Collaborative Policy Innovation Despite Competition:

A Study of Diffusion of Health Innovations across Dutch Hospitals

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ABSTRACT

This study examines how policy innovations are disseminated through collaboration in a public context shaped by competition. It builds on the literature of collaborative policy innovation and describes public innovation both as a policy approach – the joint development of new and enriched policy solutions by networks of actors – and as an intended outcome. The study focuses on healthcare innovations in relation to the underexposed topic of diffusion: the final phase of the innovation process in which innovations are shared and spread. While earlier stages of the policy innovation process, e.g. invention and implementation, receive more attention, diffusion seems particularly hard to achieve in a competitive public context, since it requires a transformation of competing interests into collective action in a stage where it seems more beneficial to withhold competitors from access to innovations. However, an in-depth case study in Dutch hospital care reveals that organizational benefits, reputational gains and legitimacy pressures enable diffusion – both in exclusive networks of hospitals (regimes) and sector-wide (beyond regimes). This paper shows how competition strengthens, rather than weakens, collaboration for policy innovation and has implications for both research and practice, in particular in relation to scaling, transfer or translation of public sector innovations. The study contributes to a better understanding of conditions under which collaborative policy innovation thrives in public sectors that are (partially) composed of competitive market mechanisms, by specifying policy innovation requirements that align the two seemingly contradictory perspectives of collaboration and competition.

Key words: collaborative policy innovation; public innovation; diffusion; collaboration; competition

Introduction

Collaborative policy innovation is widely recognized as a promising strategy for issues that governments struggle with tackling alone (Desmarchelier, Djellal, and Gallouj, 2020; Kattel, Lember, and Tõnurist, 2020; Sørensen and Torfing, 2017). The literature distinguishes several types of policy innovation – also commonly referred to as public innovation (Torfing and Triantafillou, 2016; Bekkers, Edelenbos, and Steijn, 2011; Osborne and Brown, 2011) – for example of products, processes or a combination of the two. From a management and organization perspective, policy innovation refers to a governance approach, e.g. a policy strategy, either at a micro or system level (Geels, Elzen, and Green, 2004). Against a background of complex problems that call for innovative solutions, collaborative policy innovation is described as a process in which public and/or private actors engage in the joint development and realization of enriched policy solutions that radically differ from their predecessors in terms of policy theory, objectives and strategies (Torfing et al., 2021; Stevens and Verhoest, 2016; Ansell, 2016). Policy innovation is distinguished from mere improvement, as it emphasizes sudden and drastic rather than incremental change,

discontinuity with past practice and deviation from standards used before (Hartley, 2012; Rogers, 2003).

Currently, in theory and practice, there is growing attention for collaborative policy innovation (Kattel, Lember and Tõnurist, 2020; Torfing and Ansell, 2017; Sørensen and Waldorff, 2014). Yet for long, innovation was perceived the outcome of rivalry rather than partnership, including in public sectors (Bekkers, Edelenbos, and Steijn, 2011). The belief in competition as the main driver for policy innovation is ascribed to New Public Management (NPM), a governance paradigm prevalent from the 1980s onwards that drew attention to public sectors adopting market competition in order to become more innovative (Bryson, Crosby, and Bloomberg, 2014; Pollitt and Bouckaert, 2011; Osborne and Gaebler, 1993). By contrast, collaborative approaches to policy innovation originate from New Public Governance (NPG) (Osborne, 2006; 2010), a paradigm that acknowledges the innovative potential of cross-boundary collaboration. Both approaches operate in accordance with their own logics, which Ansell and Torfing (2014: 7-15) distinguishingly label the 'NPM-logic' and 'NPG-logic' of policy innovation.

Although it seems as if the NPG-logic has become more dominant, various competitive elements, including market mechanisms, that were adopted in the past, remain operational in many public sectors nowadays (Bryson, Crosby and Bloomberg, 2014; Pollitt and Bouckaert, 2011), spurring rivalries between actors. Besides that, the political environment against which public innovations generally take place also produces tensions and competing interests among stakeholders (Qiu and Chreim, 2022). The current reorientation and progressive adoption of new and collaborative approaches to policy innovation hence require strategies that deal with divergences productively (Ansell and Torfing, 2014). This article studies actors' engagement in collaborative policy innovation in a public context shaped by market competition. It concentrates on diffusion: the third and final phase of the policy innovation process, in which innovative practices are shared and spread, following after invention and implementation (Hartley, 2014; Rogers, 2003). While literature is more attentive to early stages of the policy innovation process such as the development of new ideas, theories fall particularly short of explanations for actors' motivations for diffusion. Consequently, there is lack of an understanding of why and under which conditions actors are willing to share their innovative practices with competitors (Popa et al., 2011). As a result, barriers may be overlooked that stand in the way of collaborative policy innovation reaching its aims, including ambitions to transfer, scale up or translate effective innovative practices into different settings or implementation beyond an experimental phase (Lee and Restrepo, 2018; Zelenika and Pearce, 2014; Damanpour and Schneider, 2009).

This empirical study examines a collaborative policy innovation case in healthcare in the Netherlands, guided by the question: *Why and under which conditions are competing hospitals willing to engage in diffusion to achieve collaborative policy innovation with competitors?* While there are many different definitions used (Glor, 2021), this study follows Jordan and Huitema (2014), who emphasize that policy innovation refers to both the novelty of a policy approach and the intended new and emerging effects of it, i.e. a break-away from policy strategies formerly used, as well as an intended outcome that the policy is seeking to promote, i.e. health innovation. The studied case is a partnership between the Dutch Ministry of Health, 24 hospitals (out of 90 hospitals sector wide) and many other health actors, with a total of 288 collaborative innovation projects. During and after earlier stages, where hospitals worked together in three groups of eight in so-called "breakthrough sessions" – a methodology focused on implementing innovative changes in organizations – several

diffusion activities took place. This resulted in the exchange – and sometimes even sector wide adoption – of innovative practices, for example in relation to decubitus, post-operative wound infections, medication safety, the reduction of waiting times, productivity of operating rooms and several logistic process optimizations. The research is based on document analysis (19 documents) and qualitative interviews with 18 stakeholders, including top-level public officials, senior civil servants from the Dutch Ministry of Health, officials from representative associations, hospital boards and involved experts.

This study contributes to a better understanding of conditions under which collaborative policy innovation thrives in public sectors that are (partially) composed of competitive market mechanisms, by specifying requirements that align the two seemingly contradictory perspectives of collaboration and competition. In the literature, collaboration is often presented as an alternative to competition (see for example: Bryson, Ackermann, and Eden, 2016; Hartley, Sørensen, and Torfing, 2013), thereby inevitably dismissing possible complementary aspects. This paper brings collaborative and competitive approaches to policy innovation together, by revealing organizational benefit, reputational gain and legitimacy pressures as main drivers for competing actors' engagement in diffusion along with competitors. It thereby shows how competition may strengthen, rather than weaken, collaboration targeted at policy innovation.

In the following section, a theoretical framework is presented that brings forward a comparison between collaborative and competitive approaches to the diffusion of policy innovation based on literature. After the applied methodology is described, this framework is used to analyse an exemplary case of collaborative policy innovation. Findings are subsequently followed by a conclusion and discussion and practical implications.

Diffusion in collaborative policy innovation

Diffusion is considered the third and final phase of the policy innovation process, following after invention and implementation (Hartley, 2014). In a policy context, diffusion relates to different concepts including policy transfer, policy mobility, policy adaptation and policy translation (Minkman, Van Buuren, and Bekkers, 2018; Dolowitz and Marsh, 2000). These concepts commonly refer to policy processes in which knowledge is spread into another time or place (Dolowitz and Marsh, 1996), on the basis of voluntary or pressured adoption without coercion (Minkman, Van Buuren, and Bekkers, 2018). In the diffusion phase of collaborative policy innovation, innovations are shared and spread (Hartley, 2014). For competitors – actors striving for a competitive advantage, i.e. the possession of superior (technical, organizational or other) skills that enable a leading position over each other (Popa et al., 2011) – diffusion seems particularly hard to achieve, since it requires a transformation of competing interests into collective action in a phase where it seems more beneficial to withhold competitors from access to innovations (Waldorff, Kirstensen, and Ebbesen, 2014). Within earlier phases of the collaborative policy innovation process, actors co-develop and co-create ideas with innovative potential (invention) and translate them into actions, products or services that improve their organizational practices (implementation) (Hartley, 2014). By contrast, diffusion requires collaboration beyond these evident pay-offs.

The collaborative policy innovation literature mentions different expectations of diffusion, requiring a differentiation between diffusion within and beyond so-called 'regimes': policy networks with a limited number of key partners that work together towards a shared

public goal (Emerson and Nabatchi, 2015). Diffusion within regimes is targeted at learning from the good practices of others within a limited network of relevant actors and is beneficial for the improvement of public service delivery (Qiu and Chreim, 2022; Crosby, 't Hart, and Torfing, 2017; Carstensen and Bason, 2012). Diffusion beyond regimes boils down to the exchange of innovative outcomes with an external environment, driven by transparency and openness for the benefit of the public good (Sørensen and Torfing, 2017; Bekkers, Edelenbos, and Steijn, 2011; Beyerlein, Beyerlein, and Kennedy, 2006). Such an environment may be a broader category in which a regime is positioned, for example a sector, field or simply society at large.

Literature mentions several respects where collaborative (NPG) and competitive (NPM) approaches to policy innovation diverge, in relation to both types of diffusion (within and beyond regimes). Three aspects receive particular attention: (1) the arena, i.e. the exchange environment or context in which diffusion takes place; (2) the process, i.e. the set-up of exchange and interactions between involved actors; and (3) drivers and incentives for diffusion (Minkman, Van Buuren, and Bekkers, 2018; Dolowitz and Marsh, 2000). Table 1 provides an overview of signalled differences in the literature. Below, for both types of diffusion, characteristics are described following from the divergent approaches based on literature.

Table 1: Differences in collaborative and competitive approaches to diffusion

	Collaborative approaches to policy innovation	**Competitive approaches to policy innovation**
Originating paradigm	New Public Governance	New Public Management
Diffusion within regimes		
Arena (exchange environment)	Inclusive networks	Exclusive arrangements within market-like (public) environments (e.g. joint ventures)
Exchange process	Contributing to broad and open-ended goals (public value)	Contributing to narrow and clearly defined goals (outputs)
Drivers and incentives	Problem-driven; relational incentives (bonds and ties)	Output-driven; financial and performance-based incentives
Diffusion beyond regimes		
Arena (exchange environment)	Public sector or beyond (society at large)	Limited and selected partners only
Exchange process	High degree of exchange (knowledge sharing); public and free ('free-to-flow') knowledge	Low degree of exchange (knowledge hoarding); restrained and protected knowledge
Drivers and incentives	Legitimacy-based	Financial and performance-based

Source: Author

Diffusion within regimes: collaborative versus competitive approaches

For diffusion within regimes, collaborative approaches to policy innovation consider networks an optimal arena, because they "create, share, transfer, adapt and embed good practice" (Hartley, 2005, 25). Learning effects are promoted and knowledge is spread through mutual exchange between relevant stakeholders for the purpose of cognitive development (Qiu and Chreim, 2022; Ansell and Torfing, 2014). Governance networks of collaborating actors are considered perfect platforms for the required accumulation of knowledge, because they bring in ideas, experiences and resources from different directions and offer access to knowledge that actors otherwise could not get. Strategic alliance is hence highlighted as "the primary vehicle" for policy innovation, allowing others to build on generated ideas (Sørensen

and Torfing, 2017, 826). Cross-sectoral, cross-organizational or cross-boundary diffusion across domains of expertise is promoted (Bruns, 2013; Gray and Purdy, 2013; Seitanidi, Koufopoulos, and Palmer 2010). Therefore, ideally and typically, actors from diverse backgrounds are involved (Lasker, Weiss, and Miller, 2001). In pursuit of public value, i.e. to contribute to social meaning and community well-being (Moore, 2013; Bennington, 2011), actors are typically concerned with broad and open-ended goals and are problem-driven, i.e. focused on finding new and appropriate solutions to complex governance problems (Agranoff, 2014). Because collaborative policy innovation is recognized for its potential to close governance gaps, there is a reason for governments to be actively involved (Jordan and Huitema, 2014).

By contrast, competitive approaches to policy innovation underline the importance of a whole different type of arena: a (public) context shaped by market conditions where actors compete over clients, funds or other resources (Hartley, 2014). Under such conditions, it is considered an implicit aim to outperform others. This results in rather exclusive instead of inclusive actor interrelations (Pedanik, Uibu, and Koppel, 2022). Innovation typically takes place "in-house" within the boundaries of clearly delineated organizations (Ansell and Torfing, 2014, 3), or in specific and exclusive arrangements such as the private sector model of joint ventures: organizational structures created by a very limited number of participants only that pool resources and bundle expertise for the accomplishment of narrow and clearly defined goals (Hartley, 2014; Inkpen and Crossan, 1995). In such arrangements, actors are rather output-driven, i.e. targeted at the deliverance of better products or services than others or than before (Borins, 2000) and driven by "public entrepreneurship": the development and application of innovations for clearly delineated purposes, for example to increase productivity, expand capacity or gain efficiency in public service delivery (Hartley, 2005). Therefore, financial and performance incentive structures are necessary to persuade actors into a search for better ways of doing things (Damanpour and Schneider, 2009; Verhoest, Verschuere, and Bouckaert, 2007; Osborne, 2006; 2010).

Diffusion beyond regimes: collaborative versus competitive approaches

In relation to diffusion beyond regimes, collaborative approaches to policy innovation promote sharing and spreading knowledge openly, because cross-fertilization of ideas and the generation of new synergistic concepts beyond the boundaries of organizations may emerge from it (Beyerlein, Beyerlein, and Kennedy, 2006). Bekkers, Edelenbos and Steijn (2011: 3) consider the ability to share advanced "free to flow" knowledge even a prerequisite for policy innovation. In this light, processes of diffusion should support collective learning throughout and beyond entire policy fields (Sørensen and Torfing, 2017). Due to the typical involvement of government and public funds, transparency and openness about outcomes – the idea that results should be publicly available for society's benefit – are promoted (Jordan and Huitema, 2014; Hartley, 2014). Actors might feel pressured to share innovations in the face of emerging problems that need new solutions, and by a fear for legitimacy losses when they withdraw from such processes. Negative political discourses and media reporting are consequential associated risks (Ansell and Torfing, 2014).

By contrast, competitive approaches to policy innovation highlight that it is beneficial to preserve innovations exclusively to achieve or sustain a competitive advantage over others (Popa et al., 2011). This advantage is nullified if others adopt similar innovations, particularly at a large scale. Open access to innovations may even provoke problems of collective action: if others have similar (free) access to innovative outcomes, an incentive for engagement in earlier stages of innovation processes is lacking. Moreover, the importance of a dense policy

network, i.e. an environment based on informal relations and many face-to-face interactions, is stressed as an important factor for the mobilisation of resources required for diffusion (Minkman, Van Buuren, and Bekkers, 2018). Such density is more difficult to achieve with larger than with smaller numbers of involved actors. In addition, seeing policy innovation as an exclusive organizational gain, and perceiving others as rivals, may also result in a lack of trust and inability to see others' good intentions (Qiu and Chreim, 2022; Klijn, Edelenbos, and Steijn, 2010). Yet, for diffusion, actors need to be open to share and adopt practices of others (Minkman, Van Buuren, and Bekkers, 2018). Hence, both involved actors and outsiders may regard large-scale diffusion inappropriate, which may pressure the legitimacy of a collaboration (Provan and Kenis, 2008) and jeopardize competing actors' willingness to engage in diffusion beyond the boundaries of regimes.

Following from the literature, both types of diffusion seem difficult to achieve in hybrid contexts that foster incentives for both collaboration and competition. Competing actors are only expected to engage in diffusion within selective regimes, when other participants bring in assets that are beneficial for achieving something that cannot be achieved without them (Huxham and Vangen, 2005; also see Bryson, Ackermann, and Eden, 2016; Doberstein, 2015; Lasker, Weiss, and Miller, 2001). Furthermore, literature suggests that it is unlikely that competing actors will engage in diffusion beyond regimes, unless positive pressures (e.g. an organizational gain) or negative pressures (e.g. legitimacy pressures or incentives) are present. How diffusion is achieved in the studied case despite these discrepancies, will be elaborated in the findings, following after a description of the methodology.

Methods

The case under study is the "Faster better partnership": a collaborative policy innovation example and policy programme initiated by the Dutch Ministry of Health together with sectoral associations of hospitals, medical specialists and nurses – the Dutch Association of Hospitals; the Federation of Medical Specialists; and the General Association of Nurses – in 2003 that targeted health innovation in hospital care. Hjelmar (2021) describes such central government policies and programmes launched for public innovation purposes, and their rapid increase, as an upcoming institutionalization trend. The partnership promoted diffusion between hospitals within exclusive "regimes" (networks of hospitals) and beyond these regimes (sector-wide). Ultimately, 288 collaborative innovation projects took place within 24 partnering hospitals (about one third of the sector) by 2008. After the partnership's official ending, associations coordinated by the Dutch Association of Hospitals launched a sector-wide health safety management system as a spin-off project. By 2012, this system was implemented in all hospitals in the Netherlands. Although causality is inherently difficult to attribute, evaluators ascribe a major drop in preventable death rates in hospitals of 53 percent to this system (between 2008-2012) (Langelaan et al., 2012). Beyond 2013 (until at least 2020), sectoral associations kept organizing diffusion events (e.g. seminars and masterclasses) on the partnership's themes.

Data collection and analysis

Despite of its inherent limitations, a qualitative case study design is used to allow for the rich and in-depth analysis needed to fulfil the research aim (Yin, 2018). The selected case is relevant for various reasons. First, it combines two dimensions of policy innovation: it is a firstly applied policy strategy by the Dutch Ministry of Health and it also targets (health)

innovation as an outcome. Second, it promotes diffusion both within and beyond regimes, allowing for a meaningful distinction useful for theory advancement. Third, the case is positioned in a competitive setting where hospitals compete over clients and funds. Hospital care in the Netherlands is often described as a system of "regulated" or "managed" competition (Van Kleef, 2012), since hospitals are largely (though not exclusively) funded by private health insurers through competitive contracts. Health insurers and hospitals negotiate over tariffs for service delivery, partly depending on hospitals' benchmarked performances, where demonstrably higher quality standards or better health outcomes (e.g. lower mortality rates or shorter waiting times) lead to better rates. Hospitals' health outcomes are also openly published to serve as patients' choice input (Boot, 2013). This system was adopted with the introduction of the so-called Health Insurance Act in 2006, although Dutch hospitals already started implementing its principles as early as from the 1990s onwards (Van Kleef, 2012). The studied partnership was launched specifically in light of upcoming changes towards implementing market competition. Fourth and lastly, the studied case allows for a scope over a long period. Whereas current policy research tends to focus on ongoing or recently ended empirical examples, data was collected between 2017-2019, allowing to look back over a period of fifteen years. This is relevant since innovation is typically an outcome of long-term investments resulting in creative ideas that turn out useful later or in different contexts (Sørensen and Torfing, 2017: 829).

Data collection consisted of document analysis and interviews. The analysed documents (19) include parliamentary papers, such as policy briefs, reports and parliamentary letters from public officials about the partnership. On the basis of these documents, a detailed reconstruction was made of the partnership's objectives, key activities and events and involved stakeholders. Subsequently, qualitative semi-structured interviews with 18 relevant stakeholders were conducted, using a topic list based on this reconstruction. Topics included the partnership's background (arena) where diffusion took place, stakeholders' key activities and events in terms of diffusion processes, and lastly, drivers and incentives for diffusion, such as actors' motivation to share innovations. Respondents are high-position public officials (minister, state secretary and/or senior civil servants) from the Dutch Ministry of Health; representatives from sectoral associations (of hospitals, medical specialists and nurses) and officials from public agencies such as the Inspectorate of Health and the Dutch Health Authority; hospital board members; and experts (consultants that facilitated diffusion processes). Table 2 provides an overview. Respondent selection was based on the reconstruction derived from the document analysis, and in addition, snowball sampling (by indication of interviewees), until a point of data saturation was reached (i.e. no new information nor new stakeholders surfaced in the interviews).

Table 2: Respondent overview

Respondent category	**N**	**Ascribed codes**
High position public official (minister, state secretary) or senior civil servant, Dutch Ministry of Health	6	M1 – M6
Representative from sectoral associations or officials from public agencies	6	R1 – R6
Hospital board member	4	H1 – H4
Involved expert	2	E1; E2

Transcribed interview data was analysed by means of NVivo (qualitative data analysis software), using a two-step coding procedure. First, open codes were assigned to text fragments, staying close to respondents' own words. Secondly, initial codes were compared, ordered and clustered into thematic codes connected to categories on theoretical grounds

following a procedure described by Robson and McCartan (2016). The two dimensions of diffusion studied here (within and beyond regimes) functioned as core categories and served as an anchor point for the analysis, together with the three subcategories identified in the literature (arena, exchange process and drivers and incentives). Table 3 contains coding examples.

Table 3: Interview data coding examples

Core category	Subcategory	Thematic code	Initial code	Example
Diffusion within regimes	Arena	Competitiveness between hospitals	Hospitals were not open about their practices	'Hospitals did not want to give others a look behind their scenes.' (R3)
	Process	Mutual exchange	Interaction between colleagues of different hospitals	'Colleagues interacted with others that worked on the same issues elsewhere.' (H4)
	Drivers and incentives	Organizational gain	Participation because of paid support	'A lot of hospitals were interested in participating because of the paid support.' (R1)
Diffusion beyond regimes	Arena	Competitiveness between hospitals	Benchmarks caused hospitals to want to outperform others	'Those benchmarks, limited as they were, caused everyone to want to score' (M4)
	Process	Exchange of innovative practices	Experts asked hospitals for their innovative practices	'I would start: there are so many things going on here that you must be proud of, give us three examples.' (E2)
	Drivers and incentives	Problem-drivenness	Hospitals' ambition to contribute to solutions for pressing problems	'There was a very high ambition to reduce the preventable death rate; everyone wanted to achieve that.' (H1).

Findings

The following section elaborates on how diffusion took place, firstly within the boundaries of regimes and subsequently, beyond the boundaries of regimes.

Diffusion within regimes

How diffusion took place within the boundaries of regimes, is described in terms of the arena, the process and drivers and incentives.

Arena

The arena in which diffusion within regimes took place, was formed by a competitive environment where inter-organisational learning was absent: "Every hospital was involved with their own agenda: you would learn from abroad, but not from other hospitals within the country, there is too much competition for that." (H3). Still, the ministry considered collaboration between hospitals an important means to achieve health innovation. However, hospitals were not openly sharing practices: "Hospitals did not want to give others a look behind their scenes." (R3). Even though hospitals tended to operate independently – "It was everyone for themselves, everyone was reinventing the wheel."(R3) – the ministry believed in and invested in a collaborative approach. Yet, there were challenges, such as hospitals' unwillingness to share success and failure factors:

> It was not only about sharing success factors. Hospitals were also reserved in sharing failure causes. They found it very difficult to share their failures with a competitor. (R4).

The ministry nevertheless formed a consortium with three sectoral associations (of hospitals, medical specialists and nurses) to generate more commitment for policy innovation in the field: "A policy gets more meaning and weight, and gains commitment, when representative associations are involved as partners." (R5). The consortium formed exclusive regimes for diffusion: 24 hospitals were selected to collaborate within three exclusive groups of eight. To achieve this, the ministry invited all hospitals in the Netherlands to submit innovation proposals. The selective and exclusive design of the regimes was appealing for hospitals: "Having a selection procedure is very stimulating as such." (R1). Through an elaborate procedure, the consortium selected so-called 'best performers'. This contributed to hospitals' willingness to engage in diffusion:

> It enhanced the status of a hospital to be able to say that they participated in the partnership. They were thereby considered one of the leaders in the field. That promoted the hospital's name. Hospitals thereby demonstrated that they were doing promising things. (R5).

Still, the consortium requested something difficult from hospitals: to diffuse knowledge with competitors. In the beginning, this resulted in some constraints. Hospitals proved unwilling to exchange knowledge in one-on-one interorganisational settings:

> Initially, we thought about forming duos of hospitals that would innovate one-on-one together. It did not work unfortunately, because hospitals did not want to share their ideas with other hospitals in the region because of competition. We then tried to partner up hospitals from different regions, but that did not work either. (M3).

A solution was found in the enlargement of the regimes: "Finally, we compelled the hospitals to step into working groups with multiple others." (M5). Contrary to what may be expected, hospitals turned out more willing to participate in larger groups with (eight) competitors than in duos for diffusion.

Process

The exchange process was facilitated by external experts: hired consultants that acted as project managers for each hospital and that facilitated joint diffusion sessions: "Since innovation takes place beyond organizational borders, the idea was to get people from the work floor to talk to staff from elsewhere." (R6). So-called "breakthrough sessions" (R1) – inspired by the Boston Healthcare Institute's methodology for innovation – were organized where hospitals mutually exchanged innovative practices on two partnership themes: patient safety and logistics: "Colleagues interacted with others that worked on the same issues elsewhere." (H4). Projects on logistics dealt with the reduction of waiting times, the productivity of operating rooms and other process optimizations: "It was all about organizing care smarter, more effective and more cost-efficient."(H1). Projects on patient safety concentrated around post-operative wound infections, medication safety and bedsores (decubitus). A lot of the projects evolved around process optimization, protocolization and standardization – "Applying simple rules." (H2):

> There was a lot of knowledge available, but practical application was poor. For example, keeping the door of the operating room closed during surgery, reduces infections with ninety percent. There were technical solutions, such as electronic counters that measure how frequently doors were opened. The Faster better

> partnership was full of such solutions and how to operationalize them in practice. (H1).

Inspired by safety measures from 'crew resource management' in aviation – "Protocols help, a very simple checklist can make a difference." (H4) – hospitals exchanged practices to reduce medical errors by stimulating co-responsibility for safety:

> In aviation, the captain – the highest rank – calls the shots, but safety can only be assured if people dare to speak up to such authority. The same logic applies in the operating room. Surgeries often go wrong because surgeons make wrong decisions, and nurses would not dare to speak up about their doubts. (M5).

The idea is that everyone can contribute to safety: "What we learned is that wherever you stand in hierarchy, every single person has to agree." (R3). The regimes promoted diffusion on the basis of common interests and relevant know-how. Therefore, hospitals with corresponding innovation aims and ambitions were grouped together: "The exchange between hospitals revealed very recognizable and real problems in the sector and helped to make things more tangible for nurses and other hospital staff."(M5). Diffusion with other hospitals allowed for new and enriched exchanges to originate. This promoted learning effects: "There was a willingness to make changes, because they recognized the improvement potential for their work." (R4). Peer-learning beyond organizations – exchange between medical staff of different hospitals – turned out inspirational and sparked innovation.

Drivers and incentives

Different drivers and incentives stimulated hospitals' engagement in diffusion along with competitors, for which challenges particularly manifested at a strategic level:

> Professionals on the work floor are not the problem. The bottleneck is situated with the hospital boards, who are strategically fighting for their position in the region. (M3).

Also, the many challenges that hospitals are often faced with, may limit their innovative capacity: "Hospitals are confronted with a lot of issues, a health innovation trajectory on top can easily be too much to ask." (R4). Yet, the consortium managed to find many hospitals willing to participate: "Hospitals were very willing to learn from each other and to share information." (R1). A hospital board member underlines the importance of unconditional support here:

> As a hospital, it is pretty difficult to invest in innovation. You have to explicate outcomes beforehand to estimate whether an investment is worthwhile. Yet, with innovation you have to wait and see. The partnership made this much easier, because the offered support in-kind was basically free of charge, without any conditions attached to it. (H4).

Hospital boards' belief in the partnership made a difference: "The commitment of hospital boards was a clear success factor." (M3) A respondent explains:

> Innovation stands or falls with what local leaders, boards and directors do with it. If the board does not actively support change and does not have a vision about it, then projects remain isolated and a widely felt change remains absent. (R1).

For the boards, the offered paid support was crucial: "Hospitals would have been less willing, or able, to innovate without the support, even though they had to do the innovation themselves." (R5). Hospitals did not receive direct funding though: "The field did not even

receive a quarter, neither did any of the hospitals or associations." (R5). Many hospitals were willing to engage in diffusion with other hospitals, in exchange for support to work on their own innovation aims: "A lot of hospitals were interested in participating because of the paid support." (R1). A Hospital board member adds: "It made it interesting that the support was costless, that was one of the reasons to participate." (H4). The support with no strings attached made it worthwhile: "There were no concrete agreements on pay-offs, financial targets or savings that had to be met." (R5). Ultimately, hospitals were seeking for ways to innovate their own practices, a board member explains:

> I really wanted to improve things. If you walk around in a hospital, you get the feeling that everything could be optimized. (H4).

In this respect, the participating hospitals were output-driven, as opposed to being problem-driven: "That group of participating hospitals was very good in getting the benefits for their own organization, they were kind of willing to share knowledge, but it was definitely not their primary goal." (H1). The voluntary participation was also considered appealing: "If you did not want to join, you did not have to; it was completely voluntary." (H4). The innovation proposals provided hospitals with freedom to develop their own goals:

> It all started with the needs in the field. It was all about providing space to hospitals to come up with innovation aims themselves. (M1).

In sum, hospitals proved willing to mutually exchange innovative practices within exclusive regimes along with competitors because of the access to other hospitals' ideas and its value for their own innovation objectives. Hospitals were even more willing to step into bigger networks (of eight hospitals) than smaller ones (duos), because of the larger learning potential. The opportunity to work on their own innovation aims in combination with unconditional paid support enabled hospitals to optimize their organizational outputs, and hence were crucial motivators for engagement, particularly at a (strategic) board level. The support was considered a bigger advantage than the disadvantage of sharing knowledge with competitors. Hospitals also participated because of reputational mechanisms: the selective and exclusive design of the regimes and application procedures were considered appealing.

Diffusion beyond regimes

How diffusion took place beyond the boundaries of regimes, is again described in terms of the arena, the process and drivers and incentives.

Arena

With the entire Dutch hospital care sector as an arena, the partnership also stimulated diffusion beyond regimes. Parallelly, the ministry implemented a sectoral benchmarking system: "We demanded tangible results from hospitals." (M4). This affirmed competition in the sector: "Those benchmarks, limited as they were, caused everyone to want to score" (M4). Benchmark results were published openly and were picked up by media, enhancing this effect: "There was a top 10 and a bottom 10 performers." (M5). Still, the consortium believed in the necessity of diffusion: "In some hospitals, neurosurgeons still used fishing band, with a mortality rate of fifty percent as a consequence." (M2). The value of innovation was also recognized by hospitals themselves:

> Many medical specialists and doctors act their entire life on the basis of what they learn in the first ten years. This is understandable and also has value. It makes doctors conservative: they operate on the basis of what evidence suggests is right. However, this inhibits innovation. There is a tension between evidence-based acting and

> innovation-based acting, where you follow a hunch to what might be a better product. (H1).

However, a culture of collective learning was missing: "We were searching for a process optimally designed for collective knowledge exchange, which was absent in the sector." (E2). To achieve sector-wide diffusion despite existing rivalries between hospitals, the consortium applied different diffusion strategies that, to start with, raised awareness: "They had a big impact on the realization of the importance of quality and safety in the field." (M4). This helped overcome medical staff's conservatism:

> The gain of the partnership is that it helped getting past old-fashioned customs, such as doctors that were still using methods that are a hundred years old. If there is a qualitatively better method available, I believe you should be obliged to use it. (R3).

The applied diffusion strategies aimed for a policy reach beyond the exclusive regimes: "I believe that, as a government, you have to include all hospitals; you have to develop programs that involve everyone." (R6). Building on the regime's outputs was key in diffusion beyond them: "The idea was: if we get the frontrunners, the innovative hospitals, to move, the rest will follow." (M3) and "The assumption was that if you invest enough in the forefront, knowledge transfer will mobilize the total group of hospitals." (H1). Stimulating diffusion within the regimes, was hence considered an investment into diffusion beyond regimes at a later point in time.

Process

Different exchange processes promoted diffusion beyond regimes. First, the ministry hired consultants that collected innovative, leading-in-the-field, practices of all the hospitals in the Netherlands (about 90 in total): "I would start: there are so many things going on here that you must be proud of, give us three examples." (E2). Around 250 innovative practices were collected and distributed, as the consultants published them openly on a dedicated website:

> The partnership basically traded in second hand knowledge. First-hand knowledge was derived from hospitals and provided to others. As a policymaker, you do not have to possess that knowledge. You only have to facilitate it becoming available to all. (E2).

Even though innovations expire quickly, this still contributed to a learning culture: "A good practice has a lifespan of maximally two years, but the movement itself, of creating a learning culture, was much more essential." (E2). Second, sector-wide diffusion events were organized, including for non-participating hospitals: "Everyone was invited for these meetings." (M3). The aim of these seminars and other gatherings was to spread innovative practices and to inspire other hospitals to adopt them: "Hospitals demonstrated projects to each other, with eight to twelve teams at a time, and there were plenary sessions, all departing from the idea to learn from each other." (H4). The presence of charismatic CEOs from leading Dutch companies and the minister of health – "Men of name and fame" (M2) – at these diffusion events enhanced the willingness of hospitals to attend these meetings:

> Medical specialists and hospital boards are difficult to reach. The presence of the CEO of for example Shell or TNT was a great success in getting them to attend events, as board members wanted to talk to them or to the minister. (R4).

This enhanced their reputational status: "It gave the hospital boards the feeling that they were on par with these big CEOs." (M1). In earlier phases (invention and implementation), four CEOs formulated strategic advice to inspire hospital boards as so-called 'ambassadors':

> What struck me the most is their comment on the absence of safety protocols in our hospital. Operating rooms have many electronic devices and wires, while everyone walks criss-cross through the room. This would never happen at Shell. There, employees are called to the director's office if their computer cable hangs loose above the ground. (H4).

The ambassadors' expertise translated into relevant lessons for hospitals that were diffused later on: "A lot of the necessary solutions in healthcare, for example for waiting lists, had to do with a good operational approach, logistics and other process optimizations that commercial enterprises easily deal with." (M4). With the strategic advice as input, hospitals co-developed innovations within the regimes, that were later diffused sector-wide – "Just common sense, if you think about it." (E1): "All it took to optimize patient discharge processes, was better communication: a simple card above the bed with the expected resignation date helped the nursing staff to take care of everything that still needed to be done and reminded family members to arrange a bed at home in time." (M2). A specific well-attended format for diffusion events, was a so-called 'breakfast with the minister': "The minister sat down at every table to talk to hospital staff." (R3). Access to the minister was considered appealing – "The minister was very approachable in those meetings, the medical specialists liked that; the ambiance was very good." (R2) – and the field was enthusiastic about it: "Medical specialists and board members enjoyed attending those meetings a lot, we had no problem getting them there." (M4). Attendants valued the meetings: "Every event was inspirational." (M6). They even considered them 'fun':

> The fun factor was very important. The partnership needed to be fun, because better care lies in the passion and willingness of people to work hard for it. (M1).

Besides generating enthusiasm – "At these meetings, the field got enthusiastic about innovation." (R5) – the exchange was considered useful: "It is extremely useful to look at each other, to learn from each other and to show how things can also work." (R1). Hence, hospitals proved willing to learn from each other:

> You noticed the curiosity of hospitals growing. They started to consult the participating hospitals on how they achieved certain results, what the success factors were and what worked and did not work. (M3).

Exchange processes brought forward a spin-off project carried by the Dutch Association of Hospitals: the development of a sector-wide health safety management system. By 2012, this system was operational in all hospitals in the Netherlands: "That people started working with a safety management system, really had an impact – to me, that is the biggest success of the entire partnership." (E1). More than a decade after the partnership's official ending, the involved associations kept organizing diffusion events such as symposia and masterclasses on three of the partnership's themes (until at least 2020) – i.e. medication safety, infection prevention and the application of ICT: "Some of the networks formed then, still exist today and still come together, sometimes in a slimmed down form, but the exchange still takes place until this day." (R5).

Drivers and incentives

Drivers and incentives for sector-wide diffusion raised awareness in the sector: "We were creating a sense of urgency." (M3). An alarming international research report – the American Institute of Medicine's report 'To err is human' (2000) – generated a lot of attention. Subsequent research subsidized by the ministry, revealed dramatically high preventable death rates in Dutch hospitals: "When the number of preventable deaths was

announced, it was explosive stuff; something had to be done about it, without a doubt." (R3). Media – "It was in every newspaper." (R6) – urged hospitals to take responsibility:

> If you appear on a television program to talk about why there are 3000 to 4000 preventable deaths annually in hospitals, then you really have something to explain. Every medical specialist and every nurse that is watching, realizes that. (R6).

Hospitals wanted to contribute to solutions: "There was a very high ambition to reduce the preventable death rate; everyone wanted to achieve that." (H1). Legitimacy pressures hence enhanced their willingness to diffuse knowledge openly and actively with competitors: "It is not enough to get involved, the field should feel a sense of ownership for important health issues." (E2). Hospitals could not withdraw from sector-wide diffusion without a risk for legitimacy losses, against these acknowledged pressing problems. In addition, elaborate marketing and communication strategies enhanced the positive image of the partnership:

> Communication was a crucial instrument in creating a coherent set of activities and resources dedicated to health innovation, on the basis of which consensus between the different stakeholders occurred. There was a lot of positive energy. (M6).

The applied communication strategy contributed to hospitals willingness to attend events: "As hospitals see the discourse evolving into a positive direction, they get more enthusiastic about joining, it is all a matter of communication." (M6) and "The partnership was very much about celebrating shared successes and positive health outcomes." (R2). Reputation played an important role here again:

> On these organized events, successes were highlighted. People wanted to appear on stage because it did well to their image. There was huge spin-off from having good PR on the basis of your results. (R4).

In sum, hospitals' engagement in sector-wide diffusion (beyond regimes) was pushed by a strong sense of urgency about pressing sectoral problems – e.g. dramatically high hospital preventable death rates. Raised awareness and consequent legitimacy pressures sparked by the partnership's consortium persuaded competing hospitals into sector-wide diffusion, overthrowing competitive mechanisms, such as a simultaneously implemented sectoral benchmarking system. Media reporting, elaborate marketing and communication strategies and the presence of prominent high profile figures at diffusion events, such as the minister of health and CEOs of leading companies, enhanced this effect.

Conclusion and Discussion

This study found that competing health actors are willing to engage in both types of diffusion studied here: within and beyond regimes. Within regimes, hospitals proved willing to mutually exchange innovative practices in exclusive networks with competitors because they recognized an opportunity to work on their own innovation aims and access to other hospitals' ideas was considered beneficial to that objective. Rather than an orientation on public value or complex societal problems (Ansell and Torfing, 2014; Agranoff, 2014), hospitals were output-driven: targeted at improving their products or services (see: Hartley, 2005; Borins, 2000). The possibility to work on their own innovation aims and paid support enabled hospitals to optimize their organizational outputs, and hence were crucial motivators for engagement, particularly at a (strategic) board level. Hospitals considered funding a bigger advantage than the disadvantage of sharing knowledge with competitors. Contrary to expectations in the literature – for example Hartley (2014), who points out that competing

actors may prefer exclusive collaborative arrangements with a limited number of participants – hospitals were more willing to step into bigger networks (eight hospitals) than smaller ones (duos). An explanation is that larger networks have a bigger learning potential. This seemingly outweighed the price of sharing innovations with (even more) competitors. Hospitals also participated because of reputational mechanisms: the design of the regimes and application procedure made their involvement selective and exclusive. This was appealing because it enabled hospitals to position themselves as highly innovative, leading-in-the-field organizations and as 'best performers', fitting with competing actors' strive for a competitive advantage, as described by Popa et al. (2011).

Actors' engagement in sector-wide diffusion (beyond regimes) was pushed by a strong sense of urgency about pressing problems in the sector – e.g. dramatically high hospital preventable death rates – created by the partnership's consortium. Raised awareness and consequent legitimacy pressures persuaded competing hospitals into sector-wide diffusion, overthrowing competitive mechanisms, such as a simultaneously implemented sectoral benchmarking system. Media reporting enhanced this effect, confirming Ansell and Torfing (2014) who highlight that negative political and media discourses install a fear for legitimacy losses when organizations withdraw from diffusion while being faced with emerging societal problems. That competitors were pushed by legitimacy pressures, opposes that financial and performance incentives are required for competitive actors to participate in innovative processes (see: Damanpour and Schneider, 2009; Verhoest, Verschuere, and Bouckaert, 2007). Engagement in sector-wide diffusion at the expense of hospitals' competitive (monetary or organizational) advantage, was also carried by elaborate marketing and communication strategies and the presence of prominent high profile figures at diffusion events, such as the minister of health and CEOs of leading companies. Ultimately, this illustrates hospitals' search for reputational legitimacy, as this allowed them to position themselves. Based on these findings, this study makes two relevant contributions to the literature: theoretically and methodologically.

First, this study brought forward a meaningful distinction between two types of diffusion, useful for theory advancement. Both are crucial for collaborative policy innovation and serve different functions: diffusion within regimes allows for learning through mutual exchange (as highlighted by Ansell and Torfing, 2014; Hartley, 2014), whereas diffusion beyond regimes enables spreading innovations (as pointed out by Lee and Restrepo, 2018; Zelenika and Pearce, 2014). Although the literature mentions both functions, it does not distinguish between exchange processes, drivers and incentives. This study found distinctions for actors in a competitive though public environment: organizational gain proved an important motivator for diffusion within regimes, while legitimacy pressures turned out important for diffusion beyond regimes. Reputational gain was important for both types of diffusion. While legitimacy pressures correspond with collaboration, organizational and reputational gain rather fit with competition. Yet, the collaborative policy innovation literature pays only little attention to competitive drivers following from New Public Management due to its dominant focus on New Public Governance principles. The literature stresses the importance of collectiveness (see: Emerson and Nabatchi, 2015; Ansell and Gash, 2008), while individual organizational drivers (e.g. organizational and reputational gain) rather proved crucial for diffusion in this study. Consequently, potential drivers that (still) effectuate result may be overlooked, whereas they offer potential to motivate actors for collaborative policy innovation, particularly in a post-NPM period. Similarly, the literature emphasizes the importance of an environment (arena) fit for collaboration while this study has shown that collaborative policy innovation may also be achieved in a competitive environment. Although

the literature often presents collaboration as an alternative to competition (see for example: Bryson, Ackermann, and Eden, 2016), thereby inevitably dismissing possible complementary aspects, this article has proven that the two perspectives – collaboration and competition – can strengthen each other when conditions are optimally aligned.

Second, the applied methodology allowed for a focus over a long period (over fifteen years), useful to look beyond the studied policy's official ending. With this extended scope, important innovative spin-off processes could be incorporated in the study, such as the sector-wide implementation of a health safety management system. It thereby confirms Sørensen and Torfing's (2017) notion that innovation is typically an outcome of long-term investment, useful to study over a longer period. This yielded insights in how the two types of diffusion (within and beyond regimes) interrelate. In the studied case, diffusion beyond regimes followed after diffusion within regimes: competing actors first invested in their own innovation aims in select groups, only to share insights beyond these regimes afterwards, due to legitimacy pressures. Whether competing hospitals would have been willing to directly engage in sector-wide diffusion, is questionable in light of their initial search for organizational and reputational gain. This advocates a twostep policy innovation approach, where incentives are first directed at exclusive and selective regimes, only to spread and scale up at a later point in time, with different sets of drivers and incentives. Despite of their improvement potential for health outcomes (e.g. hospital preventable death rates dropped), large-scale diffusion processes remain questionable altogether, since they may ultimately restrain innovation. Since innovation is to be distinguished from mere improvement (Sørensen and Torfing, 2017; Osborne and Brown, 2011), it may be inherently inconsistent to target innovation throughout entire sectors. Large scaling up practices might be counterproductive, when they keep actors occupied with implementing already existing practices, instead of developing new innovations.

Practical implications

For diffusion to take place in public contexts shaped by market competition, policy makers are tasked with the challenge to persuade competing actors into mutually exchanging innovative practices, despite their strive for a competitive advantage (see: Popa et al., 2011). While policymakers tend to focus on diffusion within regimes, diffusion beyond regimes offers potential to scale up effective innovative practices and to improve sectoral performances. It therefore allows for a policy reach beyond the selective and exclusive regimes. Findings here show that competing actors definitely recognize the value and potential of both types of diffusion (within and beyond regimes). However, specific drivers and incentives are needed for either type. Besides a vulnerability for legitimacy-based drivers and an orientation on societal problems fitting with New Public Governance, competing actors also displayed a sensitivity for drivers and incentives originating from New Public Management: organizational and reputational gains. An important lesson therefore is that policymakers should not overlook the potential of competitive mechanisms, despite the current reorientation towards collaborative policy approaches but rather seek for a productive incorporation of competition. For example, although the collaborative governance literature emphasizes the value of cross-sectoral and cross-boundary exchange for diffusion (see for example Lasker, Weiss and Miller, 2001), exchange within sectoral boundaries (between hospitals) proved its particular relevance in the studied case, as common interests, corresponding innovation aims and the recognizability of each other's issues promoted learning effects. This article has shown how relevant policy innovation results are achieved when collaborative and competitive approaches are combined. It thereby shows how competition may strengthen, rather than weaken, collaborative efforts for policy innovation.

This is an important step forward, not only in theory advancement, but also in practical implementation towards more productive collaborative network strategies to achieve policy innovation.

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References:

Agranoff, R. 2014. "Reconstructing Bureaucracy For Service: Innovation in the Governance Era." Pp. 41-69 in C. Ansell and J. Torfing (eds). *Public Innovation through Collaboration and Design*. New York, NY: Routledge. doi:10.4324/9780203795958.

Ansell, C. 2016. "Collaborative Governance as Creative Problem-Solving." Pp. 35-53 in J. Torfing and P. Triantafillou (eds). *Enhancing Public Innovation by Transforming Public Governance*. Cambridge, United Kingdom: Cambridge University Press. doi:10.1017/CBO9781316105337.002.

Ansell, C. and A. Gash. 2008. Collaborative Governance in Theory and Practice. *Journal of Public Administration Research and Theory*, 18(4): 543-571. doi:10.1093/jopart/mum032.

Ansell, C. and J. Torfing. 2014. "Collaboration and Design: New Tools for Public Innovation." Pp. 1-19 in C. Ansell and J. Torfing (eds). *Public Innovation through Collaboration and Design*. New York, NY: Routledge. doi:10.4324/9780203795958.

Bekkers, V., J. Edelenbos and B. Steijn. 2011. "Linking Innovation to the Public Sector: Concepts, Contexts and Challenges." Pp. 3-32 in V. Bekkers, J. Edelenbos and B. Steijn (eds). *Innovation in the Public Sector: Linking Capacity and Leadership*. Basingstoke, United Kingdom: Palgrave MacMillan. doi:10.1057/9780230307520.

Bennington, J. 2011. "From Private Choice to Public Value?". Pp 31-51 in J. Bennington and M.H. Moore (eds). *Public Value: Theory and Practice*. Houndmills, United Kingdom: Macmillan Education. doi:10.1007/978-0-230-36431-8.

Beyerlein, M.M., S.T. Beyerlein & F.A. Kennedy. 2006. *Innovation Through Collaboration*. Oxford, United Kingdom: Elsevier.

Boot, J.M. 2013. *De Nederlandse gezondheidszorg: gezondheid en eigen initiatief voorzieningen, overheid en beleid*. Houten, The Netherlands: Bohn, Stafleu and Van Loghum.

Borins, S. 2000. What Border? Public Management Innovation in the United States and Canada. *Journal of Policy Analysis and Management*, 19(1): 46-74. doi:10.1002/(SICI)1520-6688(200024)19:1<46::AID-PAM4>3.0.CO;2-Z.

Bruns, H. C. 2013. Working Alone Together: Coordination in Collaboration Across Domains of Expertise. *Academy of Management Journal*, 56(1): 62-83. doi:10.5465/amj.2010.0756.

Bryson, J. M., F. Ackermann, and C. Eden. 2016. Discovering Collaborative Advantage: The Contributions of Goal Categories and Visual Strategy Mapping. *Public Administration* Review, 76(6): 912-925. doi:10.1111/puar.12608.

Bryson, J., B. Crosby, and L. Bloomberg. 2014. Public Value Governance: Moving Beyond Traditional Pubic Administration and the New Public Management. *Public Administration Review*, 74(4): 445-456. doi:10.1111/puar.12238.

Carstensen, H.V. and C. Bason. 2012. Powering Collaborative Policy Innovation: Can Innovation Labs Help? *The Innovation Journal: The Public Sector Innovation Journal,* 17(1): 2-26.

Crosby, B.C., P. 't Hart and J. Torfing. 2017. Public Value Creation Through Collaborative Innovation. *Public Management Review*, 19(5): 655-669. doi:10.1080/14719037.2016.1192165.

Desmarchelier, B., F. Djellal and F. Gallouj. 2020. Towards a Servitization of Innovation Networks: A Mapping. *Public Management Review*, 22(9): 1368-1397. doi:10.1080/14719037.2019.1637012.

Damanpour, F. and M. Schneider. 2009. Characteristics of Innovation and Innovation Adoption in Public Organizations: Assessing the Role of Managers. *Journal of Public Administration Research and Theory*, 19(3): 495-522. doi:10.1093/jopart/mun021.

Doberstein, C. 2015. Designing Collaborative Governance Decision-Making in Search of a 'Collaborative Advantage'. *Public Management Review*, 18(6): 819-841. doi:10.1080/14719037.2015.1045019.

Dolowitz, D. and D. Marsh. 1996. Who Learns What from Whom: A Review of the Policy Transfer Literature. *Political Studies*, 21: 343-351. doi:10.1111/j.1467-9248.1996.tb00334.x.

Dolowitz, D. and D. Marsh. 2000. Learning from Abroad: The Role of Policy Transfer in Contemporary Policy-Making. *Governance*, 13(1): 5. doi:10.1111/0952-1895.00121.

Emerson, K. & T. Nabatchi. 2015. *Collaborative Governance Regimes.* Washington, DC: Georgetown University Press.

Geels, F.W., B. Elzen, and K. Green. 2004. "General Introduction: System Innovation and Transitions to Sustainability." In B. Elzen, F. W. Geels, and K. Green (eds). *System Innovation and the Transition to Sustainability: Theory, Evidence and Policy*. Cheltenham, United Kingdom: Edward Elgar Publishing.

Glor, E.D. 2021. Defining, Distinguishing and Studying Public Sector Innovation and

Change, *The Innovation Journal: The Public Sector Innovation Journal*, 26(3), article 4.

Gray, B., and J. Purdy. 2013. "Conflict in Cross-Sector Partnerships." Pp. 205-225 in M.M. Seitanidi and A. Crane (eds). *Social Partnerships and Responsible Business*. London, United Kingdom: Routledge. doi:10.4324/9781315867175.

Hartley, J. 2005. Innovation in Governance and Public Service: Past and Present. *Public Money and Management,* 25(1): 27-34. doi:10.1111/j.1467-9302.2005.00447.x.

Hartley, J. 2014. "Public and Private Features of Innovation." Pp. 44-59 in S. P. Osborne and L. Brown (eds). *Handbook of Innovation in Public Services*. Cheltenham, United Kingdom/Northampton, MA, USA: Edward Elgar Publishing. doi:10.4337/9781849809740.00011.

Hartley, J. 2012. "Public Value through Innovation and Improvement." Pp. 171-184 in J. Bennington and M.H. Moore (eds). *Public Value: Theory and Practice*. Houndmills, United Kingdom: Macmillan Education. doi:10.1007/978-0-230-36431-8.

Hartley, J., E. Sørensen and J. Torfing. 2013. Collaborative Innovation: A Viable Alternative to Market Competition and Organizational Entrepreneurship. *Public Administration Review,* 73(6): 821-830. doi:10.1111/puar.12136.

Hjelmar, U. 2021. The institutionalization of public sector innovation. *Public Management Review*, 23(1): 53-69. doi:10.1080/14719037.2019.1665702.

Huxham, C. & S. Vangen. 2005. *Managing to Collaborate: The Theory and Practice of Collaborative Advantages*. London, United Kingdom: Routledge.

Inkpen, A.C., and M. Crossan. 1995. Believing is Seeing: Joint Ventures and Organization Learning. *Journal of Management Studies*, 32(5): 595-618. doi:10.1111/j.1467-6486.1995.tb00790.x.

Jordan, A., and D. Huitema. 2014. Innovations in Climate Policy: The Politics of Invention, Diffusion, and Evaluation. *Environmental Politics*, 23: 715–734. doi:10.1080/09644016.2014.923614.

Kattel, R., V. Lember and P. Tõnurist. 2020. Collaborative Innovation and Human-Machine Networks. *Public Management* Review, 22(11): 1652-1673. doi:10.1080/14719037.2019.1645873.

Klijn, E.-H., J. Edelenbos and B. Steijn. 2010. Trust in Governance Networks: Its Impact and Outcomes. *Administration and Society*, 42(2): 193-221. doi:10.1177/0095399710362716.

Langelaan, M., M.C. De Bruijne, R.J. Baines, M.A. Broekens, K. Hammink, J. Schilp, L. Verweij, H. Asscheman & C. Wagner. 2012. *Monitor Zorggerelateerde Schade 2011/2012: Dossieronderzoek in Nederlandse Ziekenhuizen*. Utrecht, The Netherlands: Nivel.

Lasker, R.D., E.S. Weiss, and R. Miller. 2001. Partnership Synergy: A Practical Framework for Studying and Strengthening the Collaborative Advantage. *Milbank Quarterly*, 79(2): 179-205. doi:10.1111/1468-0009.00203.

Lee, E.W.Y. and J.M. Restrepo. 2018. "Institutional Embeddedness and the Scaling-Up of Collaboration and Social Innovation: The Case of a Hong Kong-Based International NGO." Pp. 177-192 in C. Ansell and J. Torfing (eds). *How does collaborative governance scale?*. Bristol, United Kingdom: Bristol University Press. doi:10.2307/j.ctt1zqrn77.12.

Minkman, E., M.W. Van Buuren, and V.J.J.M. Bekkers. 2018. Policy Transfer Routes: An Evidence-based Conceptual Model to Explain Policy Adoption. *Policy Studies,* 39(2): 222-250. doi:10.1080/01442872.2018.1451503.

Moore, M.H. 2013. *Recognizing Public Value*. Cambridge, MA: Harvard University Press. http://www.jstor.org/stable/j.ctt2jbwqm.

Osborne, D. & T. Gaebler. 1993. *Reinventing Government: How the Entrepreneurial Spirit is Transforming the Public Sector*. New York, NY: Plume.

Osborne, S.P. 2006. The New Public Governance?. *Public Management Review* 8(3), 377-387. doi:10.1080/14719030600853022.

Osborne, S.P. 2010. The new public governance?. London, United Kingdom: Routledge.

Osborne, S.P. and L. Brown. 2011. Innovation, Public Policy and Public Services Delivery in the UK: The Word That Would Be King?. *Public Administration*, 89(4): 1335-1350. doi:10.1111/j.1467-9299.2011.01932.x.

Pedanik, R., M. Uibu, and K. Koppel. 2022. Pragmatism-based Co-inquiry in Public Service Innovation. *The Innovation Journal: The Public Sector Innovation Journal,* 27(1), article 1.

Pollitt, C. & G. Bouckaert. 2011. *Public Management Reform: A Comparative Analysis - New Public Management, Governance, and the Neo-Weberian State*. Oxford, United Kingdom: Oxford University Press.

Popa, I., C. Dobrin, D. Popescu and M. Draghici. 2011. Competitive Advantage in the Public Sector. *Theoretical and Empirical Researches in Urban Management*, 6(4): 60-66. https://www.jstor.org/stable/24873302.

Provan, K.G., and P.N. Kenis. 2008. Modes of Network Governance: Structure, Management and Effectiveness. *Journal of Public Administration Research and Theory*, 18(2): 229-252. doi:10.1093/jopart/mum015.

Qiu, H. and S. Chreim. 2022. A Tension Lens for Understanding Public Innovation Diffusion Processes. *Public Management Review*, 24(12): 1873-1893. doi:10.1080/14719037.2021.1942532.

Robson, C. and K. McCartan. 2016. *Real World Research: A Resource for Users of Social Research Methods in Applied Settings*. Chichester, United Kingdom: John Wiley and Sons.

Rogers, E. 2003. *Diffusion of Innovations.* New York, NY: Free Press.

Sørensen, E. and S. Waldorff. 2014. Collaborative Policy Innovation: Problems and Potential. *The Innovation Journal: The Public Sector Innovation Journal,* 19(3): 1-17.

Sørensen, E. and J. Torfing. 2017. Metagoverning Collaborative Innovation in Governance Networks. *American Review of Public Administration,* 47(7): 826-839. doi:10.1177/0275074016643181.

Seitanidi, M.M., D.N. Koufopoulos and P. Palmer. 2010. Partnership Formation to Change: Indicators for Transformative Potential in Cross Sector Social Partnerships. *Journal of Business Ethics,* 94(1): 139-161. doi:10.1007/s10551-011-0784-2.

Stevens, V. and K. Verhoest. 2016. A Next Step in Collaborative Policy Innovation Research: Analysing Interactions using Exponential Random Graph Modelling. *The Innovation Journal: The Public Sector Innovation Journal*, 21(2): 1-20.

Torfing, J. and C. Ansell. 2017. Strengthening Political Leadership and Policy Innovation through the Expansion of Collaborative Forms of Governance. *Public Management Review,* 19(1): 37-54. doi:10.1080/14719037.2016.1200662.

Torfing, J., E. Ferlie, T. Jukić and E. Ongaro. 2021. A Theoretical Framework for Studying the Co-Creation of Innovative Solutions and Public Value. *Policy & Politics,* 49(2), 189-209

Torfing, J. & P. Triantafillou. 2016. *Enhancing Public Innovation by Transforming Public Governance*. Cambridge, United Kingdom: Cambridge University Press. doi:10.1017/CBO9781316105337.

Van Kleef, R.C. 2012. Managed Competition in the Dutch Health Care System: Preconditions and Experiences so far. *Public Policy Review,* 8(2): 171-190.

Verhoest, K., B. Verschuere and G. Bouckaert. 2007. Pressure, Legitimacy and Innovative Behaviour by Public Organizations. *Governance,* 20(3): 469-497. doi:10.1111/j.1468-0491.2007.00367.x.

Waldorff, S.B., L.S. Kirstensen and B.V. Ebbesen. 2014. "The Complexity of Governance: Challenges for Public Sector Innovation." Pp. 70-88 in C. Ansell and J. Torfing. *Public Innovation through Collaboration and Design*. New York, NY: Routledge. doi:10.4324/9780203795958.

Yin, R.K. 2018. *Case Study Research and Applications: Design and methods.* Thousand Oaks, CA: Sage Publications Inc.

Zelenika, I. and J.M. Pearce. 2014. Innovation Through Collaboration: Scaling up Solutions for Sustainable Development. *Environment, Development and Sustainability,* 16(6): 1299-1316. doi:10.1007/s10668-014-9528-7.