



Becoming a public sector insider -A case study of Swedish digital healthcare start-ups' entrepreneurial business formation processes

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ABSTRACT

The aim of the study is to better understand start-ups' entrepreneurial business formation processes from a contextual perspective. We examine a digitalization process in the healthcare sector in Sweden, and investigate the start-up processes taking place in order to reach a better understanding of what it takes for new actors to obtain an insider position in this particular type of highly regulated networks. The study offers important insights into the dynamics of constituent elements in the process, including the sequences of events through which start-up processes evolve, and insights into new ventures' initial entry into a business network. It is concluded that the studied processes were interactive, forcing the start-ups to be both innovative and able to conform. It was also found that legitimacy constitute an important resource in this type of politically sensitive context.

1. Introduction

Despite the considerable attention given to the field of start-up development (e.g., Ambos & Birkinshaw, 2010; Landes, Moky, & Baumol, 2010), there are still many more aspects of the phenomenon to explore. Hence, in recent years, there have been repeated calls for more research on new businesses' beginnings and early development (Ambos & Birkinshaw, 2010; Dew, Read, Sarasvathy, & Wiltbank, 2011; McMullen & Dimov, 2013; Wiklund, Davidsson, Audretsch, & Karlsson, 2011). Snehota (2011, p. 2) claim, for example, that "our understanding of the new business formation process may have advanced but remains rather limited". This holds true not least concerning the impact of start-up external factors as explanations for the outcome of start-up processes (Birley, 1985; Larson, 1992; Sarasvathy, Dew, & Ventresca, 2009; Slotte-Kock & Coviello, 2010). Start-ups "arise from a specific context of social, economic and technical connections" that need to be established for them to grow (Baraldi, Ingemansson-Havenvid, Linné, & Öberg, 2019, p. 58). La Rocca et al. (2019, p. 150) argue similarly that we need to learn more about "how ongoing interdependent actions emerge and evolve and ultimately how this affects the development of a new venture".

The aim of the present study is to better understand start-ups' entrepreneurial business formation processes. This will be achieved by analysing how networks affect entrepreneurial business formation

processes in which start-ups actively relate to established businesses. Hence, using the terminology of Hoang and Antoncic (2003, p. 167), we will examine "the causes and consequences of embeddedness in the entrepreneurial process". Starting from the notion that "organizing at the interface with other organizations" (La Rocca et al., 2019, p. 151) is key, we use a business network perspective (Anderson, Håkansson, & Johanson, 1994; Håkansson & Snehota, 1995) to learn more about these types of processes. A business network perspective implies that the start-up context will be viewed as a network of interdependent business relationships (Hallén, Johanson, & Sayed-Mohamed, 1991; La Rocca et al., 2019), which affects the start-up and its development path. It focuses on how relationships are initiated, maintained, or changed, so as to allow the start-up to create a position within a network (Håkansson & Snehota, 1995). This accords well with the fact that several scholars have stressed the importance of early relationship formations for start-up development (Aaboen, Dubois, & Lind, 2013; Baraldi, Gregori, & Perna, 2011; Ciabuschi, Perna, & Snehota, 2012; Elfring & Hulsink, 2003; Hallén, 2008) and/or for the development and commercialization of a new market solution by a new venture (La Rocca et al., 2019; La Rocca & Snehota, 2014).

It has been suggested that start-ups struggle with the liability of newness and smallness (Burton & Beckman, 2007; La Rocca et al., 2019) as well as that of outsidership (Johanson & Vahlne, 2009; Lagerström &

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Lindholm, 2021; Yamin & Kurt, 2018). Jack, Dodd, and Anderson (2008) explain that networking acts as an organizing and governing mechanism that helps the start-up overcome these liabilities by providing meaning, identity, and resources. The initiation of business relationships with already established actors in the network helps the start-up to becoming an insider in relevant business networks, something that several scholars have stressed is determinative of venture development (Baraldi et al., 2019; Johanson & Vahlne, 2009; La Rocca & Snehota, 2014). This often-challenging process of obtaining an insider position (Landqvist & Lind, 2019) increases the start-up's opportunities to access external resources and achieve, for example, effectiveness (Blankenburg Holm, Johanson, & Kao, 2015). Moreover, through relationships, they often learn about various market potentials (Håkansson & Snehota, 1995; Schweizer, 2013; Uzzi, 1996, 1997).

Empirically, the present paper is based on a study of digital healthcare sector start-ups and their process of crafting new business. Healthcare sectors are described as being highly regulated and professionalized. An interesting twist is that they have undergone major transformations in recent years, with more private initiatives today (Venkatesh & Jayachandran, 2008). According to Braunerhjelm, Desai, and Eklund (2015), there is a lack of studies examining in depth the effects of regulations on new firm formation. To investigate the start-up processes taking place and what it takes for new actors to obtain an insider position in this particular type of highly regulated network, we examine a digitalization process taking place in the healthcare sector in Sweden. Earlier research seems to indicate that, in order to become an insider in this type of network, a start-up will need to form relationships with a wide range of actors, stemming not only from the business sphere, but also from the political, legal and professional spheres (Hadjikhani, Lee, & Gauri, 2008; Lagerström & Lindholm, 2021), because these types of relationships are important for gaining access to relevant knowledge (Coviello, 2006) as well as the legitimacy (Gebert Persson, 2006) required to become a network insider.

We make several contributions: One is made to the entrepreneurship literature by emphasizing the importance of contextualizing entrepreneurship in what Ciabuschi et al. (2012) call “the collective dimension of entrepreneurship”, focusing on start-up processes from a business network perspective (Håkansson & Snehota, 1995). Another contribution is made in relation to more recent studies on start-ups and new ventures in business network research (Baraldi et al., 2019; La Rocca et al., 2019; Landqvist & Lind, 2019) by adding to the agenda the investigation of start-ups' networking processes in regulated sectors. In addition, we contribute to research on regulated sectors, in general, and the healthcare sector, in particular, by addressing how network entry and change processes unfold in this type of context. We thereby fill a void because, according to Baraldi et al. (2019), most network studies on new ventures have been conducted in industrial high-tech settings. Finally, we make contributions to the research on digitalization and its impact on new business formation and networks.

The remainder of the paper is structured as follows. Section 2 presents the theoretical foundation of the paper by describing business network research, paired with research on start-ups. In Section 3, we describe the methodological considerations applied to the study, illustrating how the process study of digitalized solutions in the Swedish healthcare sector was designed, including both data collection and analysis. Section 4 presents the case study of digital healthcare in Sweden and the analysis of the findings. Finally, Section 5 concludes by discussing these findings, implications, limitations of the study and directions for future studies.

2. Theoretical underpinning

Our reasoning in the present paper is based on a business network perspective, which implies that we view firms (and other relevant actors) as nodes in a larger system of actors, resources, and activities connected to each other through the relationships that firms and other

organizations have built over time through interaction (Gadde, Håkansson, & Persson, 2010; Håkansson & Snehota, 1995; Mattsson & Johanson, 1992). A business network is dynamic by nature due to the continuous adjustments being made to the relationships among the involved businesses, and viewing firms as the product of their relationships implies that we focus on the role of interdependency and network context in the formation of a start-up business. Using the terms of Snehota (2011, p. 1), we study “the process of crafting new businesses on the existing network context”, seeing new business formation as “the collective enactment of change in the business network” (ibid.). The start-up thus needs to figure out how to become part of an established network structure and how to navigate the change process taking place in this network (Slotte-Kock & Coviello, 2010).

Being small and new, start-ups often have limited development options, one being the possibility to access resources through others in a business network (Keating, Geiger, & Mcloughlin, 2013; Song & Di Benedetto, 2008). Most start-ups begin from a position outside a core business network, which means they lack the essential resources, such as market knowledge and legitimacy often required to get the business running and to form, for example, customer relationships (Baraldi et al., 2019). According to McGrath et al. (2019, p. 215), “start-ups differ in many ways from established firms, as they need to develop their relationships with other businesses to gain legitimacy, survive and grow”. Thus, in the view of several researchers, business networks are essential for start-ups to grow (Björkman & Kock, 1995), access market knowledge (Larson, 1992), and other resources (Coviello & Munro, 1995), as networks are wider resource constellations that the firm can gain access to through its relationships.

La Rocca and Snehota (2014) argue that establishing vital relationships involves a process of ‘relating’ rather than a selection process. Thus, the interactivity in networks implies that the process of reaching a network position is based on mutuality, i.e., on both the newcomer's and already established actors' willingness to form relationships (Håkansson & Snehota, 1995; Lagerström & Lindholm, 2021). Developing these essential relationships is far from easy, but instead an investment that is consuming, both financially and timewise, for the start-up. To understand the start-up process, Johanson and Vahlne (2009) suggest that it can be perceived as an effectuation process (cf. Sarasvathy, 2001). Hence, the existing resources and the start-up's ability to form relationships with established actors influence its ability to explore opportunities (cf. Forsgren, 2016) gradually.

One important resource to consider in attempts to craft new business in established networks is what Johanson and Vahlne (2009) term market-specific knowledge. Scholars have argued that explicit knowledge can be gained from an outside position, but that a firm gains tacit and market-specific knowledge through relationships with network insiders (Hult, Gonzalez-Perez, & Lagerström, 2020; Johanson & Vahlne, 2009). Håkansson and Waluszewski (2007) add that interactions in early stages of relationships are aimed at uncovering mutual potentialities, where the goal is to find ways to ‘make use’ of each other. La Rocca et al. (2019) even argued that the start-up's limited experience can be turned from liability into asset if network actors see the stimulating development potentials of cooperation.

In line with these researchers, we argue that the business formation process is dynamic, involving not only the start-up's change through interaction with other actors, but also the change of other actors and the network that they gradually become embedded in (McGrath et al., 2019). In the present paper, we use this reasoning to study a start-up's business formation as a process of crafting new businesses in an established network, thereby also changing some of the conditions of the network. Our study shows the process through which start-ups become insiders in the relevant healthcare network. We view new business formation as an entrepreneurial process through which the start-up achieves an increased level of insidership by forming relationships and interacting with relevant network actors, thereby accessing important resources such as tacit knowledge.

Another resource that has been shown to be a particularly significant resource in healthcare, given that it is both a highly regulated and professionalized sector, is legitimacy. Legitimacy shows how meaningful, predictable and trustworthy an organization is perceived to be (Suchman, 1995) and determines the support it reaches from connected actors (Hannan & Freeman, 1976; Meyer & Rowan, 1977). DiMaggio (1992) argue that, to uphold a network position, an actor needs to be considered legitimate by the other network members. Hence, legitimacy also marks the acceptance and credibility of the start-up as perceived by network partners (Bangara, Freeman, & Schroder, 2012). A profession develops norms, values and ethical codes, not least when a long and standardized education is required (Abbott, 1988). These norms, values and codes govern professionals' actions and decisions and may well come in conflict with other kinds of regulations, primarily political and financial. It has been stated that the medical profession is one of the most traditional and strongest professions, due to its knowledge advantage and high legitimacy (Abbott, 1988; Freidson, 2001). This position is further strengthened by the healthcare sector's vital importance in relation to welfare and our need, as citizens and patients, to feel safe and secure. From a legitimacy perspective, arguments implying that healthcare is deteriorating or improving are particularly powerful, as shown in the present study.

3. Method

3.1. The research design

We conducted a longitudinal case study and adhered to several procedures to build theory on the new business formation process and network dynamics (cf. Lee, 1999; Strauss, 1987). This is in line with Hoang and Antoncic's (2003) call for more longitudinal research to examine how different network governance characteristics affect entrepreneurial outcomes. To grasp the new business formation process, the study develops process-focused explanations in accordance with suggestions by scholars such as Langley (1999), Pettigrew (1997), and Van de Ven and Huber (1990). This is also in line with Snehota's (2011, p. 5) argumentation that “an effective analysis of new business cannot be limited to structural explanations but has to consider the time dimension: it begs to take into account how it is likely to affect other businesses over time”. Given that this research design required detailed processual accounts, we took an iterative and open approach to data collection and analysis (Dubois & Gadde, 2002; Strauss, 1987), which allowed us to explore and theorize about this process and these dynamics.

The longitudinal research design was chosen first because it allows observation, description and/or classification of the phenomenon of new business formation in such a way that the process can be identified and empirically documented (Dunkerley, 1988; Miller & Friesen, 1982). Moreover, a longitudinal approach to process studies enables elucidation of the sequence of events in relation to some underlying mechanisms (in this case start-ups' relationships) and the particular circumstances or contingencies that apply when these mechanisms operate (Baraldi et al., 2019; Hoang & Antoncic, 2003; Van de Ven & Huber, 1990). Because we started from a known outcome (new business) and worked backwards to understand how it came about (Bizzi & Langley, 2012), a retrospective case research design was appropriate for the study. By taking a step back in time, archival research highlighted what was taken for granted and unquestioned at that time in the process of new business formation. As suggested by Slotte-Kock and Coviello, (2010, p. 33), we were able to see how network characteristics were “understood and managed for the benefits they provide to the venture over time and at specific stages of development”.

3.2. Case selection

Our study is empirically grounded in the healthcare sector. Theoretically, this sector is interesting from a process perspective because it

has been subject to major transformations during the past decades and, among other changes, has enabled for more private initiatives (Lagerström & Lindholm, 2021; Venkatesh & Jayachandran, 2008). The same reasons also make the study focus relevant from an entrepreneurial perspective, as there is a lack of studies on entrepreneurial activity in highly regulated sectors (Braunerhjelm et al., 2015). Finally, it is also valuable from a network perspective because it adds knowledge about relationships with non-business actors, as it has been argued in earlier research that the healthcare sector is heavily influenced by the institutional context and relationships, not only with customers and suppliers but also with various socio-political and institutional actors (Lagerström & Lindholm, 2021).

Empirically, the setting was considered both interesting and well suited to conceptualizing the new business formation process due to its recent transformation, resulting in the emergence of several start-ups and new businesses in only a few years. In this regard, the dynamic of collaborations between relevant actors extended over a period of only 4 years, during which involvement increased from one start-up in 2013 (MinDoktor) to more than a dozen start-ups in 2017. This allowed a comprehensive investigation of path-dependent network dynamics, including a variety of change episodes (cf. Capaldo, 2007). Moreover, the moderate size of this network allowed us to identify key actors and investigate their relationships.

We decided to focus on the time from 2013, when the first two start-ups were created, to 2017, when the ambition of the start-ups to be incorporated into the publicly funded primary healthcare system was fulfilled. The end date was determined using the argument made by Blank and Dorf (2020), which is that because start-ups are temporary entities working to find a repeatable, scalable business model that solves a compelling problem, it is only once the problem and business model are established on the market that the start-up can be considered a company. The data analysed revealed that, after 2017, not only these start-ups, but also the digital primary healthcare sector as a whole developed dramatically as is shortly described in the case epilogue. Start-ups were no longer regarded as such, mainly because they operated under completely different conditions than existed at the beginning of the process, regarding their size, knowledge, position in the market and own resources.

3.3. Data collection

The present article concentrates on the use of archival material as the main data source for the study of the new business formation process and network dynamics (cf. Easton, 1995). As Layder (1993, p. 172) argues, archival data has a place in “contemporary, theory-generating research”. At their best, archives allow the ‘thick description’ that is so important to case study research (Welch, 2000). In our case, these data gave us detailed knowledge of how network actors interacted over time in the process of new business formation as well as of their reasoning about the interactions at that time. Another important advantage of archival research is that it is often less contingent than interviews, which might be affected by several extrinsic conditions (Welch, 2000). Archival research offers the advantage of being unobtrusive and non-reactive (Guba & Lincoln, 1988). In this way, we avoided several issues involved when conducting interviews, such as those related to distortion of the respondents' responses. The archival material allowed us to locate, uncover and interpret events in relation to some underlying mechanisms and the circumstances in which these mechanisms operate viewed from different points in time (Easton, 1995; Möller, 1993; Welch, 2000). In our case, the use of archival data was necessary as new business formation cannot be limited to structural explanations but must consider the time dimension of the developmental process (Snehota, 2011).

An extensive amount of data covering the period 2013–2017 is included. The data were primarily collected from the Retriever (Mediarkivet) database, which contains approximately 25 million news full-

text articles, dating from 1981, from approx. 500 news sources such as newspapers, magazines and news agencies. In addition, the database also provides access to other media channels, such as the Swedish web archive, blogs and TV/radio. Through Retriever Business, it was possible to gain access to information about companies involved in the process, such as the number of employees, contact information, board information, annual reports, memos, etc. The data used in the present study include a large collection of memos, public filings and a comprehensive array of media coverage, such as reports, press releases, and interviews with founders and different employees. In [Appendix 2](#), we offer a description of the newspapers, magazines and news agencies named in the present article.

To collect this exhaustive corpus of data, we followed the guidelines for electronic data gathering suggested by [Schafraad, Wester, and Scheepers \(2006\)](#) to obtain a valid, reliable, and reproducible corpus for subsequent content analysis, using the following steps: We first created a keyword list to select articles from the Retriever database. Empirical information on public and private actors and the context within which they operate during the new business formation process provided important inputs to the selection of keywords. The keyword list primarily included the terms KRY, MinDoktor, Visiba Group, digital primary healthcare, the Patient Law and SALAR (SKL in Swedish). The keyword list produced an output of 399 articles that were supplemented with 87 press releases from the companies' websites. We also found 54 interviews with founders and other relevant employees in the articles and press releases retrieved. [Appendix 1](#) offers a detailed description of the data collected for the study.

3.4. Data analysis

The study was initiated based on an interest in the empirical phenomenon of digital healthcare and the changes we noticed in the overall sector for healthcare owing to this movement. An overall empirical focus on the change process and relationships was also established quite early, which steered us towards business network theory as a perspective that could guide the study. Based on these initial starting points, we have taken an abductive approach to the study, constantly moving back and forth between theory and empirics ([Dubois & Gadde, 2002](#)). After an initial reading and analysis of the collected data, we created chronological narratives, including one overall narrative and additional narratives based on each of the participating start-ups. The coding process was greatly inspired by [Gioia, Corley, and Hamilton \(2013\)](#), advocating a mix between empirically and theoretically based coding and recoding.

During the first-order coding, a list of relationships was constructed, divided into the main categories privately owned actors or publicly owned actors. The first-order coding also revealed that the process was divided into three distinct phases based on the actors' argumentation and actions. The first phase concerned establishing and developing the digital technology outside the publicly funded healthcare system. During the second phase, the digital services were established and developed within the publicly funded healthcare system. And, finally, it was during the third phase, when the financial consequences of the implementation and development appeared, that the start-ups faced resistance from the publicly funded healthcare system.

The empirically based first-order coding directed us to the literature on start-ups, SME's entrepreneurial processes, relationships, networks and healthcare. The initial part of the coding process, the first-order coding, was hence followed by a second-order coding based on two main theoretical concepts of particular empirical and theoretical importance: legitimacy and knowledge. During the second-order coding, the start-ups' endeavour to achieve legitimacy was coded as statements and arguments aimed at promoting acceptance of the newly developed healthcare service among different actor groups (target groups). The concept of knowledge was coded as different forms of knowledge relevant within the business formation process and was divided into two main categories: knowledge that the start-up gained access to through

the relationship and knowledge that the start-up added to the relationship. The main theoretical categories, divided into subcategories, constituted a coding tree that guided the analysis.

4. The case of digital healthcare in Sweden 2013–2017

4.1. Digital healthcare in a regulated network – A background

International evaluations have shown that the Swedish healthcare sector is highly developed, regarding both medical competence and invested resources ([SALAR, 2019](#)). However, the resources and supply of healthcare services are unevenly distributed within the sector. European comparisons have shown that Swedish patients have less access to primary care, that is, basic healthcare services, than do patients in comparable countries. In contrast, access to specialists and hospital care is good and above average ([Lennartsson, 2017](#)). An additional international comparison, highly relevant in this case, concerns the national level of digitalization. According to the Network Readiness Index (a report published by Portulans in collaboration with UNESCO; [Dutta & Lavin, 2020](#)), Sweden is ranked as the world leader in digitalization. Research has shown that, in an international comparison, the Swedish healthcare sector has previously acted as a pioneer in providing digitalized healthcare services to increase patient access (cf. [Erlingsdottir & Lindholm, 2015](#); [Huvila, Cajander, Daniels, & Åhlfeldt, 2015](#)).

Furthermore, the case description will show that competition between healthcare providers, both privately and publicly owned, is of vital importance in the studied process. This has been possible due to legislation from 2010, stating that any primary care provider who fulfils pre-defined requirements has the right and opportunity to establish a primary care healthcare centre. Regardless of whether the healthcare centres are publicly or privately owned, all healthcare providers have the right to be treated equally, in accordance with the legally established principle of non-discrimination. The healthcare centres are expected to compete for patients through various attractive offerings, which means that the patients become 'consumers'. In addition, the patients' position as consumers was further strengthened in 2015 by the Patient Law, which gave patients the right to freely choose any primary care provider in the country. These pieces of legislation constitute important cornerstones in the start-ups' process of becoming an insider in the healthcare network.

The case description will also show how the healthcare sector is regulated to address the challenges posed by the rapid digitalization process. To better grasp that part of the story, it is important to understand the structure and organization of the Swedish healthcare sector. The sector is characterized by decentralization, as the 21 regions have primary responsibility for providing all forms of healthcare. According to the constitution, the regions are politically governed and autonomous in relation to the national level, implying that the government has limited means to regulate this important welfare service. Along with financial incentives, the main means of governing and controlling the Swedish healthcare sector is through legislation, which is considered a complex, rigid, and time-consuming process. Therefore, important parts of national healthcare coordination are carried out by SALAR (Swedish Association of Local Authorities and Regions), an interest organization jointly owned by regions and municipalities. In practice, recommendations made by SALAR constitute important parts of the healthcare regulatory system, as they are respected and followed by the regions regardless of their informal nature.

4.2. First phase – Start-ups entering the network (2013–2015)

The development of digital primary care commenced when a future major network actor, Min Doktor, was founded in 2013 by Magnus Nylén, a physician previously employed within the publicly owned healthcare system. He strongly believed in digital technology as a mean to increase healthcare efficiency, but his previous attempts to gain

acceptance for such solutions from his former employer had been met with such obstacles that he decided to start his own company. In retrospective interviews in major Swedish business magazines (e.g., *Life-Time*, 2015-12-14; *Veckans Affärer*, 2016-06-28), Nylén stated that his inspiration at the time was his conviction that “approximately half” of all physical primary care visits were unnecessary and could be favourably handled on line. Digital primary care was portrayed as a means to increase cost efficiency in the healthcare sector.

Besides increased cost efficiency and increased patient accessibility, a related advantage was emphasized by the actors: digital technology transferred responsibilities to the patient. The patient described his/her medical history and symptoms in writing – a rather unqualified task that was otherwise performed and documented by the physician – thereby creating time that could be used more efficiently. As a first step to reach patients, Min Doktor started a collaboration with an insurance company, Euro Accident, which meant that policyholders with private health insurance now had access to digital primary care.

In 2014, two more actors entered the network – the start-ups Kry and Visiba Group. In contrast to Min Doktor, there were no physicians among the founders, and the start-ups merely offered technical solutions by developing digital platforms for various established healthcare providers. Both start-ups emphasized, however, that their business idea arose from experiencing a lack of accessibility in Swedish primary care.

In January 2015, the Patient Act entered into force, giving patients the right to choose primary care providers anywhere in the country. Two months later, Kry launched its platform, which enabled physicians and patients to connect via video link. The start-up collaborated with two privately owned healthcare centres in Stockholm, and the new digital service was immediately criticized by medical professionals, claiming that physical examination of the patient is necessary to maintain acceptable healthcare quality (Karin Båtelson, *Sjukhusläkaren*, 2015-03-10). However, some representatives of the medical profession expressed a different opinion and advocated limited use of digital technology. In a widely spread article in one of Sweden's most-read newspapers, the chairman of the medical professionals' association stated: *If we believe it is sufficient that patients only connect via internet, then there is a risk of poorer healthcare quality, but as a complement it is exciting and I believe it will become more common* (Heidi Stensmyren, *Dagens Nyheter*, 2015-04-05).

The technology was also described as a means to create change and improve the relationship between physician and patient. At an important technology fair, Kry announced that the start-up was developing apps for mobile phones and tablets, which would further increase patient accessibility (*My News Desk*, 2015-04-22).

As the technology developed, discussions about the need to integrate digital primary care into the publicly funded healthcare system became more frequent in media articles. The patient fee for a digital visit was still higher than the corresponding fee for a physical visit, and the start-ups expressed that digital care required “new rules, working methods and reimbursement models on the part of the regions” (Josefin Landgård, CEO, Kry in *Dagens Samhälle*, 2015-05-28). In several articles, Kry representatives emphasized that they were in continuous negotiations with healthcare regions about future collaborations. These negotiations, however, were hampered by what was described as “slow processes and a general reluctance to change” (*LifeTime*, 2015-08-14).

Besides presenting their digital healthcare services at technology fairs and successfully participating in contests aimed at innovative and growth companies, all start-ups attracted venture capitalists and other investors, who expected future profitability and returns on investments. The start-ups' financial conditions improved substantially during the period.

4.3. Second phase – Becoming an actor in the publicly funded healthcare network (2015–2016)

In October 2015, a collaboration contract between Kry and a publicly

owned and financed healthcare centre in Region Jönköping was signed – a contract of great importance to the development of digital primary care. The incentive for this collaboration, on the part of the region, was lack of primary care accessibility, and the regional politicians urged the Primary Care Administration to resolve this situation. The primary care manager and a physician, manager at a publicly owned healthcare centre, decided to handle the problem by implementing a digital service for their own patients. Due to their ambition to implement the new service in only six weeks, implementation had to include a short-term collaboration with Kry, which provided the technical platform at a very reasonable price. As both the public healthcare representatives and Kry intended the collaboration to be short-term, the region was not informed in advance. Instead, the newly developed digital service was presented, in its finished condition, as a creative and surprising solution to a well-known and long-lasting problem.

The physician, responsible for the implementation project, argued that digital primary care included several advantages for patients “who want to take a little more responsibility for their care” (Ulf Österstad in *Läkartidningen*, 2015-12-02) and led to increased cost efficiency: “I'm pretty sure that we can expect this to pay off in the long run. Surely from the beginning if we think socio-economically with, among other things, travel, but also for the region in the medium- to long-term perspective” (Ulf Österstad in *Nya Wermlandstidningen*, 2015-12-15).

However, the new digital service involved another, and not intended, surprise to the actors within the publicly owned primary care. The short-term collaboration made Kry a subcontractor to the public healthcare system and, due to the legal principle of equal treatment and non-discrimination, digital healthcare providers were now allowed into the publicly funded healthcare sector. Unlike the start-up representatives, the public sector actors were not aware of the far-reaching legal consequences of the collaboration which opened the network to new actors. Digital healthcare providers, among them Min Doktor and Kry, could now become subcontractors to any healthcare centre within the publicly funded healthcare system. Both start-ups entered into contracts with large privately owned healthcare centres, all of them included in the public healthcare system in Region Jönköping. Major advertising campaigns were launched in newspapers and TV to inform potential customers/patients about the new service – digital primary care visits at the same price as regular primary care visits. The Patient Law provided opportunities to offer this service on a national basis. The arguments spread by the start-ups were designed to suit patients as well as future investors: “No more hours waiting on the phone and no more waiting rooms. The digital physician comes to your home – and the investors are lining up”. (*Veckans affärer*, 2016-04-28).

Both Kry and Min Doktor were now adding a new argument to support digital healthcare: equality. Including digital primary care in the public healthcare sector made it accessible for everybody, in accordance with the Patient Law. In several media articles, the need to adapt the healthcare reimbursement system was discussed when both Min Doktor and Visiba Group established collaborations with public healthcare centres. Once again, the development attracted venture capitalists, which created high expectations. As argued by Charlotte Tönsgård, CEO at Min Doktor; “Now we have an opportunity to do everything we want. Our goal is to be part of the healthcare system of the future by revolutionizing the flow of care”. (*Veckans affärer*, 2016-02-15).

In addition to the arguments stated above, the start-ups were also keen on emphasizing benefits for the medical profession. The main argument directed to this actor group was that the digital tool improved working conditions by decreasing stress and placing more responsibility on patients, with the argument that: “It saves an enormous amount of time and effort in the handling of each patient.” (Henrik Kangro, Medical Operations Manager, Min Doktor in *Sjukhusläkaren*, 2016-09-23).

In 2016, the short-term collaboration between Region Jönköping and Kry ended in accordance with the previous plan. Simultaneously, Kry decided to change its business concept from being a system supplier to becoming a digital primary care provider: “We [...] have long agreed not

to extend the collaboration with Region Jönköping. Our vision is to provide accessible, qualitative care to all patients in Sweden, and we will focus on that instead of building and managing apps for others.” (Josefin Landgård, Chief Operating Officer in Dagens Industri, 2016-10-30).

The interest in developing digital primary care within the public healthcare system increased rapidly in late 2016, and another system supplier was established: Doctrin. Region Jönköping, however, experienced unexpected problems due to the number of patients using the digital services – how should they price the services when invoicing other regions.

4.4. Third phase – Unexpected costs and quality issues create a requirement to regulate the digital primary care services (spring and summer 2017)

In January 2017, all Swedish regions were receiving invoices from Region Jönköping regarding out-of-region digital primary care. Each visit was priced at 120 € and the total sum amounted to 3.8 million €, equalling a total of 20,000 digital visits. Venture capitalists expressed hopes and expectations that this development would continue at an even faster pace: “As an investor, this is an incredibly interesting area where gigantic transformations are waiting around the corner.” (Lars Jörnöw, EQT Ventures in Dagens Industri, 2017-01-18)

However, parts of the medical profession expressed doubts about “the digital physician phenomenon” (*Läkartidningen*, 2017-01-24), and this initiated a media debate about the healthcare transformation process. Some representatives of the medical profession were extremely critical and emphasized that the development was changing the ethical foundations of healthcare. Digital primary care was considered “demand driven” rather than a complement to primary care, contrary to the legally established, ethical principle of distributing healthcare services in accordance with patients’ care needs (rather than demand for care). Furthermore, demand-driven healthcare entailed a significant risk for unnecessary digital visits, consuming resources to the detriment of other parts of the healthcare sector (*ibid.*).

The digital primary care providers, on the other hand, responded immediately by claiming that the digital services created time and space for physical primary care to focus on patients with, for example, chronic illnesses and that “it should be stimulating to be able to take care of chronically ill patients in the best way” (Henrik Kangro & Magnus Nyhlén in *Läkartidningen*, 2017-01-30).

The media debate between the medical profession and the digital care providers continued later in the spring, when a study on the quality of digital primary care in Region Jönköping was presented. The study indicated that digital primary care physicians had prescribed antibiotics without sufficient evidence for a diagnosis. The Region attached great importance to the study and required action plans from the two healthcare centres collaborating with Kry and Min Doktor, otherwise these centres would face the risk of financial sanctions (*Dagens Medicin*, 2017-06-02).

However, from February onwards, the media debate focused on other issues related to digital primary care services. Public sector actors, both on the national and regional levels, were concerned about unexpected costs, and the media discussion revolved around the financial consequences of the new development. Critics claimed that the Patient Act, in combination with Region Jönköping’s decision to include digital visits in their reimbursement system, had “opened the playing field for private actors” (*Läkartidningen*, 2017-02-10), even though the intention had been to handle problems within their own region. The controller in Region Jönköping, responsible for the pricing, was self-critical and stated that: “The intention of the Patient Act is not for private companies to make money, but to increase patients’ freedom of choice. (Jonathan Vincent,

Controller, Region Jönköping in *Läkartidningen*, 2017-02-10).

The healthcare regions were reluctant to pay the invoices and required national guidelines from SALAR¹ regarding a recommended price for a digital primary care visit. The start-ups, on the other hand, emphasized that they welcomed such national guidelines as long as their production costs, as well as the increased cost efficiency they added to the healthcare sector overall, were taken into consideration. In May 2017, SALAR recommended a uniform price for reimbursement per digital visit, and this meant a drop in price from € 120 to € 65. The Minister of Health stressed that it was time to ensure that public healthcare itself offered most of the digital services needed. In contrast to the digital providers, regions prioritized patients from their own area, which was considered beneficial because it helped to maintain close patient contact as well as facilitate communication within the healthcare organization. However, the development continued to attract healthcare providers who entered the network, providing not only digital primary care but also digital healthcare services aimed at patients with other health conditions.

5. Discussion

The study shows a dynamic development process as start-ups, providing digital primary care, became actors in a politically sensitive and heavily regulated healthcare network consisting of both publicly and privately healthcare providers, medical professionals and, over time, venture capitalists. The process is summarized in Table 1 below and further discussed in the following sections.

The process of becoming a network actor was dependent on the start-ups’ capacity to initiate and maintain relationships (shown in the table) as important means both to gain access to resources but also to provide and make use of their own resources. In this highly professionalized and regulated network, two forms of resources became particularly important – the start-ups’ knowledge and their ability to create legitimacy as will be further discussed below.

5.1. Becoming a network actor by supplying technological knowledge

The start-ups entered the network, as well as developed their network position, by creating relationships with various actors within the network and the significance of these relationships recur during the entire process. During the first phase of the entrepreneurial business formation processes, the start-ups initiated collaborations with pharmacies and insurance companies, as means to gain access to the most important resource at the time: patients. These relationships gave the start-ups opportunities to strengthen their network position by providing technical knowledge – an essential resource throughout the entire process. This knowledge not only created opportunities to form relationships with established actors but also constituted a prerequisite for the start-ups to use their medical knowledge as it was communicated through the technology.

The ambition to become an insider in the public funded healthcare system, with all the benefits this entailed, was evident even during the first phase and the start-ups made several attempts to negotiate with actors embedded into what they believed to be an important but outdated system, unwilling to accept changes and renewals. Though, during the second phase, Kry was given the opportunity to collaborate with innovative actors within ‘the outdated system’ who acted on their own and without informing the regional management in advance. The relationship was intentionally short-term and based on mutuality – the healthcare centres got access to the digital technology, on very favourable terms, and the start-up was finally included in the public healthcare reimbursement system. The latter, however, was an un-intended

¹ Swedish Association of Local Authorities and Regions (presented in Section 4:1).

Table 1
The entrepreneurial business formation process for digital health care providers.

Phase	First phase 2013–2015	Second phase 2015–2016	Third phase 2017
Main events	The start-ups enter the network by collaborations with pharmacies and insurance companies.	The start-ups enter the publicly funded health care by collaboration with publicly owned healthcare centres. Their activities expand substantially.	The start-ups encounter resistance due to cost and quality issues. Digital primary care becomes regulated by SALAR.
Resources	Patients Financial capital	Public funding Financial capital	Public funding Financial capital
Relationships	Pharmacies Insurance companies Venture capital	Publicly owned healthcare centres Privately owned healthcare centres within the publicly funded healthcare system Venture capital	Publicly owned healthcare centres Privately owned healthcare centres within the publicly funded healthcare system SALAR
Knowledge	Technical knowledge Medical knowledge	Technical knowledge Legal knowledge	Venture capital Technical knowledge Medical knowledge in new areas
Legitimacy and target audience	Cost efficiency – politicians Accessibility – patients and relatives Patient empowerment – patients Time efficiency – medical professionals Future profitability – venture capital	Cost efficiency – politicians Accessibility – patients and relatives Patient empowerment – patients Increased equality – Society Future profitability – venture capital	Cost efficiency – politicians and SALAR Accessibility to new medical services – patients Time efficiency – Primary care providers who could focus on physical visits Financial returns – venture capital

consequence from the public healthcare organization's perspective.

During this part of the process, the start-ups technical knowledge was complemented by an extended understanding of the legal system which was crucial to obtain a stronger position in the network. The representatives of public healthcare did not have corresponding knowledge concerning the legal non-discrimination regulation, and the start-ups' knowledge advantage concerning this aspect, in practice, created access to the publicly funded part of the network.

The business opportunities within the network increased substantially as the start-ups were allowed to build relationships within the publicly funded healthcare sector. That meant that the network became open to publicly financed collaborations, both with publicly and privately owned healthcare centres within the publicly funded healthcare system. The already established start-ups entered into relationships with large privately owned but publicly funded healthcare centres as well as started media campaigns to develop their activities and attract patients from other parts of Sweden. In addition, these opportunities attracted new actors as the start-ups' access to financial resources improved substantially and the number of actors within the network increased. The progressive development, and therefore expectations of future financial returns, created interest among venture capitalists who entered the network which further strengthened the start ups' financial situation.

This favourable and dynamic development was regulated during the third phase by the important network actor SALAR. Despite the financial constraints, the network kept attracting venture capitalists who predicted a positive future development.

5.2. Striving for legitimacy in a highly professionalized, highly regulated and politically sensitive network

The entrepreneurial business formation process is characterized by the start-ups efforts to, in various ways, gain legitimacy and acceptance by presenting various advantages and values offered by the digital technology. To a large extent, the argumentation was guided by ambitions to frame digital healthcare services as solutions to perceived public healthcare shortcomings and the study shows an on-going debate between the start-ups and public healthcare actors, mainly medical professionals and politicians. The debate illustrates a constant strive for legitimacy as well as ambitions to reduce legitimacy gained by other actor groups – a strive for de-legitimacy. Furthermore, the study shows that the arguments presented were clearly adapted to fit the selected target group which in some cases were used by other actor groups as means to reduce the start-ups legitimacy.

When the argumentation was aimed at society (i.e., taxpayers), in general, and politicians, in particular, the start-ups stressed the digital services ability to improve cost efficiency, meaning that implementation and use of such services would lead to more efficient use of healthcare resources. As the number of digital primary care visits increased over time, and particularly during the final phase, this argument was met with considerable resistance and the network was finally regulated by SALAR, a strong network actor which based its authority on legitimacy among public healthcare providers.

Some arguments aimed at the same target audience were based on powerful, legally established, ethical principles and used both to legitimize as well as to delegitimize the digital healthcare services. The start-ups argument during the second phase that increased accessibility also meant increased patient equality referred to an important basic value of relevance for the entire Swedish public sector. The counter argument, used during the third phase by actors within the politically governed healthcare system, stated that the increased accessibility threatened the most established ethical principle in healthcare – that access to healthcare must be governed by patient needs.

The medical profession is considered one of the strongest and most traditional professions and being accepted as knowledgeable and competent among peers are particularly important in the strive to gain legitimacy. Several examples illustrate the start-ups' ambitions to be accepted by the medical profession, such as the founders' efforts to emphasize that their inspiration for developing the digital services emanated from their own background. Another argument was used to demonstrate an understanding of the daily challenges facing medical professionals – time shortage. The argument revolved around the services' ability to optimize time efficiency and transformed during the process. Initially the arguments focused on the digital services' capacity to increase the individual medical professional's time efficiency to later stress that digital primary care enabled public healthcare actors to focus on patients with more chronic illnesses and greater need for advanced healthcare. The latter argument was intended to strengthen the start-ups' legitimacy by questioning the public healthcare actors' intentions and ethics.

The main argument, aimed at patients, was based on a frequent criticism of public healthcare – the lack of accessibility. The argument that digital services increased patient accessibility remained throughout the process but developed during the final phase when the digital actors started to provide additional forms of healthcare outside primary care. In addition to patient accessibility, the start-ups argued that digital primary care increased the patients' freedom of choice as well as patient empowerment. These arguments were fully in line with the legal development, primarily the Patient Act which came into force during the process.

Finally, venture capitalists constituted an important actor group in the network and the argument towards this target audience transformed during the process, from expectations of future profitability to ascertained profitability. Even though the argument was attractive to the

target audience, it was used by politicians and medical professionals as counter-argument by stating that the healthcare sector now faced the risk of becoming “demand-driven”.

6. Conclusions and implications

The aim of this study has been to analyse start-ups' entrepreneurial business formation processes. It shows how privately owned start-ups with access to, and knowledge about, digital technology launched digital primary care by relating to (La Rocca & Snehota, 2014), and forming relationships with, different actors already established within the healthcare field. The entrepreneurship literature (e.g., Slotte-Kock & Coviello, 2010) has stressed the need for more studies on the role of network interaction for the initiation of new business. Our study offers a novel entrepreneurial perspective on starting up new business ventures, shifting the attention towards process explanations, and towards an external perspective. The study is in line with Baraldi et al., (2019, p. 58) claim that we need further knowledge on “how new ventures *actively* influence networks”. Responding to calls for more process-oriented research on new business formation (Landström, Harirchi, & Åström, 2012), our study offers important insights into the dynamics of constituent elements in new ventures' initial entry process into a business network (Snehota, 2011).

It is obvious, based on our findings, that the start-ups followed an establishment process that would have been difficult to fully understand if we had not grounded it in the contextual setting of the healthcare network into which they entered. In line with earlier business network studies on start-ups (Aaboen, La Rocca, Lind, Perna, & Shih, 2016; Snehota, 2011), the present study shows that an exchange of resources between start-ups and established actors in the healthcare sector is crucial to the new digital business formation process. Moreover, in line with earlier network studies on relationship processes (Håkansson & Snehota, 1995), our study shows that relationships that were initially beneficial for both parties in the new business formation process can become burdens for the start-up at a later stage. This is illustrated when the start-up Kry decided to end its collaboration with Region Jönköping to develop its business concept by transitioning from being a technical supplier to becoming a digital primary care provider. At this stage, the importance of legal knowledge on behalf of the start-ups is evident as the start-ups were able to enter the publicly funded healthcare system owing to their knowledge concerning the regulation on non-discrimination.

Legitimacy proved to be of central concern for the start-ups and their business formation processes (cf. Bangara et al., 2012; Lagerström & Lindholm, 2021). The present study shows that, despite their quick entrance and growth or perhaps even due to it, the digital healthcare providers were dealing with several issues of achieving legitimacy. Especially the third phase is characterized by criticism of the digital services, in relation to quality but above all in relation to the financial effects for the public healthcare system. The ‘marketization’ of healthcare (Barèsa, Covab, Fardec, & Salled, 2020; Möller & Halinen, 2017) was discussed, criticized and regulated at this stage. The importance of legitimacy is at least partly explained by the fact that the entrepreneurial process unfolded in a highly professionalized context, but most importantly in a politically sensitive context. The study shows that the start-ups were building legitimacy and using it as a valuable resource during the business formation process and that media played an important role in the legitimacy-building process. This is made particularly evident by the fact that the arguments differed considerably depending on the target audience. The study contributes to a deeper understanding of the concept of legitimacy in networks by showing that the same argument, in a context characterized by complexity, may increase or decrease legitimacy depending on the actor group being targeted.

The study also shows that the start-ups' extended knowledge concerning the healthcare regulation system does not only create legitimacy, but constituted a crucial resource when entering the publicly funded healthcare network. The regulations drawn upon by the start-ups

were developed before digitization to solve politically sensitive problems such as patient empowerment, patient accessibility, increased cost efficiency and increased competition in the primary care sector. The legislator had not foreseen the digital development, particularly not the opportunities that came from combining regulations aimed at resolving different healthcare challenges. Our study shows not only how the start-ups overcame regulatory issues, but also how those actions and decisions influenced the environmental context in which they were embedded. The actions the start-ups took to navigate regulatory issues forced regulators to act (or react) in different ways, which in turn caused increased complexity and dynamic effects. Therefore, the present study contributes to a better understanding of how the process of new business formation unfolds in heavily regulated sectors, in general, and in healthcare sectors, in particular, which is in line with Braunerhjelm et al. (2015), who emphasize the importance of conducting more research on the connections between regulations and their dynamic effects.

6.1. Managerial implications

During the creation and development of new ventures, managers of start-ups must take different decisions, many of them with unforeseeable impacts not only on the success and performance of the new venture (Reuber & Fischer, 1999; Vohora, Wright, & Lockett, 2004), but also on the context/environment in which the new venture is created and developed (Alvarez & Barney, 2005; Alvarez & Barney, 2007). In this regard, our case revealed that start-up managers dealing with regulations persisted in the face of strong regulatory headwinds, challenging regulators and probing the contours of regulatory boundaries. Although such aggressive decision-making was criticized, start-ups' provocations succeeded in “forcing the conversation” by creating enough urgency to force regulators to resolve regulatory issues and to clarify where they stood on digitalization of the primary healthcare market. Ultimately, this created an opportunity for both start-ups and SALAR to collaborate on creating a more comprehensive regulatory framework for digital visits to primary healthcare (cf. Bengtson, Pahlberg, & Pourmand, 2009).

6.2. Limitations and directions for future research

The findings of this study are based on a retrospective method and the case is analysed at one point at time. Future research could benefit from meta-analyses of different case study materials that increase comparability between cases, especially longitudinal ones, through analytical framing, as suggested in the present paper. Future research could also change the perspective from focus on the start-ups and their interaction with its context, to investigation the effects of entrepreneurial action and interaction on a certain setting, call it a network (Håkansson & Snehota, 1995), or a market (Araujo & Kjellberg, 2009).

This study is based on archival data, mainly media articles, and the advantages of using this form of data have already been discussed. Despite the advantages, we believe that future research would benefit from including interviews with key actors in the data base. Adding interview data would make it possible to get an even deeper understanding of the process as well as getting additional perspectives. Our initial ambition was also to complement our archival data with interview data which, however, proved impossible. As the data collection started, digital primary care was a highly controversial issue, debated and questioned by many actor groups. The sensitivity of the then ongoing process meant that potential respondents chose not to participate in the study. Today, digital primary care, as well as digital healthcare overall, constitute recognized and important parts of the healthcare sector and there is reason to assume that interview data would be accessible to future researchers.

Our study shows that relationships between actors not only lead to the emergence of new business, but also increase the chances of success

for start-ups. In this regard, the importance of the effectuation principle of partnership for start-ups and their ventures is emphasized, as entrepreneurial relations represent the starting point for effectual action. Through these relationships, start-ups co-created a new venture with the public actors in the healthcare sector and defined the network to enter or/and the new network to create (Dew et al., 2011; Sarasvathy, 2001). Therefore, we believe that future studies could benefit from an exploration of effectual networks (Read, Song, & Smit, 2009; Sarasvathy & Dew, 2005) together with business network theory (Håkansson & Snehota, 1995). This combined approach could result in theoretical advancements in relation to underdeveloped concepts in effectuation theory (e.g. effectual alliance and pre-commitments), as well as provide new insights by examining other central constructs, such as “opportunities”, included in these theories.

7. Epilogue

The study shows the emergence of digital primary care in Sweden between the years 2013–2017. Much has happened since then. Today,

digital primary care constitutes an established and mostly appreciated part of the healthcare sector. Both publicly and privately owned healthcare providers have developed a large number of digital services and the importance of these services was further accentuated during the Covid 19-pandemic. The start-ups in our study are now established companies and they have expanded their businesses by, among other things, buying and establishing physical healthcare centres, offering both physical and digital primary care.

Digital primary care has been further regulated by SALAR, to increase both cost and quality control. The reimbursement per visit has been further reduced as well as differentiated depending on which professional group who perform the service – medical doctors, nurses, or other professionals. Furthermore, the legislator has initiated a still ongoing legislation process, aiming at further regulating this area. A most interesting part of the proposed legislation aims at increasing national healthcare governance, thereby reducing the regions’ scope for action. If the proposal eventually becomes law, digital primary care have contributed to challenge a long-established Swedish tradition – local and regional autonomy and self-determination,

Appendix 1. Description of archival material (2015–2017)

Firm - interviewed	Number interviews found in articles	Number of articles	Number of Press Releases
KRY		204	6
Johannes Schildt - founder and CEO	7		
Josefin Landgård - founder and operations manager	6		
Min Doktor		120	40
Magnus Nyhlén - founder and CEO	5		
Charlotta Tönsgrård - operations manager	6		
Henrik Kangro - medical operations manager	9		
SALAR (SKL)		16	37
Anders Henriksson - vice chairman	1		
Marie Morell - chairman	1		
Patrik Sundström - programme manager (e-health)	1		
Lars Kolmodin - administrator	1		
Louise Callenberg - manager for digital renewal	1		
Daniel Forslund - innovation manager	1		
Doctrin		8	3
Magnus Liungman - founder and CEO	1		
Doktor.se		4	1
Martin Lindman - CEO	1		
Visiba Care		10	
Johan Gustafsson - CEO	6		
Bra Liv Nära		18	
Ulf Österstad - operations manager	3		
Other Actors		19	
Jonathan Vincent - controller, Region Jönköping	1		
Lars Jörnnow - investor, EQT Ventures	1		
Heidi Stensmyren - moderator, Swedish Medical Association	1		
Karin Båtelson - moderator, Hospital Doctors	1		
Total	54	399	87

Appendix 2. Newspapers, magazines and news agencies named throughout the present article

News source	Description
Dagens Apotek	Dagens Apotek is an independent news service focusing on the new pharmacy market. At www.dagensapotek.se , the latest news about pharmacies, medicines and health finances can be found. It specifically monitors the re-regulation of the pharmacy sector. In addition to the unique news material on dagsapotek.se, all news in the pharmacy and pharmaceutical area from dagsmedicin.se are collected, including blog posts, job postings, debate posts, expert answers, etc. An electronic newsletter is distributed every week and four times a year, the printed newspaper Dagens Apotek is published.
Life-Time	Life-time is an editorial media channel for news, consisting of an online magazine, a newsletter that is published about every two weeks, and a printed magazine that is distributed a few times a year. It monitors and debates drug-related health issues in a broad sense, standing for knowledge, facts, different perspectives, in-depth coverage and external monitoring of important issues for healthcare. Life-time publishes daily editorial articles in the online magazine. The news articles are written by very experienced freelance journalists. Editorial articles are written by industry representatives and by leading people with insight and experience in healthcare policy issues.
Veckans Affärer	Veckans Affärer is a business magazine that addresses digitalization and rapid technology development, new deregulated global markets, new knowledge, skills and new organizational forms. It is focused on growth-oriented future companies and concerns entrepreneurship and innovation. The news articles

(continued on next page)

(continued)

News source	Description
Dagens Nyheter	include interviews with innovators, personal portraits of the power players, big company executives, entrepreneurs, as well as the most important international business trends, rankings and listings of the most relevant industries, and business strategies Dagens Nyheter was founded in 1864 and is Sweden's largest newspaper. It includes in-depth reports, interviews and sharp coverage of major contemporary issues. Everything on both a local and global level - DN's award-winning writers and photographers report from the centre of events around the world. Dagens Nyheter covers and sheds light on culture, business, sports and the economy. Its interviews, essays and chronicles include today's most interesting people and important trends.
Mynewsdesk	Mynewsdesk was founded in 2003 and offers all types of digital PR solutions to engage and interact with journalists, opinion leaders, customers, bloggers and other relevant audiences. Companies and organizations create and share information for increased exposure. Mynewsdesk is the Nordic region's leading platform for digital PR. More than 5000 brands such as Google, Viasat, Gröna Lund and Johan & Nystrom use the newsrooms on Mynewsdesk to publish and distribute their news, increase their visibility and establish relationships with their market and their most important journalists.
Dagens Samhälle	Dagens Samhälle writes for decisionmakers in the public market. It reaches managers and politicians in municipalities, regions, government agencies, authorities and publicly owned companies. They also write for companies in the growing welfare sector, those that run schools, hospitals and private care. Dagens Samhälle Debatt is Sweden's most important debate platform for welfare issues. Every day, a serious debate flows on topics such as healthcare, school, infrastructure, economics and democracy.
Läkartidningen	Läkartidningen consists of the paper edition and the website Läkartidningen.se. The paper edition, which was founded in 1904, is usually published weekly and has a circulation of 42,600 copies. All articles in the paper edition (ISSN: 0023-7205) are also available at Läkartidningen.se (ISSN: 1652-7518), together with web-unique material. On the web, it can be also found Läkartidningen's archive where the articles are available in full text from the year 1996. Most scientific articles are peer-reviewed before publication. This is done by about 200 referees under the leadership of Läkartidningen's medical editors. Läkartidningen is published by Läkartidningen Förlag AB, which is owned by the Swedish Medical Association, which is responsible for the content on Läkartidningen's editorial page (Signed) and on special association pages in the magazine. Läkartidningen Förlag also organizes symposia and career evenings and publishes books.
Nya Wermlands-Tidningen	Nya Wermlands-Tidningen (NWT) is one of Sweden's largest local newspapers. The magazine covers news in Värmland, Dalsland and Västerdalarna. The magazine is part of the NWT Group, together with another 15 magazines in Värmland and Skaraborg. As recently as 2007, they launched their first news website. In 2009, the magazine had an average circulation of 52,000 copies per day of publication.
Sjukhusläkaren	The magazine Sjukhusläkaren is published by Sjukhusläkarna – the largest professional association within the Swedish Medical Association – with around 20,000 members. The magazine is published six times a year and it is also published on the web. The web version is updated frequently with news and debates. They monitor trade union and healthcare policy issues to create debate and shed light on the hospital doctors' situation. The magazine organizes all specialist doctors and chief physicians in hospitals, as well as professors, associate professors and university lecturers at medical faculties.
Dagens Industri	Dagens Industri is the Nordic region's largest business magazine with 328,000 readers a day (Orvesto Konsument 2017: 1). With Sweden's foremost financial journalists and analysts, every day Dagens Industri offers an important tool for achieving business success on the financial market and in private finance. Dagens Industri informs about the Swedish and international business community in a qualified, but at the same time easily accessible, manner. The newspaper is fearless in its relationship with power.
Dagens Medicin	Dagens Medicin is the country's leading industry monitor for decisionmakers in Swedish healthcare. Dagens Medicin is aimed at doctors, nurses, managers, administrators, politicians, government employees and others who make decisions in healthcare. Dagens Medicin has several foreign sister magazines, in Denmark (Dagens Medicin), Norway (Dagens Medisin), Finland (Mediutiset), Poland (Puls Medycyny) and in Estonia and Slovenia. Under the name Dagens Medicin Agenda, Dagens Medicin arranges seminars and courses for the same target group as the newspaper, i.e., doctors and other licensed healthcare staff, as well as politicians and other decisionmakers in the area. Dagens Medicin also published Dagens Apotek during the period 2009–2017. In addition to Dagens Medicin, Bonnier Business Media's business area Medicine includes the digital news services Läkemedelsmarknaden, Apoteksmarknaden, Digital Hälsa and Kommunal Hälsa.

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