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**POLICY-MAKING AS A STRUGGLE FOR MEANING: DISENTANGLING
KNOWLEDGE TRANSLATION ACROSS INTERNATIONAL HEALTH
CONTEXTS**

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Abstract: Over the last decade, research in medical science has focused on knowledge translation and diffusion of best practices to enable improved health outcomes. However, there has been less attention given to the role of policy development in influencing the translation of best practice across different national contexts. This paper argues that the underlying set of public discourses and ideological presuppositions of healthcare policy significantly influence its development with implications for the dissemination of best practices. Our research examines the policy discourses surrounding the treatment of stroke across Canada and UK, and how they are constituted by different underlying meanings of innovative best practice, user participation, and service restructuring. These findings provide an important yet overlooked starting point for understanding the role of policy development in knowledge transfer and the translation of science into health practice.

Keywords: policy-making, healthcare, knowledge translation, discourse analysis, ideology, user participation

INTRODUCTION

While evidence-based medicine has increasingly sought to transform decision making in clinical practice, this trend has not been followed by a similar logic in health management and policy-making. This has ultimately led to 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 directing healthcare policy, but moreover vis-à-vis its ability to render visible concurrent political structures and mechanisms (Moon and Brown 2000). Moreover, we explore the linkages between the rise of a public sector discourse and its varied manifestations with the different notions of citizen, user and, in our case, patient in co-designing best practice and transferring knowledge during service restructuring (Löffler 2009), which has emerged as an important area of debate in healthcare policy (Dawson and Morris 2009). Rather than being viewed as a passive recipient, the patient as service user may be central in re-structuring care, especially through making “informed choices” and as well as participating in the service design and thereby acquiring more control over the process of care delivery (Fotaki 2005; Le Grand 2004; Löffler 2009).

Our approach is to unearth how different underlying meanings of best practices - deemed as gold standards by medical science - are discursively enacted in health policies across different institutional and political contexts. To this end, we analyzed stroke care related policies in the UK and Canada. In the UK, we examined 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 various strategic provincial initiatives, focusing on the Ontario Stroke System, which has been acknowledged as an exemplar of successful implementation (Black et al 2003). We examined what stroke care knowledge was thought to be critical and how this knowledge and best practice was diffused.

Our findings suggest that although the policy development regarding stroke services in the two countries seemed to occupy a different discursive space, there were also shared ideological references. Canada has a bottom up approach to policy development and knowledge sharing in a decentralized provincially led policymaking model. The emphasis on technology and knowledge transfer between providers produced a policy discourse around the ‘service’ as encompassing the range of providers involved in stroke care. This contrasted with a focus on user/patient involvement in co-producing best practice in service restructuring in the UK - an informed patient discourse suggesting power, choice, and control by the patient in the service provision. By considering these contrasting themes that appear to frame the formation of policy and best practice in the UK and Canada, we attempted to unveil their latent ideological meanings in order to better understand how they were related to translation of medical science into practice.

POLICY-MAKING AND KNOWLEDGE TRANSLATION

Policy is inexorably linked to new specifications of public governance as denoted by contemporary discourse of neoliberalism (Larner 2000, Bovaird and Löffler 2009). In this light, policy literature has highlighted the intricacies of translating evidence into policy (or institutionalizing best practice) and employed the Foucauldian notion of “governmentality” to conceptualize political change associated with government restructuring 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 ‘beyond Left and Right’ politics of the Third Way as well as their links with the rhetoric of innovation (Prince et al 2006). ‘Informed choice’, ‘participation’ and service orientation are integral to the New Public Management (Hood 1991, Osbourne and Gaebler 1992) rhetoric. As a meta-discourse concerning public service delivery, New Public Management seeks to promote efficiency and private sector thinking in public services, in contrast to earlier assumptions of bureaucracy, stasis and focus on professionals needs (Hood 1991).

New Public Management has led to an emphasis on knowledge translation and sharing processes as accounting for new, more dynamic types of user-provider relationships. The hybrid term “co-creation” has been suggested to inherently contain

some contradictory ideological signifiers that point toward the overlapping space of public policy and participative forms of governance. Turner (2005), for example, has highlighted the ability of policy to enter multiple discursive registers simultaneously, namely the bottom-up, participative service development on the one hand, and rational economic notions of top-down service control on the other. In New Public Management (NPM) discourse, duplicity of meanings is evident in the notion of ‘best practice’, as being defined by scientific (medical) evidence *and* customer preference. In this latter view of knowledge translation to enable service innovation, the unfolding of innovation is not considered a staged, “controlled” process, wherein rational and autonomous individuals make definitive choices (Fonseca 2001).

Another discursive focus for the translation and transfer of ‘best practice’ is rooted in the Evidence Based Medicine movement (Sackett and Rosenberg 1995) and the increased standardisation in healthcare (Timmermans and Berg 2003). These premise that science is able to determine optimal treatment options for a given disease or condition. This optimal treatment, based on rational scientific evidence, is then considered the gold standard and the basis for a standardised ‘best practice’. However, despite accepted views of best practice in the medical literature, there persists significant variation in practice (Timmermans and Berg 2003). Baumbusch et.al. (2008) suggests that knowledge exchange has the potential to address this research-practice gap by bringing together researchers and practitioners in a dynamic process toward improving service delivery. Mitton et.al (2009) identify that interactively engaging key leaders and champions in practice as an important success factor in facilitating the integration of research into practice. Literature has also identified that opportunities for building long term relationships are needed to foster knowledge exchange activities (Trostle 1999, Bowen et al 2005). In Canada there has been an early and significant focus on knowledge translation and exchange activities in order to enable best practice and improve health services (Lomas 2007).

Our study challenges this discursive “scientific” notion of knowledge translation that necessarily requires reaching a consensus of terms and the “establishment of a common nomenclature”. It highlights the multiplicity of possible involved stakeholders, and the need to consider the various meanings that become attached to ‘best practice’ as these stakeholders interact. Our study also highlights how

knowledge translation can vary in its focus of who is translating to whom, and which actors are involved in the process.

We consider this process of knowledge translation as a continuous creation and negotiation of new meanings, 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). Under this perspective, we aim to illuminate the political facets of ‘knowledge translation’, which have been overlooked in extant literature in spite of their central role in the knowledge creation and diffusion cycle. Our study of health policy development in two countries allows us to examine these discursive themes in different institutional contexts.

To this end, we conducted a discourse analysis of healthcare policy around stroke services in the UK and Canada. We examine the evolution of policy discourse that describes the planning and implementation of services restructuring programmes and the role of knowledge translation and transfer. 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 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 in its ability to put down the manifestations of dispute and “hold up the emergence of common interests” (Ranciere 1999: 86). Our analysis of translating best practice in the UK and Canada seeks to extend Grant and Hardy’s problematizing of the interplay between national health 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 the gap between knowing and doing, and needs to be addressed in discussions of policy's implementation gap.

METHODOLOGY

Case Background: Up until the mid 1990's stroke patients had been treated with bed rest and variable levels of rehabilitation; doctors largely considered the condition as having minimal or no acute intervention. However a series of high profile scientific studies published in 1996 and 1997 demonstrated that stroke could be more actively managed with significantly reduced morbidity and mortality. This led the way for developing more systematic stroke care strategies in order to transfer these best practices into new ways of delivering care. Best practice now became defined by rapid administration of 'clot busting' drugs (which requires brain imaging scan to be performed first), intensive rehabilitation in designated stroke units and stroke prevention clinics. This level of change and innovation required restructuring of care at multiple levels.

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 regional (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 2005).

In the UK, health care strategy is designed centrally and implemented regionally, with Health for London constituting the local implementation of the large London region.

The stroke strategy developed in London, as part of the overall strategic review of their services (Darzi 2007), also sought to ensure alignment with the national document. For the national policy, there was significant representation from voluntary organizations such as the Stroke Association, lay 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 restructuring of stroke service has unravelled.

Data Collection and Analysis: We employed a combined interpretative approach, primarily based on policy document analysis. These were informed by 12 in-depth interviews with policy experts (3), service providers (3) and users (6) in both 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.

Our methodological approach involved a combined, two-part 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 innovation” and “knowledge transfer”, and the ways in which they were integrated in discussions of best practice 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 (four caregivers in the UK and two in Canada), service providers (one in UK and two in Canada) policy makers (one in UK and two in Canada) 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 best practice and service improvement. 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.

FINDINGS

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

Canadian Stroke Policy Findings: Broadly, our analysis found that a seemingly neutral “service” language characterized the Canadian policy & evaluation documents, and this contrasted with political engagement 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 that would afford considerable legitimacy to the effort as well as potential national cohesion.

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 provider continuum.

We started meeting around 1999 ... having a committee to look at how we would organise this thing and we divided it into three groups. There was a Prevention Group, an Acute Group and a Rehab and Community Reintegration Group... [we] wanted to show that we had the multidisciplinary group- multiple stakeholders that could come up with a plan with a partner which was the Heart and Stroke Foundation of Ontario. (*senior doctor, service provider*)

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. (*Ontario Stroke System Strategic Plan 2007-2012*)

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 in its full lifecycle 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*)

While issues of power were seemingly ignored in the policy documents, providers on the ground acknowledged that the neutral inclusion of all service providers as important partners in service provision leaves open the more contentious task of prioritising these providers in a resource constrained environment.

Stroke's a real continuum but the groups are quite different and quite different in their goals... We ran into a problem ...in that the Ontario Stroke Strategy put all their money into TPA and very little money into Rehab... most of the money into Acute Care and Prevention. I think three percent of the money went into Rehab... Rehab is not as sexy. (*senior doctor, service provider*)

UK Stroke Policy Findings: Meanwhile, in the UK, the National Stroke Strategy echoed a rather different discursive formation. Policy discourse surrounding the service itself was placed in the background of a thematization around lay actor (e.g. patient) empowerment, targeted information provision to the user, participative management of care through increased patient choice. This policy emphasis is the key message in the health policy document 'Our health, Our care, Our say' (DoH 2006) which foregrounds the importance of public and lay involvement in service delivery. As alluded to in a number of policies, there seemed to be less of an emphasis on effective knowledge transfer between providers and process integration around the service. More specifically, evidence-based practices were not embedded in a service lifecycle, an issue reflected in the deficiencies of service integration and management at different stages of the stroke pathway. Further, knowledge silos often appeared in processes that remained 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". (*UK carer*)

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". Nonetheless, there was ongoing acknowledgement that this emphasis on lay participation needed to be embedded in the overall service restructuring:

The[re was a] need for rapid acute care, for the acute event; systematic approach to handling that whole acute pathway. And then the important of rehabilitation... we set up six focus groups to look at the six key areas and we appointed independent chairs to each of those groups. They were all supported by people of each of the relevant disciplines that deal with strokes, so the groups that sat down to do the work were entirely multi-disciplinary. They also had patients and carers in each group. (*UK senior policy maker*)

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 previous quotation was followed by a revealing admission:

... [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 knowledgeable or 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 and knowledge sharing 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 knowledge sharing and in organizing and delivering health services.

DISCUSSION

Stroke care in Canada reflects a more decentralised policy-making model. 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 places 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 and those providing the service, as opposed to the user and their potential role in co-constructing the service. 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 knowledge sharing and the implementation of system change, which must involve successful integration of skills, resources and establishment of robust communication channels throughout.

“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 diverse actors across the service continuum and their value networks (Lusch et al 2007). Terms such as “power”, “choice” and “control” have little or no place in this discourse, wherein the patient *qua* user is viewed as external to the knowledge sharing and 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. 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).

In the literature, a service logic has been 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). Drawing on the metadiscourse of NPM, which emphasises stroke care as a ‘service’, both countries’

policies demonstrate how other broader discourses influence the interpretation of policy texts (Fairclough and Wodak 1997). In Canada, where the Evidence Based Movement had its inception at McMaster University, the work of ‘knowledge translation’ remained focused between the multiple service providers and ‘the evidence’. However stroke policy in the UK was heavily influenced by the Labour government political focus of lay involvement in service restructuring and thus in the knowledge transfer process.

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 innovation that shares a multitude of ideological meanings. This “shared ground” can be seen as the expression of an equilibrium in the balance between democracy and efficiency (Okun 1975). The UK healthcare policy seems to be founded on the idea that more user involvement and knowledge equal (ultimately) better service. The Canadian policy prioritized knowledge transfer and service improvement, posing 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 (Zizek 2006; Ranciere 1999).

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 (between providers) 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 innovation and service restructuring 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 formally, and knowledge asymmetries were not mentioned in policy documents. 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 restructuring was discursively constructed as “scientific fact” (Maguire 2004) containing no conflicting meanings. In the UK, potential conflict between different actors creating meanings (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 what constituted a service. In Canada, service restructuring was projected as an imperative that seemed to invite an undifferentiated set of actors to engage collaboratively across the service continuum, in the absence of lay involvement. 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 knowledge sharing and 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 and knowledge between existing healthcare groups remained unaccounted for.

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 multiple meanings of innovation constructed and communicated in the development of healthcare policy, with implications for its eventual translation into day-to-day practice. In so doing, we highlighted the importance of contextualizing the analysis and including the political and ideological subtext. To this end we explored the conceptual links between innovation, service restructuring and knowledge translation, and suggested that they result in different discursive formations internationally, which nonetheless shared a notion of “working toward consensus”. In light of the increased policy emphasis on lay user involvement, we sought to contribute to “opening up” conventional framings of knowledge translation. We suggested however that insofar as policy appears to privilege uncontested and de-politicized notions of knowledge sharing, its ability to address the gaps between specialist and lay knowledge will remain significantly undermined.

Our approach contributes a more nuanced understanding of the complexities associated with 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) and points towards the less ostensible differences, misunderstandings and conflicts that define and re-define innovation in practice (Kontos and Poland 2009; Asimakou 2009). It moreover suggests an analytical lens that focuses on the political texture of these differences, which is often obscured in dominant discourse, despite constituting a fundamental dimension of the activities of policy makers, providers and users.

Future research could examine more closely the links between policy discourse and the practice of service restructuring. 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 efficiency and

effectiveness and its entry in the political realm, invites further unpacking of the multitudes of meaning for the various stakeholders and laypersons that are invited to become “healthcare innovators”.

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Table 1: Data Collection from Canadian Policy Documents

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Table 3: Discursive Themes in UK and Canadian Policy Development

National Health System	Stroke Policy	Key Discursive Themes
<p>Canada</p>	<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 occurs among equal stakeholders (patient not involved)</p> <p>Knowledge Transfer as best practice sharing</p> <p>Innovation as a depersonalized “shared objective”</p>

<p>UK</p>	<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 stoke 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>
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