthcare is better led from the bottom-up.” (CL#6)

### Clinical Engagement

Cross-border health is a policy designed to extend clinical engagement with health systems, products, services and medical professionals across the EU (European Commission, 2012a, Eason, 2007). By informing clinicians about the ‘benefits’ of HIT, rapid implementation of digital technologies is assumed in policy documents rather than questioned. Engagement of different stakeholder groups is a primary objective as *‘doctors are no longer the sole arbiters and interpreters of medical information for patients’* (European Commission, 2012, p.16).

Traditionally, clinicians were the primary gatekeepers of the doctor-patient relationship. Information asymmetries between doctor and patient prevailed, with the former unlikely to share medical/health data with the latter. In recent years, the relationship between doctor and patient has undergone change with the intervention of government policies to extend managerial control and scrutiny of the medical profession (Wismar et al, 2011). Respondents’ views about the changing role of medical professionals from increased managerialism received mixed opinions from stakeholder groups. The doctrine of managerialism extends across health systems in Europe, as policy-makers, hospital managers and external regulators impose ‘managerialist’ procedures, processes and performance criteria on health professionals. Cross-border health is a primary goal with digital technology having greater capacity to extend the storage, recording, manipulation and sharing of medical/patient data with other stakeholder groups.

The following comments on cross border health were given by interviewees:

“I work in public health, but I also have a private practice. Information technology has been useful because potential patients can find me on the Internet. This means I receive more enquiries about my services. If anything, cross-border health is likely to impact private healthcare, as the resources in public health are squeezed to the limit. Managers might want to increase the number of patients from other EU countries in public health but this can only be done if more resources are put into the system. Right now, there are too many other priorities in public health above offering services to citizens from other countries.” (CL#2)

“An integrated European health market will mean citizens will be empowered to benefit from health services from across the region. This is the goal of integrated healthcare, and digital technology will play a major role in achieving this objective.” (EU#2)

Other interviewees express less optimistic views:

“Opening up a cross-border market for healthcare will take many years to develop. What I am seeing is increased pressures on health services, with ageing populations and more people living with chronic conditions. National governments will give priority to their own citizens, so I question the policy behind cross-border health. Technology can give more people access to information about health services but making services available is about politics and economics, rather than technology.” (CL#6)

“I work in a UK hospital. I am a neuro-psychiatrist. I have constant battles with management about my role and responsibility. I want to serve patients, but so much of my time is taken up with admin. Cross-border health, in my view, would increase the admin. The IT referral systems are OK, but mistakes still get made. If cross-border health is going to work, there needs to be harmonisation, not just with technology, but also about doctors’ credentials and different types of practices, which are culturally based.” (CL#7)

“Over the past two decades, managerialism has crept into the healthcare systems of Europe by imposing principles and practices of standardisation, market incentives, outsourcing, devolved budgets, technology and performance indicators. Providing good healthcare to patients is not always compatible with meeting stringent financial targets, and the standardisation of technical systems does not capture the complexity of individual patient clinical needs. GPs are increasingly expected to increase their efficiency and effectiveness by seeing more and more patients, but for shorter appointments, with patients losing out.” (CL#10)

## Patients as Consumers

Pan-European policy on the digital society is oriented towards patients being at the centre of the health system. A two-fold restructuring plan aims to replace a *symptom-based* approach with one that promotes *preventive and personalised* healthcare, moving from a hospital-based to a person-centric approach (European Commission 2006). The ‘patient-as-consumer’ model is a significant challenge, requiring a shift in patient perceptions about clinical engagement. Empirical data from patients and patient groups found a mis-match between policy-makers and IT vendors who promote the ideal of patient-as-consumer and clinicians who predominantly expressed a paternalistic attitude towards patients:

“The boundaries are blurring between health professionals and patients, as patients become more active in seeking diagnosis and treatments from a range of health services, including alternative medicine. The internet has changed everything as patients become more knowledgeable about health conditions.” (EU#5)

“Our organization aims to empower patients to take more control over their health. Information technology enables them to find out about health services and better engage with health professionals. We see an emerging market for healthcare where the citizen will be at the forefront of decision-making.” (IT#2)

Others expressed caution about treating patients as consumers:

“Patients should take more interest in their health with the help of technology. But I work in geriatrics and many of my patients are unable to take decisions, especially those with dementia and other medical conditions. The one-size-fits-all policy of cross-border health cannot be driven by patients alone, so the policy does need to take into account patients’ conditions, and whether treatment in another country is possible”. (CL#8)

“Health technology offers great benefits to patients and health workers...but I worry about some of the websites that give advice to users. Some sites charge money for a doctor’s consultation, and I have heard some stories of different opinions given users seeking diagnosis and treatment. Healthcare in my opinion works better when the patient develops a strong relationship with their own doctor. Healthcare is not a commodity service.” (CL#2)

## Analysis and Discussion

The data section with selected quotes from stakeholder groups gives mixed views on EU HIT policy. Isolated comments from individual stakeholders are interesting, but not sufficient to provide theoretical and empirical insights about policy orientation and outcomes. More interesting insights emerge from comparing primary and secondary data on stakeholder agendas that reveal diverse and mis-aligned views and opinions on HIT policy. The next section uses Bourdieu’s field theory to analyse stakeholder values, dispositions and engagement in supra-national HIT policy.

### Bourdieu and Field Theory: Tensions, Stakes and Positions

Theoretical concepts of field and habitus describe ingrained dispositions among field agents who promote or inhibit institutional change (Bourdieu, 1984). The EU health field is a complex and highly differentiated geopolitical entity of 27 Member States. Countries defined as sub-fields interact with other fields (medicine, IT vendors, policy-makers, patient advocacy groups) to produce a rich landscape for supra-national HIT policy formation and implementation. The sociological habitus of stakeholders in a given social field influences their action and behaviour, consciously and unconsciously, towards policy initiatives at all levels of analysis (supra-national, national or regional).

Findings from this research reveal the supra-national health field is a dynamic, evolving and unstable social space. Stakeholders immersed in struggles and conflicts express different ‘*ways of looking at the world*’ (Brubaker, 1993: 217). Context-specific empirical observations of Bourdieu’s concepts reveal diverse opinions among stakeholder groups with conflicting sociological stakes, positions and dispositions. The relational scenario manifests ongoing and potentially, irreconcilable tensions, *typical* of the social position, status and power (habitus) of stakeholders (Bourdieu, 1977).

Cross-border HIT policy developed at supra-national level spans multiple levels and units of analysis. Health fields and field members have intersecting and overlapping trajectories. The specific configuration and characteristics of the field and habitus at any given time are influenced by this intersection (Waquant, 1996). Institutional theorists assert that stable fields are strengthened by members’ acceptance of governance structures and dominant ideologies (Fligstein, 1991). Field *incumbents* legitimate governance structures and ideologies that promote institutional stability. Conversely, field *challengers* exert destabilizing pressures for change or de-institutionalization (Oliver, 1992, Greenwood et al, 2008). Identifying field pressures of stability and change from interactions of different stakeholders provides insights on the preconditions for consensus or conflict (Accardo et al, 1995, Meyer, 2008, 525).

### Insert Figure 1. Destabilising pressures and institutional stability in health sub-fields

Figure 1 is a schematic of this scenario. Theoretically, challengers to existing health systems are depicted as policy-makers and IT vendors. These stakeholders occupy different roles but share common stakes and positions for promoting Europe’s digital agenda. Policy-makers assert the digital health market will *level the playing field*

for citizens. Similarly, IT vendors view healthcare as an opportunity to generate revenue streams from new consumer-led markets. Incumbents are stakeholders who critique the digital agenda. Empirical data reveal health professionals view technological change as inevitable in healthcare, but articulate concerns about how HIT policy translates into practice. Aligning EU and national health policy, using digital technology *road maps* for each Member State, is a significant implementation challenge. Tensions arise from incompatible ideologies of market-driven healthcare and medical professionalism. Similarly, patient advocacy groups, show support for the digital agenda as a policy initiative; with the caveat that comparative health inequalities in citizens' access to, and use of, digital technology must be eliminated.

Empirical data provides a backdrop for theorizing stakeholder tensions manifesting from the dynamics of four oppositional themes: market mechanisms vs. state monopolies, technological determinism vs. social construction of technology, managerialism vs. medical professionalism, and patients-as-consumers vs. patient-as-passive recipient of care (see Table 3). Each example contains the preconditions which manifest as field tensions that impact the ideological acceptance or rejection of EU HIT policy. Oppositional relationships in health systems are discussed at national and regional levels contributing to the body of work in institutional theory (Scott, 2001). Our analysis builds on institutional accounts theorizing stakeholder group interactions on a single policy initiative in the wider geo-political region of the EU. In addition, Bourdieu's concepts offer an analytical framework for understanding competing stakes and positions of challenger and incumbent groups.

### **Table 3. Tensions, Stakes and Positions Among Stakeholder Groups in Health Fields**

First, complexity in supra-national health fields increases tensions in the intersection of market mechanisms and state monopolies. Healthcare is an 'opaque institutional field' (Wijen, 2014) with boundaries extending beyond multiple legal and regulatory jurisdictions. Across Europe, market and monopoly ideologies create an incompatible set of policy, institutional and market pressures for change. Multiple stakeholders pursue their own agendas which promote or resist policy intervention in health fields. Health technology, politicised as a means of improving health services for citizens aligns with rhetoric in favour of market-driven health. The European Commission asserts, Europe's 'digital future' rests on three pillars: data access and sharing; connectivity; and citizen empowerment (European Commission, 2018).

Tensions manifest as market-monopoly dynamics, mediated by stakeholders, align or mis-align with supra-national policy and national health policy. Supporters of public (monopoly) health systems resist transitioning towards financialized (market) health systems. Specifically, clinicians articulate their reservations about creating a market for health in the context of other, more pressing issues, facing national health systems. Examples include, rationing health services for citizens, long waiting times for appointments (diagnostics and treatment) and restrictions in pharmaceutical options for patients due to cost. Policy directives which exaggerate the benefits of market-driven healthcare conflict with many clinicians' perceptions, who argue that HIT policies promoting eHealth and mHealth need to align with all types of health systems. Empirical data reveals complex and diverse stakeholder agendas, with vastly different priorities, preferences and conditions in monopoly and market systems.

Second, determinist perspectives view technology as an essential causal element in processes of social and cultural change (Marx and Smith, 1994). Adhering to the ideology of *technology-as-progress*, EU policy-makers present arguments that social and economic problems are resolved by technological advancement. Underlying assumptions suggest, as technology becomes more stable or embedded in the digital society, its effects on users' behaviour will be profound and beneficial. Technological determinist language imbued in EU policy documents conflicts with respondents' views. Clinicians and patient advocacy groups point to well documented empirical evidence of how government-led technology programs are seldom fully implemented in practice. Dismissing one-dimensional thinking that digital technology is a *force for good* in society, interviewees cite examples of top-down, technology-push strategies with mixed results (e.g. The UK's NPfIT, Germany's health card, and France's eHealth program).

Stakes, positions and dispositions of policy-makers presented as abstract ideas in policy documents are challenged by those who question how these ideas translate into practice. A point of contention is the failure of policy-makers to engage clinicians in the policy-making process. Clinicians reject simple technological determinist positions, perceiving technological change as a negotiated, iterative and organic process. Isolating digital health as an abstract concept with a wish-list of benefits to citizens is not reflective of how technology shapes institutional and organizational change. Health professionals and citizens who resist HIT initiatives potentially create an unintended dynamic. Incumbents' attempts to preserve institutional stability may lead to destabilizing effects, as powerful challengers (policy-makers, hospital executives, IT consultants) use their privileged position to enforce technological change on others. An example is the top-down led U.K. NPfIT, which imposed technological change on health professionals (and patients) despite leading professional groups (British Medical Association) and academic contributions raising concerns about efficacy of the program (Greenhalgh and Russel, 2010; Currie, 2012).

Third, the shift from state monopolies to market mechanisms disrupts the values and ideals (*habitus*) of health stakeholders (Gaffney et al, 1999). The *habitus* of medical professionals governed by ideals of “*doing no harm to patients*” (Hippocratic Oath) mis-aligns with managerialist goals of “efficiency gains” and “cost reduction” in health service delivery. Clinicians describe this dynamic as a tension between policy makers promoting a managerialist agenda and health professionals whose primary role is patient care. Encouraging patients to adopt *abstract* eHealth and mHealth policy ideas, for example, is secondary to clinicians’ priorities. Tensions emanating from the managerialist – medical professionalism dynamic arise from mis-information about the purpose, scope and benefits from HIT. Clinicians caution against the hype contained in policy documents on eHealth and mHealth. A point of contention is the different motivations of clinicians and patients for adopting digital health. Clinicians observe that cross-border health facilitated by digital technology is at odds, not only with national health policies, but also patient priorities for sourcing health services. Patient advocacy groups report that patients prefer to access local services rather than travel to other Member States for cross-border healthcare. Destabilizing pressures to reduce autonomy of clinicians are less effective if policy objectives conflict with patient preferences for using digital health.

Fourth, empirical data suggest policy recommendations to transition patients from *passive* recipients to *consumers* of healthcare is mediated by shared cultural understandings of the *habitus* of clinicians and patients. Health fields, described as ‘battlefields’ (Scott et al., 2000) express multiple and conflicting pressures for retaining and destabilizing institutional patterns. Tensions arise as patient advocacy groups promote ‘patient empowerment,’ yet recognize patients as a heterogeneous group with complex demands on health professionals and organizations. Clinicians question the rationale for promoting the idea of patients as consumers, especially as monopoly health systems are held in high regard by citizens in many countries who access health services free at the point of use. Digital health exerts pressure on patients to evolve from passive recipients of health services to become active participants with access to, and control of, their eHealth record. Historically, patients have not had access to their health data. Despite HIT policy promoting patients as consumers, data/information asymmetries between clinicians and patients serve to maintain governing/administrative structures. Clinicians express little enthusiasm for encouraging patients to access and modify their health data. Similarly, patient groups support retaining some elements of the paternalistic relationship between clinician and patient, particularly in cases where elderly and disabled patients, for example, are less able to use information technology.

Bourdieu’s concepts of field and *habitus* are powerful analytical tools for empirical enquiry, with ‘ambivalence and lack of closure’ to some extent intentional (Benson, 1999, 488). An important observation by Bourdieu is that field structures the *habitus* (Bourdieu, 1989:44). Understanding how ‘ingrained dispositions of the sociological *habitus*’ (Brubaker, 1993) construct, maintain and change field practices is central to this research enquiry. We observe dispositions of stakeholder groups align towards policy objectives if compatible with personal and professional agendas. Mis-alignment occurs if policy threatens stakeholder interests. Complexity arises as field influences on diverse stakeholder groups, structure and shape the sociological *habitus*, which inevitably leads to multiple interpretations of HIT policy and practice.

This research builds on institutional accounts of societal pressures and effects on institutions and organizations by illustrating Bourdieu’s concepts in the focal domain of EU HIT policy. The focus on stakeholder views and opinions on macro-level policy adds an empirical dimension to Bourdieu’s concept of *habitus* by providing insights on how diverse stakes and position coalesce to produce multiple interpretations of the meaning and application of supra-national HIT policy. Theorizing four oppositional scenarios provides empirical context for analysing stakeholder group engagement and areas of conflict.

### Methodological Observations

The field theory of Bourdieu’s is ‘intrinsically comparative’ (Brubaker, 1993, 229). In this paper, the supra-national EU state is theorized as a complex health IT field, simultaneously impacted by pressures from multiple sub-fields of Member States (countries) and professional entities (policy-makers, medicine, IT vendors, patient advocacy groups). Field theory and institutional accounts examine a fundamental issue in social science - the conflict between structure and agency (Sullivan, 2002, 150). In this study, *habitus* is not isolated as a theory of individual behaviour and action. More specifically, *habitus* is influenced by field structure and hierarchy (Bourdieu, 1977). *Habitus* is a broader concept than institutional logics since it encapsulates not only how agents develop views and opinions on social phenomena (stakes, positions, dispositions) but also the background and socialization of stakeholders in social fields.

Theoretically and methodologically, field research in institutional theory is depicted as macro level analysis of social phenomena (Fligstein and McAdam, 2012). Table 1 (above) delineates field analysis from the societal (macro) level to the individual/agency (micro) level. Institutions and organizations are positioned at meso level. A closer reading of Bourdieu’s concepts of field and *habitus* reveals a blurring of the macro-meso-micro distinctions as field shapes the sociological *habitus*. Actors, or *agents*, within a given field display the stakes, positions and dispositions typical of the field. External pressures and effects from other fields/sub-fields also

create conditions for institutional stability and change. A methodological observation is EU-wide policy-making imbues social dispositions shared by stakeholders with similar backgrounds. But these dispositions become challenged as other groups attempt to change the social order by imposing new ideas and practices that compromise personal and professional agendas. Habitus of stakeholders observed at the individual (micro) level of analysis signals field (macro) level priorities and preferences for shaping policy outcomes and vice versa. Further qualitative research on supra-national HIT policy enactment at Member State level contributes to comparative benchmarking studies on health systems that reveal variability in performance outcomes (WHO, 2000; OECD, 2005; Cruz-Jesus et al, 2012; Oderkirk et al, 2012; Asolfi et al, 2012). More specifically, case studies on country-level HIT policy give rise to complementary and conflicting stakes, positions and dispositions of national, regional and local stakeholders.

### Implications for Practice

The research presented in this paper adopts a generic perspective on supra-national HIT policy eliciting views and opinions from diverse stakeholder groups. EU reports advocate digital technologies will transform national health systems to become cost effective, market driven and consumer oriented. Comparative stakeholder analysis plays out in a complex landscape. Interviews with challengers and incumbents reveal conflicting opinions and views about the translation of abstract policy directives into organizational and professional practice. Comparative country data provides examples of performance metrics/indicators that distinguish Member States as *leaders* and *laggards* in the adoption and diffusion of digital technology (Currie and Seddon, 2014). Without providing detailed analysis of socio-political and economic conditions for performance variability, *best practice* guidelines are directed to under-performing countries, albeit, without context-specific examples. In this study, findings suggest top-down HIT policy invoked by politicians offers few guarantees of unproblematic implementation at Member State level. Stakeholder groups (clinicians and citizens) unpick policy objectives and goals and caution against over-simplified digital solutions. Clinicians are not ideologically opposed to HIT policy, but point to the lack of detail across an economic region with vastly different national and regional health systems.

Implications for practice from this study are informed by comparing findings with prior work on national IT programs. Articles and reports on the termination of the U.K.'s NPfIT, Europe's largest civil IT program, document human and technical failures over the ten year duration of the program (Greenhalgh and Russell, 2010; Greenhalgh and Stones, 2010; Mark, 2007). Resistance to the NPfIT from conflicting logics among stakeholders resulted in lengthy implementation delays and the eventual termination of the program (Currie and Guah, 2007). Other studies show similar shortcomings from European digital technology programs. Germany's eHealth card was put on hold due to clinicians' and data experts' concerns over poor security of patient data (Klocher, Bernnat and Veit, 2014). France's national electronic medical record (DMP) was delayed due to technical and implementation difficulties (Burnel, 2018; Metzger, Durand, Lallich, Salmon, Castets, 2012; Grady, 2012). The examples point to serious mis-alignment of HIT policy with stakeholder expectations. In particular, failures in strategic planning that under-estimate the importance of securing clinical engagement at the start of a large IT program; and over-stating technical issues of 'interoperability, testing and certification frameworks' as the main barriers to successful implementation (European Commission, 2014c). Practical implications for future HIT programs, however, suggest that, whilst securing clinical engagement is an important requirement, the complexity of the habitus of diverse stakeholder groups invites a more nuanced understanding of how and why tensions and conflicts arise from diverse political, professional and personal agendas.

### Limitations

Bourdieu's (1984) concept of field extensively developed in institutional theory over several decades, offers analytical tools for isolating exogenous and endogenous pressures that maintain or change fields and sub-fields (Fligstein and McAdam, 2012). Field theory, however, has some limitations for social enquiry. Field, as a multi-level concept, supports comparative methods, but is more commonly used in organizational fields (Fligstein and McAdam, 2012; Greenwood et al, 2008). Prior work suggests the functioning and diffusion of processes in organizational fields is not well understood (Fligstein, 1991). Theoretically and empirically, fields provide a framework for locating and bounding the phenomena of interest. But this is not 'non-problematic and unchanging' (Scott et al., 2000, 13).

Limitations of field theory apply to comparative research. One problem arises from the relationships between societal phenomena, including political and economic power (Benson, 1999, 482). Defining field parameters presents challenges for researchers, as field boundaries are often empirically unspecified. Jurisdictional frontiers reveal strong or weak institutionalized barriers to entry, yet fields have no pre-determined boundaries (Fourcade, 2007). The limits of a field are situated at the point where field effects cease, and there is little transparency about the activity which provides the content, or *raison d'être* for the existence of a field (Warde, 2004:14).

This study theorizes the EU health IT field to encapsulate diverse sub-fields including countries, medicine and policy-making. Empirical data positions respondents' comments within their political or professional sub-field. A limitation is stakeholder agendas interact across sub-fields with clinicians, for example, assuming more political roles removed from their professional habitus. An example is where clinicians become policy advocates in support of national IT programs despite opposition from members within their own stakeholder community (Pouloudi et al, 2016). Further work on complementary and conflicting roles within stakeholder groups will contribute to institutional accounts of field theory across other geo-political sectors, industries and organizations. Another limitation arises from Bourdieu's work in the 'Anglophone academy' that has many definitions of 'habitus' (Brubaker, 1993; Bourdieu and Wacquant, 1992). The notion that habitus is 'the past which survives in the present' (Bourdieu, 1977) challenges other ideas that social practices are just as likely to arise from unconscious and unintentional behaviour, as they are from intended rational-actions. Habitus regulates practice and has an even greater role in societies where few things are codified (Bourdieu, 1986). In this study, our intention is to analyse the sociological habitus of different stakeholder groups, notwithstanding the shortcomings of the concept. Further work may therefore consider the 'unintended consequences' of individual action towards policy-making agendas.

## Conclusion

This study uses a field analysis of supra-national HIT policy in the economic region of the EU. Specifically, we focus on the views and opinions of key stakeholder groups (policy-makers, IT vendors, health professionals and patient advocacy organizations) translating abstract digital health policy into cross-border health services for all citizens. The research offers a number of contributions. From a theoretical perspective, we revisit the seminal work of Bourdieu (1977, 1984). Bourdieu's concepts of field and habitus provide insights into macro-level policy directives and micro-level interpretations from diverse stakeholders. A closer reading of Bourdieu's work reveals environment and structure impact the sociological habitus, thus shaping and re-shaping the stakes, positions and dispositions of individuals. Articulating this relationship through empirical investigation, the macro-meso-micro level demarcations, conceptualised as inter-related, illustrate field pressures on the habitus of stakeholders.

In addition, we theorize four scenarios of field tensions, as stakeholder groups offer different interpretations about the implementation challenges of HIT policy. Each tension reveals ideological oppositions arising from political, technological, managerial and consumer perspectives. Reconciling the tensions and conflicts is further complicated by the potential mis-alignment of EU directives with national HIT policy. Developing a conceptual framework for analysing supra-national HIT policy, this research builds on institutional and organizational level accounts, extending field analysis of the health domain in information systems research. The EU HIT field is thus a dynamic and evolving social space where stakes, positions and dispositions articulate national, regional and local health priorities, are negotiated and challenged by diverse stakeholder groups with different social, political and economic agendas. In sum, to achieve EU-wide HIT policy implementation, the observed tensions and challenges suggest health stakeholders need to articulate how *one-size-fits-all* policy aligns with national (and regional) systems and, more specifically, understand how and why different stakeholder groups position themselves as challengers or incumbents in the complex domain of digital health.

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<sup>i</sup> The term 'Health Information Technology' (HIT) will be used throughout this paper to serve as an umbrella term for a range of technologies in healthcare including, cloud computing, telemedicine, mobile devices and applications, and others.

<sup>ii</sup> The study was carried out prior to the UK leaving the E.U on 31<sup>st</sup> January 2020.

<sup>iii</sup> Health information technology policy focuses on the intersection between health policy and technology where policy-makers aim to promote technology to enhance health service delivery. In this context, technology is perceived as playing a positive role in society where its design and implementation is expected to improve health systems (see various European Commission reports/directives in reference section).

<sup>iv</sup> The World Health Organization published one of the first benchmarking studies which controversially 'ranked' country health systems (WHO, 2000). The Organization for Economic Co-operation and Development also supports governments in benchmarking performance in healthcare with two of the highest systems of profile metrics: the System of Health Accounts and the Health Care Quality Indicators Initiative (OECD, 2011). Countries are increasingly publishing health system performance statistics which can be used for comparative analysis to benchmark progress against their peers (Forde, Morgan, Klazinga, 2013). This work is of immense interest to policy-makers, although it can prove contentious where disagreement arises about the validity and robustness of indicators (measures/metrics).

<sup>v</sup> Field as a 'network, or configuration, of objective relations between positions. These positions are objectively defined, in their existence and in the determinations they impose upon their occupants, agents or institutions, by their present and potential situation (situs) in the structure of distribution of species of power (or capital) whose possession commands access to the specific profits that are at stake in the field, as well as by their objective relation to other positions (domination, subordination, homology, etc).' (Bourdieu and Wacquant, 1992: 97).

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<sup>vi</sup> Bourdieu developed many definitions of *habitus* throughout his career. The concept is viewed as a ‘mysterious entity’ in the field of social theory (Lizardo, 2009). One definition from Bourdieu’s later work is: ‘Systems of durable, transposable dispositions, structured structures predisposed to function as structuring structures, that is, as principles which generate and organize practices and representations that can be objectively adapted to their outcomes without presupposing a conscious aiming at ends or an express mastery of the operations necessary in order to attain them. Objectively ‘regulated’ and ‘regular’ without being in any way the product of obedience to rules, they can be collectively orchestrated without being the product of the organizing action of a conductor (Bourdieu, 1990, 53).

<sup>vii</sup> The term sub-field is used to differentiate over-lapping fields from the EU health field which is central to this research.