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Institutional Health Voids, Learning Myopia, and Counter-Knowledge: Unveiling Blind Spots in Healthcare Decision-Making

Juan-Gabriel CEGARRA-NAVARRO[1], Aurora MARTINEZ-MARTINEZ[2], Raghda EL EBRASHI[3], Anthony WENSLEY[4]

[1] Faculty of Business Sciences, Universidad Politécnica de Cartagena, 3 Real, 30201 Cartagena, ES; juan.cegarra@upct.es

[2] Faculty of Business Sciences, Universidad Politécnica de Cartagena, 3 Real, 30201 Cartagena, ES; aurora.martinez@upct.es (corresponding author)

[3] Faculty of Management Technology, German University in Cairo, 11835 New Cairo City, EG; raghda.elebrashi@guc.edu.eg

[4] Department of Management, University of Toronto Mississauga, 3359 Mississauga Rd., Mississauga ON L5L 1C6, CA; anthony.wensley@utoronto.ca

Received: April 6, 2025
Revised: May 9, 2025
Accepted: May 25, 2025
Published: June 25, 2025

Abstract: This study explores how Institutional Health Voids (IHVs) contribute to the emergence of weak signals, which lead to the spread of counter-knowledge and the formation of blind spots among healthcare stakeholders. Focusing on the Spanish National Health System (SNHS), the research investigates how these voids, characterized by fragmented knowledge and misinformation, hinder effective decision-making and exacerbate crises. The study incorporates the concept of learning myopia, which explains the cognitive limitations in interpreting weak signals, thus reinforcing institutional inefficiencies. The findings suggest that IHVs create gaps in knowledge structures, causing delays in response times and misaligned policies, ultimately compromising the system's ability to adapt and respond effectively to health challenges. This study reveals that addressing these gaps requires the development of knowledge structures that not only improve transparency but also foster inter-organizational trust and promote adaptive decision-making processes. By linking the theoretical frameworks of institutional voids with knowledge management, the study offers a fresh perspective on the impact of weak signals, counter-knowledge, and blind spots within the healthcare system. The research contributes to the understanding of how these factors shape decision-making and governance in healthcare systems, providing valuable insights for policymakers aiming to improve healthcare management, particularly in times of crisis. This work underscores the importance of strengthening knowledge structures within healthcare systems to enhance resilience, trust, and long-term sustainability. We explicitly adopt a conceptual methodology based on systematic literature review and critical analysis to integrate theories, clarifying how institutional voids shape healthcare decision-making through weak signals and counter-knowledge.

Keywords: institutional voids; blind spots; counter-knowledge; learning myopia; healthcare.

Introduction

Blind spots are aspects that often go unnoticed by individuals, especially knowledge workers, despite being seemingly evident to others (Haney et al., 2022; Meissner et al., 2017; Tackett et al., 2022). These oversights can result in incorrect perceptions or misunderstandings of the information that is observed (Wiegand, 1999; Zajac & Bazerman, 1991). Despite existing research on blind spots and institutional voids, their connection to economic growth in the healthcare system remains underexplored. The notion of blind spots is connected to the concept of "institutional voids", which refers to the lack or insufficiency of institutional structures (Dieleman et al., 2022). The concept of institutional voids has been researched widely in the literature as one of the main

How to cite
Cegarra-Navarro, J. G., Martinez-Martinez, A., El Ebrashi, R. & Wensley, A. (2025). Institutional Health Voids, Learning Myopia, and Counter-Knowledge: Unveiling Blind Spots in Healthcare Decision-Making. *Management Dynamics in the Knowledge Economy, 13*(2), 105-119. DOI 10.2478/mdke-2025-0007
ISSN: 2392-8042 (online)
www.managementdynamics.ro
https://content.sciendo.com/view/journals/mdke/mdke-overview.xml

challenges against market access and opportunity identification (Mair et al., 2012; Mair & Marti, 2009; Parmigiani & Rivera-Santos, 2015; Rodrik, 2011). This paper aims to fill this gap by examining how knowledge gaps within healthcare institutions influence inefficiencies and hinder healthcare accessibility. This study contributes by identifying research gaps, questioning the assumption that developed economies have robust institutional structures, and analyzing how weak signals in the healthcare sector contribute to inefficiencies. Like "institutional voids", blind spots refer to the lack of knowledge frameworks, such as institutions or intermediaries, that typically support and enable economic transactions (Palepu & Khanna, 1998).

Although Spain is a developed country and institutional voids are usually present in developing and emerging markets (Andrews & Luiz, 2024; Deng, 2024; Ebrashi & Darrag, 2017; Papadimos et al., 2020), the management of various crises has exposed certain defects and weaknesses within the Spanish National Health System (Ammirato et al., 2021; Cegarra-Navarro et al., 2021; Deng, 2024; Erkoreka & Hernando-Pérez, 2023). Although we are primarily thinking of COVID-19, the issue extends beyond that, as many studies indicate that austerity measures implemented after the 2008 financial crisis, such as cuts in public healthcare spending, have had a direct impact on both the delivery of healthcare services and the daily operations of healthcare professionals (Otero-García et al., 2023). Furthermore, healthcare continues to receive low consideration in terms of spending, with insufficient resources allocated to address the growing demands on the system. For example, due to misunderstandings arising from Institutional Health Voids (hereafter IHVs), the SNHS (Spanish National Health System) has faced delays in implementing timely responses to critical health threats, such as pandemic time travel restrictions and containment measures. In addition, the lack of legal protection to sustain the lockdown caused a considerable increase in infections and the spread of new virus variants since the SNHS tried too quickly to return to normality during the summer months after the first wave.

A growing body of research highlights the importance of effective management in addressing complex challenges within healthcare systems, particularly in times of crisis. As noted by Bratianu, (2020) and Romanelli, (2017), the sustainability of healthcare organizations relies not only on responding to immediate challenges but also on developing long-term strategies that ensure resilience and adaptability in healthcare delivery. These studies emphasize the need for sustainable approaches to healthcare management that integrate knowledge management principles and strategic decision-making to enhance organizational effectiveness in a rapidly evolving environment.

While there was an immense need for more transparency and structure to distribute the European funds for the recovery, transformation, and resilience of Europe's public funding is another section that can be considered an IHVs. Even though Spain is the third largest beneficiary of European funds, expenditure dedicated to healthcare in Spain during 2022 fell by 9.88% compared to 2021 (Drago et al., 2023). In 2023, continued this then Spain's healthcare expenditure saw a continued decline, with a reduction of around 4% compared to previous years (OCDE, 2023). In 2024, despite the increased allocation of funds, Spain's healthcare expenditure per capita remains below the European Union average, reflecting ongoing challenges in balancing recovery funds and ensuring equitable healthcare access (OECD, 2024). These reductions highlight ongoing concerns about the sustainability of Spain's public healthcare system, which, while maintaining universal access, faces challenges in balancing budget constraints with increasing healthcare demands (Bernal-Delgado et al., 2024; Cegarra-Sánchez et al., 2025). Hence, citizens are facing institutional voids related to "healthcare coverage" and "healthcare accessibility", these are marked by direct out-of-pocket expenses and varying levels of healthcare quality and benefits, influenced by both the type of coverage and the patient's geographic location. The healthcare system in Spain is currently suffering from lack of information and obsolescence, which can have serious consequences on public healthcare (Laihonen et al., 2024). Counter-knowledge is characterized by elements such as misinformation,

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misinterpretation, lack of awareness, outdated knowledge, and the deliberate concealment of information (Bolisani & Cegarra-Navarro, 2021; Cegarra-Navarro et al., 2021; Thompson, 2008a). The knowledge management literature asserts that when human beings do not have access to adequate knowledge structures (Dzenopoljac et al., 2024; Gaviria-Marin et al., 2018; Hujala & Laihonen, 2021, 2022; Kosklin et al., 2023; Timiyo & Foli, 2025), counter-knowledge is generated, which has negative effects on the relationships among different actors (Bolisani et al., 2021; Proeger, 2020). In that sense, it is important to understand the relationship between institutional voids in the healthcare sector, or what we call IHVs and counter-knowledge.

When counter-knowledge prevails over knowledge, this gives rise to the so-called blind spots (Soto-Acosta & Cegarra-Navarro, 2016; Wiegand, 1999). In the context of SNHS, blind spots represent expressions of counter-knowledge at the actor level, which may not be directly visible to users but can still be sensed informally or through indirect means. Notably, these blind spots pose risks not only to those who create them but also to those affected by their influence (Mavin et al., 2004). The main purpose of this study is to identify blind spots in the SNHS, explain counter knowledge present, and link those to IHVs. By doing this, we are contributing to the ongoing discussion around institutional voids (Ebrashi & Darrag, 2017; Mair et al., 2012; Parmigiani & Rivera-Santos, 2015; Webb et al., 2019) and issues of counter knowledge and blind spots in the knowledge management literature (Alstete, 2012; Goode & Lacey, 2022; Klammer & Gueldenberg, 2019); especially in the healthcare system (Gillespie & Reader, 2018; Papadimos et al., 2020).

This paper adopts a conceptual approach based on a systematic and critical review of relevant literature. Following recent theoretical studies (e.g., Cegarra-Navarro & Wensley, 2019), we integrate, synthesize, and critically analyze existing theoretical frameworks. Our aim is to identify and explicitly question obsolete assumptions and propose a novel integrated framework linking institutional voids, weak signals, counter-knowledge, and cognitive myopias.

This paper serves as basis for healthcare policymakers to understand the challenges in the SNHS system from multiple stakeholder perspectives. To achieve the purpose of this study, the paper starts with discussing the concept of Institutional Health Voids by conceptualizing related literature, followed by linking institutional voids to the concepts of weak signals and that of counter-knowledge. This takes us to how learning myopia streamlines institutional voids and weak signals to counter-knowledge and blind spots. The paper ends with a conclusion and emphasis on the theoretical and practical implications, as well as possible future research.

Finding institutional health voids in the SNHS

Following our methodological approach, we conducted critical literature analysis to identify institutional voids relevant to the SNHS context. Institutional voids refer to the lack of appropriate intermediaries in emerging markets, which leads to increased transaction costs and operational difficulties (Palepu & Khanna, 1998). Palepu and Khanna (1998), identify three primary drivers of institutional voids: (1) inadequate information for linking producers with consumers; (2) political actors prioritizing their own agendas over economic performance; and (3) a dysfunctional legal system. These institutional gaps disrupt the functioning of product, capital, and labor markets by limiting the presence of effective intermediaries (Andrews & Luiz, 2024; Ebrashi & Darrag, 2017; Parmigiani & Rivera-Santos, 2015; Webb et al., 2019).

Attending to the work of Sánchez-Polo et al. (2019), there is a need to contribute to the literature on issues related to institutional voids in developed economies. Given that developed economies have strong institutional structures, circumventing institutional voids should be through formal policies rather than third party interventions or

replacement by informal institutional strategies as in the case of developing and emerging markets (Parmigiani & Rivera-Santos, 2015; Webb et al., 2019). This study identifies three key institutional voids within the Spanish healthcare system:

1. Coordination between institutions, a lack of alignment and shared perspective between educational and health authorities concerning healthcare needs, which contributes to the absence of a unified national education policy and inadequate medical training;
2. Public funding, demographic ageing and modest economic growth are projected to intensify the strain on the public financing model of the SNHS; and,
3. Structures of social power, existing political and social disparities, partly stemming from the decentralization of authority to autonomous communities, further exacerbate these institutional gaps.

Addressing institutional voids in the healthcare sector is essential, as doing so can help reduce or eliminate their adverse impacts. For instance, improved identification and response to these voids can enhance the efficiency of public resource allocation and amplify their benefits for end users. Nonetheless, several of the institutional healthcare voids (IHVs) remain unaddressed, leading to the spread of counter-knowledge, such as misconceptions and misinformation, among various stakeholders, including healthcare professionals, administrators, and policymakers. The following section delves into specific dimensions of counter-knowledge.

Linking institutional voids with counter-knowledge

Our critical analysis and synthesis of the literature revealed explicit connections between institutional voids and the generation of weak signals leading to counter-knowledge. The presence of institutional voids sends confusing signals in the form of misinformation and misunderstandings to citizens about what health management priorities should be. Such institutional voids may also distort institutions' call for transparency and reputation among users of health institutions (Gao et al., 2017; GRI, 2020). Several researchers refer to counter-knowledge as the result of weak signals perceived when people look beyond their core knowledge base and day-to-day business activities (Day & Schoemaker, 2004, 2006; Haeckel, 2004; Pina e Cunha & Chia, 2007; Thompson, 2008). For example, information against vaccination, the so-called "miracle cures", "magic cures", or "superfoods", among other elements in which many of us are not experts, are sources of misinformation that can lead us to counterproductive decisions (i.e. counter-knowledge).

If the above argument is correct, for a given individual, the creation of counter-knowledge depends on one's exposure to contradictory information (i.e. weak signals). From this point of view, institutional voids might be one of the sources of weak signals among actors. It is important to point out that while counter-knowledge occurs at the individual-actor level, institutional voids occur at the institutional level, and hence, weak signals arising from institutional voids lead to counter- knowledge among individuals. The existing literature showed how weak signals might pose threats to individuals and firms' performance (Ansoff, 1975; Day & Schoemaker, 2004, 2006; Ilmola & Kuusi, 2006; van Veen & Ortt, 2021), where institutional voids can create organizational tensions (Jabbour et al., 2020). Table (1) shows how the IHVs recognized before may cause weak signals and hence counter knowledge.

To explain this further, the lack of vision and coordination as mentioned before between health and education authorities give weak signals or wrong impression to different internal actors (e.g. medical students, physicians, and administrators) that priority and merit go to those who can produce more "health" at lower costs (Pedrero-Garcia, 2017). This leads to counter-knowledge at healthcare users in the form of rumors regarding healthcare quality. Additionally, the decreased public financing on SHNS and the economic

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crisis have prompted healthcare institutions to gravitate toward patients beyond their direct and indirect taxes (now even more charged), where medical care is covered through the co-payment of medicines with indefinite sharing percentage (Gallo & Gené-Badia, 2013; Ortuzar et al., 2021; Prieto-Herraez et al., 2020). This lack of unclear procedures sends confusing signals about the final price of the drug and causes counter-knowledge regarding how to claim the difference in prices, and who to submit such claims (Ortuzar et al., 2021). Finally, although Article (43) of the Spanish Constitution recognizes the right to health protection, there are discrepancies in health care provision based on the citizen's residential area (Prieto-Herraez et al., 2020). For example, the Autonomous Communities dedicate 46.1% of their budget to health, with a difference that oscillates between 35.7% in Catalonia and 58.8% in Aragon (Ortuzar et al., 2021). The IHVs of social power systems send weak signals that there is a discrepancy in providing health services based on community affiliation, which in turn creates counter-knowledge healthcare users that political and economic interests prevail over social and civil ones(Cegarra-Navarro et al., 2021).

Table 1. Institutional health voids, weak signals, and corresponding counter knowledge

Institutional Health Voids (IHVs)	**Weak signals**	**Counter-knowledge**
Inter-institutional coordination	Cost-based service	Rumors regarding healthcare quality
Public financing	Unclear procedures	Confusion regarding the final price of medications
Social power systems	Discrepancy based on community-affiliation	Impression of bias toward political or economic interests

Source: own processing

The extant literature on weak signals illustrates the concept of "myopia of learning", and how managers are influenced by various factors including: a) the wrong contexts; b) the wrong timing; and, c) previous prejudices that prevent them from seeing reality (Czakon, 2022; Larwood & Whitaker, 1997; Levinthal & March, 1993; Natarajan & Kumar, 2025; Seo et al., 2020; Smith et al., 2010). Extrapolating these three scenarios to the context of this paper, the present study relates the creation of counter-knowledge to three forms of learning myopia as conceptualized by Miller (2002) and (Cegarra-Sánchez et al., 2024):

1. "Spatial Myopia" happens when looking into an empty visual field without frames of reference. In the case of SHNS, the youngest people are the most vulnerable. Let us think about the case of people without previous experience exposed to weak signals in a new context for them. When faced with weak signals, they will respond with more credulity and innocence in the face of misinformation or fake news.
2. "Temporal Myopia" can be likened to the momentary difficulty in adjusting vision after prolonged near-focus, when one looks up, the eyes need time to refocus. In the context of the SNHS, this phenomenon reflects how counter-knowledge may emerge from users' limited adaptability or responsiveness to weak signals. While this condition disproportionately affects older adults, it is important to note that the effects are temporary and potentially reversible.
3. "Procedural Myopia" refers to a form of rigidity characterized by unwavering adherence to established routines, protocols, or bureaucratic procedures, often at the expense of adapting to specific contexts or evolving circumstances. Rather than facilitating learning and improvement, these procedures may become ends in themselves, detached from their original intent. A useful analogy is how individuals with glaucoma or color blindness perceive colors differently from those with normal vision. Similarly, within the SNHS, individuals influenced by religious, political, ethnic, or social biases may interpret signals through the lens of their personal beliefs and experiences, leading to skewed perceptions.

Finding blind spots between the different actors involved

By explicitly applying our conceptual analysis and integration, we propose that blind spots emerge at multiple stakeholder levels due to counter-knowledge resulting from weak signals generated by institutional voids. The brain governs voluntary actions, speech, cognition, memory, and emotions, while also processing sensory input, including visual information. In this sense, counter-knowledge can be either fully or partially mitigated through the brain's attentional mechanisms and intuitive cognitive processes (Damasio, 2010; Tulving, 2002). When faced with weak signals while processing counter-knowledge, the brain attempts to interpret, or more accurately, to compensate for, it by drawing on knowledge derived from surrounding intuitive cognitive processes. (Castelfranchi & Miceli, 2009; Schwenk, 1984). It is important to note that not only rational knowledge intervenes in this cognitive process, as Bratianu (2017) suggests, emotional and spiritual knowledge can also help to create "awareness" and "understanding" in the learning process.

Based on the above, this study focuses on those cases where misunderstandings and misinformation prevail over knowledge, giving rise to the so-called "blind spots" (Wiegand, 1999). For instance, during crisis, such as the recent pandemic, different blind spots emerged in public healthcare, counter-knowledge as the promulgation of pseudoscience, and academic dishonesty emerged as significant threats to population health and stability. Blind spots create ignorance among population members, or misinformation, which might be used for manipulation and selfish gains (Papadimos et al., 2020). Eliminating and mitigating counter-knowledge and blind spots and their effects are important in public healthcare so as not to fall into "missed opportunities" as, for example, what happened during the first wave of the pandemic (World Economic Forum, 2020). Taking institutional voids as constraining factors for business operations stemming from different blind spots is becoming vivid in the literature (Dieleman et al., 2022).

Assuming that all individuals possess certain blind spots, intentionally seeking to identify them may offer a valuable strategy for addressing counter-knowledge (Tackett et al., 2022). Hence, addressing blind spots can advance meaningful reform in of the Spanish National System and the healthcare of other countries. SNHS blind spots would be those forms and manifestations at the actor level, based on misunderstandings and misinformation received from IHVs in such a way that, although users do not observe them directly, they can perceive them informally and indirectly. It is important to point out that blind spots can endanger not only the actors that generate them, but also those whom they can influence. For example, let us take the case of a driver who does not see a car coming from behind when he is about to overtake. When that happens, not only will the driver be in danger, but also the occupants of the other vehicles would be at risk, coming from different directions. One important thing about a blind spot is that just because it is blind to one actor does not mean it is blind to another. For example, the fact that I do not see the car ahead does not mean that the other driver does not see me.

Based on these ideas, the only way to understand blind spots is to see them as a whole and from different perspectives. Although blind spots in this study are analyzed in the context of SNHS, literature highlights findings that may indicate the presence of such blind spots in the health systems of other countries. Table (2) illustrates the most significant blind spots in SNHS, which should be monitored very closely and understood by healthcare authorities. From the users' perspective, blind spots are areas in healthcare where patients experience problems while healthcare service providers oversee those needs; for instance, difficulties in accessing care (O'Dowd et al., 2022). For example, the lack of doctors in primary and hospital care due to political decisions in the selection processes, as well as collapsed emergencies and drug co-payment systems, are all perceived as abusive among health care users and create systemic problems (Coventry et al., 2020; Fotaki & Hyde, 2015; Morsø et al., 2022; O'Dowd et al., 2022). Regarding blind spots at the

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health care provider levels (i.e., doctors and nurses), SHNS suffer from various issues, prevailing across the system. For instance, listening to and communicating with patients is given less time, and there is low awareness regarding data privacy, in addition to providing inaccurate medical diagnoses. This might be the result of low salaries received by healthcare providers, which encouraged simultaneity of work in the public and private sectors, as well as high turnover and migration of health workers (i.e. brain drain), and the issuance of temporary contracts for young physicians (Coventry et al., 2020; Kruse et al., 2017; Latukha et al., 2022).

Table 2. Blind spots in the Spanish national healthcare system

Actors	Blind spots	References
Users	- Excessive delays in care delivery, with waiting times frequently surpassing two weeks. - Shortages of medical professionals in both primary and hospital care, largely stemming from politically driven selection and hiring processes. - Overburdened emergency services and an increasingly burdensome medication co-payment scheme. - Structural and systemic inefficiencies affect the overall functioning of the healthcare system. - Limited awareness and enforcement of data privacy, resulting in obstacles to accessing personal health information.	(Coventry et al., 2020; Fotaki & Hyde, 2015; Gillespie & Reader, 2018; Morsø et al., 2022; O'Dowd et al., 2022)
Doctors and Nurses	- Low public sector salaries have led to significant dual employment, with many healthcare professionals working simultaneously in both public and private sectors. - An aging medical workforce, combined with precarious employment conditions for younger doctors, often limited to temporary contracts, has resulted in high staff turnover. - Diminished patient engagement, with reduced time allocated per patient, negatively affects communication and the speed and accuracy of diagnoses. - Inadequate data privacy awareness, limiting effective protection and management of personal health information.	(Coventry et al., 2020; Kruse et al., 2017; Latukha et al., 2022)
Administrators	- The duplication of medical records and documentation contributes to poor coordination between primary care and specialized services. - Poor management of public hospitals and lack of resources. - Existence of individual interests. - Inadequate attention to organization culture. - Lack of awareness about patients' data protection.	(Coventry et al., 2020; Denis et al., 2021; O'Malley et al., 2010; Papadimos et al., 2020)
Policymakers	- Politicizing the process. - General complacency. - Poor essential infrastructure and public works. - Weak legal frameworks.	(Adebowale et al., 2020; Motta et al., 2020; Papadimos et al., 2020; Scopelliti et al., 2015, 2017)

Source: own processing

Administrators' blind spots highlighted in the literature include the duplication of medical records and files that result in poor coordination between primary and specialized care, as well as the lack of resources and poor management of public hospitals. This is in

addition to the existence of individual interests and inadequate attention to organization culture, coupled with lack of awareness regarding cybersecurity for protecting patients' data (Coventry et al., 2020; O'Malley et al., 2010; Papadimos et al., 2020). Lastly, blind spots of policymakers center on the issue of decision making that rests on opinion polls, politicizing and electioneering the provision of healthcare. This is in addition to general complacency, and poor provision of essential health infrastructure and weak legal frameworks (Adebowale et al., 2020; Motta et al., 2020; Papadimos et al., 2020; Scopelliti et al., 2015, 2017). For example, in the allocation of European funds, policymakers making decisions are influenced by emotional knowledge (Cegarra-Navarro et al., 2023). Having said this, we may deduce that institutional health voids generate weak signals, which are processed into the brain based on relevant learning myopia. This, in turn, leads to counter-knowledge that manifests in blind spots.

Figure 1 shows a conceptualization of the process described. The actor recognizes a certain phenomenon, in our case, weak signals from institutional voids, which is processed inside the brain based on temporal, spatial, and error myopia. What the brain processes is different from what the actors have recognized in the first place, because myopia leads to counter-knowledge, and accordingly blind spots are created.

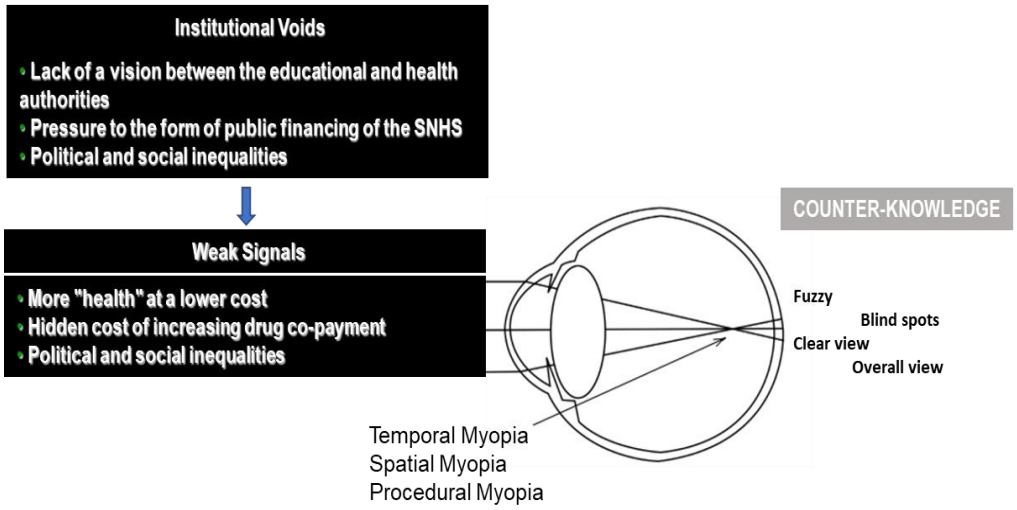

Figure 1. The influence of weak signals on the formation of counter-knowledge
Source: own processing

Conclusion, contribution, and future research

This study explicitly adopted a conceptual and critical methodological approach based on systematic literature review and theoretical integration. By critically questioning existing theoretical assumptions, we developed an integrated framework clarifying how institutional health voids create weak signals, resulting in counter-knowledge and blind spots. Our methodological choice provides clear theoretical insights that enable future empirical research on healthcare decision-making and governance. The present study suggests that the presence of institutional voids triggers weak signals, which in turn generate counter-knowledge and manifest as blind spots for healthcare users, providers, administrators, and policymakers. Mitigating the harmful effects of blind spots and enhancing the likelihood of achieving equilibrium among stakeholders requires the development of knowledge structures that cultivate empathy and trust within the healthcare sector. From a knowledge management standpoint, a blind spot can be understood as an individual's knowledge deficit, which the brain compensates for by generating counter-knowledge in response to weak signals. Consequently, it becomes

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essential to establish knowledge frameworks that support trust-building and reciprocal adaptation among diverse interest groups.

This study extends the literature on institutional voids and knowledge management in the public health sector, offering a new perspective on how these voids affect decision-making in Spain's National Health System. It also provides practical implications for improving knowledge structures and coordination in healthcare, emphasizing the importance of transparency, inter-organizational trust, and rapid adaptation to change.

This research has several theoretical and practical implications. For the theoretical contribution, the research responds to the need for producing theories explaining the antecedents and responses of blind spots (Kühl, 2020; Meissner et al., 2017; Wiegand, 1999; Zajac & Bazerman, 1991). In addition, the core of this study is to link institutional voids with blind spots through understanding counter-knowledge in the Spanish Healthcare System. This, in turn drives theory development in the area of knowledge management to the public health sector (Pepple et al., 2022; Razzaq et al., 2019) especially amid and after pandemics (Ammirato et al., 2021; Deng, 2024). In addition, the study contributes to the extant literature on cognitive biases and decision-making under environmental changes (Acciarini et al., 2020), and institutional voids (Parmigiani & Rivera-Santos, 2015; Webb et al., 2019) on the level of policy making in developed countries (Cegarra-Navarro et al., 2021; Proeger, 2020).

As for practical implications, the current study has numerous contributions. The study revealed that healthcare authorities should establish appropriate knowledge structures that minimize singular and sectarian viewpoints. Among these knowledge structures is the decentralization of decision-making to allow for immediate feedback and decreasing regional inequalities. In addition, the healthcare system should not interact with, or its decisions should not be based on unspecialized political advice. To recall, Spaniards suffered during the years of the pandemic because of the wrong decisions taken by a health minister with certain political ambitions (Cegarra-Navarro et al., 2021). In addition, it is very important that healthcare authorities focus on the coordination between public and private health provision (Couzin et al., 2011; Hart, 1991; Janis & Hart, 1991). Cooperation between public and private healthcare institutions can help address structural shortcomings and prevent the dissemination of ambiguous messages that contribute to the proliferation of counter-knowledge (Cegarra-Navarro et al., 2021). This collaboration can be used especially to reduce the blind spots of end users, for example, to reduce the waiting lists of patients. This way, costly and inefficient decisions such as hiring non-EU doctors by public healthcare institutions without the required knowledge can be avoided.

This study also highlights the importance of addressing institutional voids that generate weak signals, which in turn facilitate the spread of misinformation among healthcare actors, fostering rumors and enabling the belief in and dissemination of false information, commonly referred to as counter-knowledge. Another practical implication of this study is that it contributes to the need for policy formulation for the better and more efficient use of public funds, especially in times of crisis and pandemics. Lastly, studying blind spots offers opportunities to improve the healthcare system and offer quality service to users. While this paper focused on the Spanish Heath System, the conceptualization of the voids, weak signals, and counter-knowledge and how they are related to each other can be relevant to the case of the public sector in other countries. Future research, however, should focus on empirically studying these relationships, potentially comparing the cases of developed, developing, and emerging countries. Additionally, future research could explore how institutional voids, and blind spots may serve as opportunities for other actors or organizations to address through institutional entrepreneurship, whether through activism, social entrepreneurship, or corporate social entrepreneurship.

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