

Policy Development and Service Innovation: An Ideological Discourse Analysis

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Abstract

Healthcare research has tended to focus on the implementation of innovation, and its non-linear progression towards successful dissemination and widespread adoption. There has been little research that has investigated the discourses that have informed policy development across different national contexts. This paper argues that assessment of failure or success in implementing healthcare policy is inexorably linked with a broad set of public discourses and the ideological presuppositions upon which they are based. Our research examines the policy discourses on stroke care developed across Canada and UK, and how they are constituted by different underlying meanings of “public service innovation”. Our paper highlights the value of unpacking the ideologies that become embedded in the process of policy development, which we suggest is an important yet overlooked starting point for understanding their translation and implementation.

Introduction

Healthcare policy has long provided an arena for debate around themes of services re-structuring and the challenges associated with implementation initiatives in the public sector (Dawson and Morris 2004). Increasingly, researchers have been concerned with unpacking the “gaps” between policy and practice in the process of healthcare reform. Notably, it has been argued that whilst evidence-based medicine has transformed clinical practice by rendering it more effective, this trend has not been followed by a similar logic in health management and policy-making, ultimately resulting in significant discrepancies between policy and practice (Walshe and Rundall 2001, van der Schee et al 2007).

In this paper, we argue the need to step back and analyze the development of policy discourse in different institutional and national contexts as an important starting point in further understanding how this policy-practice ‘gap’ develops over time. We consider this discourse not only regarding its role in the development of extant healthcare policy, but moreover vis-à-vis its ability to render concurrent political rationalities visible (Moon and Brown 2000). In this light, we consider the specificity of innovation in public settings, which is increasingly viewed as the key driver to performance improvement (Walker et al 2002).

Moreover, we aim to explore the linkages between the rise of a public sector innovation discourse and its varied manifestations with the different notions of citizen, user and, in our case, patient role in the innovation process. In so doing, we discuss the relevance of recent developments in services research, notably regarding the notion of “service logic” (Chesbrough and Spohrer 2006; Lusch & Vargo 2008, which places emphasis on the continuous user involvement through the various stages of service development and delivery. The user is hence viewed not as a passive recipient but rather as central to value co-creation in service innovation. In public healthcare, this approach is increasingly relevant in conceptualizing the patient’s central role in re-structuring care, especially through making “informed choices” acquiring more control over the service (Fotaki 2004; Le Grand 2004).

This paper unearths recent discourse developments, focusing on how different underlying meanings of innovation are discursively enacted in health policies across different institutional and political contexts. Following an approach to the study of innovation as a multi-dimensional and inherently political process (Frost and Egri 1991), we suggest that an international perspective on policy development can afford useful insights on the power dynamics that define the innovation language game (Asimakou 2009).

To this end, we analyze stroke-care related policies in the UK and Canada. In the UK, we look at both the general “umbrella” healthcare strategies that informed and influenced the re-organizing of stroke care services as well as the various reviews and policy guidelines that were generated after the launch of the National Stroke Strategy. In Canada, we looked at the two levels of policy development, the federal Canadian Stroke Strategy and the various strategic provincial initiatives, focusing on the Ontario Stroke System, which has been acknowledged as an exemplar of successful implementation (Lewis et al 2002).

Our findings suggest that although the policy development of re-organizing stroke services in the two countries seemed to occupy a different discursive space, there were a number of shared ideological references that became manifest in the different institutional contexts. We found that in Canada a bottom up approach to service innovation was at play in a decentralized policymaking model. The emphasis on knowledge transfer and technology produced a policy discourse around the ‘service’. This contrasted with more user centred notions of the service logic in the UK, with an informed patient discourse suggesting power, choice, and control by the patient in the service provision. By considering these conflicting themes that appear to frame the formation of policy in the UK and Canada, we attempted to unveil their latent ideological significations in order to better understand how they were related to “service innovation”.

Policy Development and Service Innovation

Public policy research has highlighted the lacunae of translating evidence into policy; Lang and Rayner (2006) have drawn attention to what seems to be a cacophony in

theorizing disease in frameworks “fissured by significant ideological distinctions”. Policy is inexorably linked to new specifications of the object of public governance as denoted by contemporary discourse of neoliberalism (Larner 2000). In this light, policy literature has employed the Foucaultian notion of “governmentality” to conceptualize political change associated with government re-structuring and the ways in which subjects discursively define their space in this process (Raco 2003). In healthcare, ideological analyses have focused on the values of “informed choice” and “participation” postulated in the politics of the Third Way as well as their links with the rhetoric of innovation (Prince et al 2006).

However, the nature and impact of service innovation in public sector settings continues to be under-researched (Walker 2007). A growing literature looks into the value of a more consistent theorization of services as a field that integrates science research with management and policy research in order to better understand innovation (Spohrer et al 2006; Chesbrough & Spohrer, 2006). Yet services research has not adequately explored the institutionally distinctive challenges associated with service innovation (Barrett et al 2008). Innovation is increasingly discussed as a process whereby provider and user engage in form of relationship that allows them to co-generate service exchange by sharing knowledge practices (Chesbrough & Spohrer 2006). Yet it is argued that, despite the rapid growth of innovation discourse and its relevance to healthcare services, health policy research has not been reconciled with the service innovation agenda (Lehoux et al 2008).

The hybrid term “co-creation” has been suggested to inherently contain some contradictory ideological signifiers that point toward the overlapping space of the public policy and the services logic perspectives. Turner (2005), for example, has highlighted the ability of policy to enter multiple discursive registers simultaneously, namely the bottom-up, participative innovation on the one hand, and rational economic notions of top-down innovation control on the other.

The rise of the service innovation discourse has been manifest amidst the growing interest around New Public Management (NPM). NPM arguably represents a paradigmatic shift from the traditional model of public administration (Hood 1991), advocating a “new pragmatism” approach to managing public services (Hughes 2006)

and a new type of relationship between service providers and customers (Hoggett 1996). Yet existing literature tends to portray NPM as a blanket discourse that colonises public services, effectively overlooking the extent to which its normalizing effects and cohesion are in fact highly context-dependent (Thomas and Davies 2005).

Furthermore, the NPM logic shares a great deal with the notion of innovation as rational planning (Bessant and Tidd 2007). Key to this conception is the role of sequential models that describe the unfolding of innovation as a staged, “controlled” process, wherein rational and autonomous individuals make definitive choices (Fonseca 2002). Our study further highlights, however, the multiplicity of involved stakeholders in public sector innovation, and the need to consider the various meanings that become attached to innovation as these stakeholders interact. We consider this process as a continuous creation and negotiation of new meanings (Asimakou 2008), whereby it is not necessarily sharing and consensus that leads to innovative behaviors, but additionally a combination of miscommunication, anxiety and conflict that may lead to new meanings potentially becoming “actualized as innovations” (Asimakou 2008: 67). Our study of health policy development in two countries allows us to examine these discursive themes in different institutional contexts.

Our research contributes a discursive understanding of the linkages between healthcare policy development and the “ideological signifiers” of service innovation. To this end, we conduct a discourse analysis of healthcare policy in the UK and Canada, focusing on the area of stroke services. We examine the evolution of policy discourse that describes the planning and implementation of services restructuring programmes. In so doing, we explore the relevance of Grant and Hardy’s (2004) conception of discourse as a “struggle for meaning”. We look at “texts” as a manifestation of this struggle and not merely as linguistic objects; in that sense, the array of policy texts do not simply reflect social conditions, but rather *are*, in fact, context (Chalaby 1996).

Yet, this struggle for meaning that inhabits policy discourse is not always overt. The apparent ‘universality’ of policy ends and the consensus-based processes that seem to underpin them, often disguise the involved stakeholders’ ‘political appearance’, which

“is reduced to the level of an illusion concealing the reality of conflict” (Ranciere 1999: 86). Hence ideology does not enter the discursive milieu of policy in the occurrences of political terms, such as “patient empowerment”, but rather in its ability to put down the manifestations of dispute and “hold up the emergence of common interests” (Ranciere 1999: 86). Our analysis of “innovation meanings” in the UK and Canada seeks to extend Grant and Hardy’s problematizing of the interplay between local discourses and the “context that is made up from them through the negotiation of meaning” (2004: 8), by challenging the origins of the notion of ‘agreement over meaning’. This implicit ‘agreement over meaning’, which we argue is lacking, contributes to the gap in translating policy into practice, and needs to be problematised in discussions of policy’s implementation gap.

Methodology

We employ a combined interpretative approach, primarily based on policy document analysis and informed by 10 in-depth interviews with policy experts, service providers and users in Canada and the UK. At the policy level, we analyzed eight Department of Health stroke-specific policy documents and ten Canadian policy documents, at the national and various provincial levels. Tables 1 and 2 below provide details of these policy documents.

Insert Tables 1 and 2 here

Whilst an analysis of the restructuring of stroke services delivery in the Canadian and the UK contexts affords useful perspectives on the role of inter-organizational knowledge sharing and best practices diffusion, one must note that differences exist in the organizational structure of services between the two countries. Suffice to say in Canada, there is a federal model of governance, which provides province-controlled, funded – and hence planned – healthcare, with loose overarching administration. However, despite the increased autonomy in designing and implementing strategy at the local (provincial) level, the provincial Heart and Stroke Foundations and Health Care authorities are connected at the national level through the Canadian Stroke Strategy (CSS). The CSS is a joint initiative of the Canadian stroke network and the Heart and Stroke Foundation of

Canada, a “strategy of strategies” which provides both a forum for the exchange of information on national and provincial initiatives (and research) in stroke, and a platform for coordinated activity at the national level to support best practice implementation on the ground (British Columbia Stroke Strategy 2007).

In the UK, health care strategy is designed and implemented regionally, with Health for London constituting the local implementation of the large London region. The stroke strategy was developed in the area, as part of the overall strategic review of their services but regional managers worked toward ensuring alignment with the national document. For the national policy, there was significant representation from voluntary organizations such as the Stroke Association and ‘patient’ representatives. The Department of Health (DoH) and the produced policy seemed to emulate a shifting political/ideological apparatus and hence a new institutional context within which the stroke service restructuring unravels.

Our methodological approach involved a combined, two-path discursive analysis. Over a period of 16 months, we analyzed a sample number (10) of Canadian Stroke Strategy documents across 8 provinces. In trying to make sense of the text and understand the main themes arising in the first reading, we drew on some of the involved actors’ knowledge as recorded in interviews. We then returned to the policy texts, conducting an inter-discursive analysis of previously identified themes, such as the “service logic” and “cross-organizational knowledge transfer”, and the ways in which they were integrated in discussions of service innovation and quality improvement. In the UK, we looked at both Stroke-specific and general DoH policy documents (8 in total) and in a similar fashion we used material from interviews with stroke survivors, carers and policy makers before conducting a secondary reading of the policy text. We focused on the most frequently appearing themes of “informed patient” and “knowledge asymmetries” and explored their positioning in the texts *vis*

a vis the rhetoric of innovation. Lastly, informed by the UK policy analysis we returned to the Canadian documents once again and attempted a final assessment of the ways in which themes of knowledge transfer were conceptualized, notably with reference to the different meanings of shared and participative innovation that were produced in the countries.

Analysis

Table 3 summarises the key discursive themes with supportive evidence from stroke care policy documents across Canada and the UK.

Insert Table 3 here

Broadly, our analysis found that a “service logic-informed” language characterized the Canadian policy & evaluation documents, and this contrasted with political discourse being largely adopted in the UK DoH reviews. In Ontario, an exemplar case of successful re-organization of Stroke services in Canada, strategy was designed around what is specifically defined as the *continuum of stroke care*. The following text from the provincial five-year strategic plan illustrates the significance of the key discursive themes: *knowledge translation, innovation, quality improvement and integrated service delivery*:

[B]uild capacity through the generation, translation and integration of knowledge and foster effective use of resources through innovation, system change, quality improvement, and integration and coordination of service delivery (Ontario Stroke System Strategic Plan 2007-2012)

In the production and formation of a stroke-specific strategy and the ensuing policies, knowledge input from non-government actors, such as volunteer organizations, seemed to be more widely used and embedded in Canada. As early as 1997, the need for integration of the disorganized Ontario stroke services forged the basis of the Ontario Stroke Strategy. Actors in the volunteer sector were identified as leading partners involved in the design and launch of the coordinated stroke strategies.

Moreover, whilst in both systems, the value of coordinating actors, resources and services across the stages of stroke care provision was recognized, in Canada this value was consistently linked with the use and sharing of evidence-based best practices across the service continuum. Hence, at the level of horizontal knowledge sharing (between stroke actors in the various stages of the service provision), the Canadian stroke strategy carefully considered the linkages between medical research and scientific evidence, evidence-based guidelines and other knowledge repositories:

The Ontario Stroke Strategy promotes the use of practices and care that have been supported by scientific evidence, or are considered the gold standard (“best practice”) to prevailing knowledge.

The discourse reflected a structured approach around themes of continuity, integration and transitionality of the service:

A comprehensive set of services ranging from preventive and ambulatory services to acute care to long term and rehabilitative services. By providing continuity of care, the continuum focuses on prevention and early intervention for those who have been identified as high risk and provides easy transition from service to service as needs change (New Brunswick Integrated Stroke Strategy 2007; 48)

At the national level, the Canadian Stroke Strategy emphasized the successful implementation of an integrated approach to service delivery and presented it as model for service innovation internationally. Efficiency of the offered services was especially emphasized:

All Canadians have optimal access to integrated, high quality, and efficient services in stroke prevention, treatment, rehabilitation and community reintegration. The Canadian Stroke Strategy serves as a model for innovative and positive health system reform in Canada and internationally (The Canadian Stroke Strategy: changing systems and lives 2007: 10)

Finally, across the Canadian policy texts, the notion of a shared vision of Innovation was promoted without references to different stakeholders interests or power positions, but rather as a depersonalized, common and ‘systemic’ objective:

[F]oster effective use of resources through innovation, system change, quality improvement, and integration and coordination of service delivery (Ontario Stroke System Strategic Plan 2007-2012)

Meanwhile, in the UK, the National Stroke Strategy echoed a rather different discursive formation. The service itself was placed in the background of a thematization around lay actor (i.e. patient) empowerment, targeted information provision to the user, participative management of care through increased patient choice. As alluded to in a number of policies, there seemed to be less of an emphasis on effective knowledge transfer and process integration around the service. More specifically, evidence-based practices were not embedded in the service lifecycle, an issue reflected in the deficiencies of people skills development and management at different stages of the stroke pathway. Further, knowledge silos often appear in processes that remain unlinked as a result of the absence of a nation-wide education program:

Specialist knowledge has developed ad hoc in practice and there is no nationally recognised stroke-specific training. Nationally recognised, quality-assured and transferable training and education programmes for stroke linked to professional roles and career pathways are needed (The National Stroke Strategy 2007; 55)

This view was reiterated by carers in the conducted interviews, wherein there were frequent references to dissatisfaction with the practice of interacting with multiple points of contact – which appear to be disconnected from one another:

It's not looking at the administration side and the qualification side and how a patient is treated and the Stroke Unit equipment and all that, it's a mindset which affects all the staff, the "just do my task" mindset" (Carer, UK)

Recently, in order to address this need the DoH established the UK Forum for stroke training with a steering group and four task groups that consist of relevant professional bodies, voluntary organizations, social care and stroke survivors, hence emphasizing the importance of user involvement in developing a "Stroke-specific Education".

However, the priorities set by the DoH seem to put little stress on the actual processes of training, education and knowledge transfer; rather the produced discourse was characterized by a focus on the power/control shifts that these processes would entail. Thus the reference to empowerment, informed choice and control of care *qua* "the service" seemed to assume straightforward linkages between these notions:

If stroke survivors and carers receive more appropriate information and are more satisfied with support this will help empower them to take control of their own care. (DoH 2007)

Interestingly, the NPM logic of "efficiency" and "cost control" appeared, somewhat contradictory, to co-exist with allusions to positive evaluation of patient involvement.

The aforementioned quotation was followed by a revealing admittance:

... [A]lthough the benefits are valued by stroke survivors and carers they will not bring any direct health or social care savings (ibid.: 34)

Whilst the concept of the informed patient is consistently reflected in discussions of user involvement in the restructuring of stroke services, it also appears to be systematically associated with the (need for) shifting focus of the delivery of care:

from in-hospital provision to community services as well as home-care and ultimately self-care. This direction of organizational change is moreover presented not as an ad hoc initiative but rather as addressing the lay citizen needs as they have been communicated to the provider:

People tell us that they want more services in the community, closer to home (DoH 2006)

Overall, the stroke policy discourse seemed to draw heavily on the more general yet influential healthcare report, “Our Health, our Care, our Say”, published by the DoH in 2006. Throughout the stroke-specific policies there were a number of direct references to this document, which provided the framing for a patient-centered focus in organizing and delivering health services.

Discussion

Stroke care in Canada reflects a more decentralised policy-making model, and this appeared to lay the ground for a bottom-up approach to service innovation. The geography of public services in the country is characterised by high degrees of autonomy at the local administrative level, namely the provincial governments. The multiplicity of needs dictated by a diverse set of local conditions, placed an emphasis on the role of knowledge transfer and information technologies throughout the development, provision and support of the care service. The produced policy discourse reflected these institutional tendencies and focused the innovation debate around “the service” itself as opposed to the user. A “service logic” had been integrated in the advancement and re-definition of NPM notions that influence the vocabularies of re-structuring and innovation. Hence the interaction between involved actors at the local, provincial and national level is recognized as an important success factor in the implementation of system change, which must involve

successful integration of skills, resources and establishment of robust communication channels throughout.

The service logic has been consistently theorized as a concept that considers provider and customer in an emergent form of relationship and assumes a dynamic, “becoming” view of resources (Vargo and Lusch 2004); these include “communication, involvement and a deep commitment to working across organizational boundaries” (Prahalad and Hamel 1990: 82). “Efficiency” is of acute importance in service provision in the overlapping space marked by services research and NPM, however it has entered the two countries’ policy discourse in rather different ways. In the case of Canada, efficiency is predominantly discussed in the context of the providers’ ability to develop “collaborative competency” by absorbing knowledge from the user and their value networks (Lusch et al 2007). Terms such as “power”, “choice” and “control” have no place in this discourse, wherein the patient *qua* user is viewed as external to the service provision continuum.

In the UK conversely, more user-centered notions of the service logic seem to constitute the backbone of the re-structuring discourse; the idea of the “local” and its connection to the principle of “responsibility” originate from the early Thatcherite NHS reforms (Moon and Brown 2000) and have constituted building blocks of the New Labour policy of “empowerment” and “informed patient” from the late 1990s to most recent changes. Studies of these reforms have explored these themes as part of a “consumerist discourse” that nonetheless does not meet the lay user’s embodied and affective dimension of illness (Lupton 1997; Mol 2007). Moreover it has been suggested that modernization policy is inexorably linked to a discourse that

challenges the traditional distribution of expert knowledge (Dawson et al 2007), which illustrates the transition toward demedicalization of health care policy and a break with hospital-based medical domination (Ranade 1997). Conversely, it emphasizes the notion of self-management and patient control over health care (Fox et al 2005; Mol 2008).

Despite these differences in different political tone and rhetoric (servitization versus empowered participation), policy discourses across UK and Canadian institutional contexts reflect a view of service innovation that shares a multitude of ideological significations. This “shared ground” can be seen as the expression of an equilibrium in the balance between democracy and efficiency (Okun 1975 in Box et al 2001). The UK healthcare policy seems to be founded on the idea that more user involvement equals (ultimately) to a better service. The Canadian policy prioritized knowledge transfer and service improvement, positing no challenges to the concept of “care as a right”. Yet the dominance of non-political, service-centered discourse that seems to almost refute the very idea of ideology is *per se* profoundly ideological.

Some of these arguments can be further elucidated by looking at the role of knowledge transfer in the two countries of our case. Again, although a first analysis of the use of “knowledge”, “communication” and “information” in the policy language in the Canada and the UK suggests an apparent division: emphasis on cross-boundary sharing of best practices in the former seems to be at odds with a top-down knowledge transfer that empowers patient choice in the latter. However, in both cases the participative/bottom-up *and* the top-down innovation models seemed to co-exist (Turner 2005).

We thus acquire a clearer view of the two sides involved in the “innovation game” by actors in the UK, both provider (of which there are many) and user, which are explicitly identified as partners in a process of value co-creation. Knowledge transfer may not be acknowledged as a driver for service innovation in the UK policy discourse, it is albeit assumed to unproblematically render the provider-user relationship into a ‘partnership’, by addressing knowledge asymmetries that previously hindered collaborative behaviours.

Conversely, the forms of relationships presented in Canadian healthcare discourse seem to be somewhat depersonalized and the re-structuring of the service appeared to mediate knowledge “diffusion” and “integration”. No stratification of the involved stakeholders was acknowledged, and knowledge asymmetries were not mentioned. Knowledge sharing was in Canada, as in the UK, viewed to be the ultimate target and means to raising service quality; however pre-existing ideological presuppositions and power dynamics among patients, clinicians and policy makers, all seemed to be muted. In this case, there was no question of innovating through challenging the current *status quo*; service innovation appeared in policy discourse devoid of any “discursive manoeuvres” (Grant and Hardy 2004). The reality of care, following that of NPM, was systematically depoliticized and the primacy of “service logic” was discursively constructed as “scientific fact” (Maguire 2003) containing no conflicting meanings. In the UK, potential conflict between different actors creating meanings of innovation (Asimakou 2008) was alluded to, but assumed to be unproblematically resolved by means of knowledge transfer and empowerment.

Policy discourse in both countries illustrates how, whilst the restructuring of care services is based on a vision of “continuous quality improvement”, it produced different meanings of service innovation. In Canada, innovation was projected as an imperative that seemed to invite an undifferentiated set of actors to engage collaboratively across the service continuum. In the UK, the sharing of knowledge was invested with political meaning and the value of a consensual approach to innovating was entangled with delegating control to the lay patient. The notion of consensus (Ranciere 2003; 2010), at least at the official policy level, that underlines both institutional contexts, privileged a unified message of innovation. This was presented as an uncontested process (Kontos and Poland 2009), by “abstracting meaning away from the specific actions that gave rise” (Grant and Hardy 2004: 8) to the policy discourse. Hence the struggles involved in the inevitable re-ordering of relations of power between existing healthcare groups remained unaccounted for.

More importantly, the most profound type of innovation stimulus, that which is based on the very heterogeneity of perception was evacuated, especially regarding the ways in which the involved stakeholders negotiated and disagreed over meanings. What became dominant discourse was thus detached from those political activities in which patients, doctors and policy makers engage, and through which they do not “solve problems in partnerships” but they “address what remains irreconcilable within a community that is always unstable and heterogeneous” (Ranciere 1995: 103).

Conclusions

This paper has provided a discursive analysis of recent policy development in the UK and Canadian stroke care systems. Throughout we have argued the need to unearth

the meanings of innovation that are being constructed and communicated in understanding the development of health care policy with implications for its eventual translation into practice. In so doing, we highlighted the importance of contextualizing the analysis and including the political and ideological subtext of the process of service innovation. To this end, we explored the conceptual linkages between innovation, service logic and knowledge, and suggested that they result in different discursive formations internationally, which nonetheless shared a notion of “working toward consensus”.

Our approach contributes a more nuanced understanding of the complexities associated with healthcare policy interventions. It builds on the need for more critical reflection on how contextual factors shape healthcare professionals’ assumptions and practices (McCormack et al 2002). It moreover calls for a re-consideration of the role of knowledge transfer in the creation of new meanings of innovation and points towards the less ostensible differences, misunderstandings and conflicts that define and re-define innovation in practice (Kontos and Poland 2009; Asimakou 2009).

Future research could examine practice changes over time to allow a better understanding of the links between policy discourse and practice of service innovation. More specifically, there seems to be a fruitful research direction in the area of public involvement and patient empowerment that is rapidly incorporated in health care structures, and poses some exciting challenges to the process of policy making. In this context the language of service innovation and its entry in the political realm, invites further unpacking of the multitudes of meaning for the various stakeholders that are invited to become “healthcare innovators”.

**Policy documents
Canada**

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Table 1: Data Collection from Canadian Policy Documents

Policy documents UK
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Department of Health (2006), ASSET – Action on Stroke Service: an Evaluation Toolkit, Case Study Pack, May 2006
Department of Health (2006), Our Health, our care, our say: a new direction for community services, January 2006
Department of Health (2006), Improving Stroke Services: a guide for commissioners, December 2006
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Darzi, A. (2007), Our NHS, our future: NHS next stage review, Interim Report, Department of Health, October 2007
Department of Health (2007), National Stroke Strategy, December 2007
Department of Health (2007), Impact Assessment: National Stroke Strategy, December 2007

Table 2: Data Collection from UK Policy Documents

National Health System	Stroke Policy	Key Discursive Themes
Canada	<p>“The change represents a paradigm shift in how stroke is treated. Integration across the continuum of care represents a major challenge that requires expertise in change management”</p> <p>“All Canadians have optimal access to integrated, high quality, and efficient services”</p> <p>“Knowledge was exchanged between clinicians, managers and policy makers across regions”</p> <p>“Enhancing the transfer of knowledge and skill sets to the primary stroke centers”</p> <p>“The Ontario Stroke System will stimulate innovation and leverage knowledge across the continuum of stroke care”</p>	<p>The value of adopting a “service logic”</p> <p>NPM focus on efficiency and optimization</p> <p>Knowledge Transfer among equal stakeholders (patient not involved)</p> <p>Knowledge Transfer as best practice sharing</p> <p>Innovation as a depersonalized “shared objective”</p>
UK	<p>“Support for the active, engaged citizen, making our vision a reality”</p> <p>“I want each group to listen to patients, staff and the public...”</p> <p>“Quality information and education, provided at the right time and in an accessible format, can improve opportunities for choice and levels of independence.”</p> <p>“Take into account the knowledge and understanding relating to methods of feeding back to stroke patients how their contributions have influenced services”</p>	<p>Lay actor as innovator</p> <p>Focus on user involvement</p> <p>Knowledge transfer as a means to informed patient choices and bottom-up control of the service</p> <p>Sharing knowledge about patient impact as integral part of service innovation</p>

Table 3: Discursive Themes in UK and Canadian Policy Development

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