JÖNKÖPING UNIVERSITY
School of Health and Welfare

Doctoral Thesis

The Process of Change in Introducing Coproduction

- the Case of the ESTHER Network in Singapore

Esther Lim Li Ping

Jönköping University
School of Health and Welfare
Dissertation Series No. 149 • 2025

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With this strong network of mentors, colleagues, friends, and family, we can only grow from strength to strength.

Abstract

Organisational change is often driven by strategy, structure, and leadership. Yet beneath these formal mechanisms lie the socio-cultural and linguistic foundations that shape how change is understood, enacted, and sustained. This dissertation explores these foundations through the case of introducing coproduction of care—specifically, the ESTHER Network —within Singapore's public healthcare system. Originating in Sweden, ESTHER Network represents a shift toward collaborative, person-centred care, making it a useful lens to examine how coproduction is translated in hierarchical and efficiency-oriented health systems.

Using an insider action research approach, the study investigates how managers, practitioners, and service users interpret and negotiate coproduction in practice. Multiple qualitative and quantitative data sources—including interviews, focus groups, observations, document analysis, and a validated survey—were analysed iteratively and triangulated to capture both the structural and relational mechanisms of change.

The findings show that coproduction in Singapore remains at a nascent stage, often enacted as improved communication from practitioners to improve treatment adherence rather than genuine power-sharing. First-order change in terms of structural support—such as achieving innovation–system fit, strengthening vertical integration, and training—helped establish alignment and coherence in the early stages. Service users' past experiences with practitioners significantly shaped current interactions, providing insights to the challenges in translating coproduction in practice. Signs of second-order change emerged through the work of ESTHER coaches and champions, who bridged service users, practitioners, and managers, fostering relational shifts. Dialogue, enacted through structured cross-boundary spaces such as ESTHER cafés, was identified as a critical mechanism for generating shared understanding and new meanings of care. These encounters acted as microstructures for change, helping teams navigate complexity and ambiguity.

Interpreting these findings through the lens of change as a socially constructed process, the study demonstrates that sustained transformation emerged from the ability as an organisation to adapt – understanding the critical and often overlooked role of culture, values and shared meanings. This form of third-order change requires individual and organisational reflexivity – deep understanding comes from not resolving the tensions of change superficially but engaging with them adaptively. The dissertation culminates in a reflexive model for adaptive working, which articulates five interrelated dimensions to guide dialogue, learning and reflection, to enhance deeper understanding between service users and practitioners. This model contributes a practical and relational framework for navigating adaptive challenges in complex systems.

Keywords: Organisational change, coproduction, socio-cultural foundations, discourse, positioning theory, adaptive practice, insider action research, dialogue, improvement science

Original papers

The following papers are enclosed as appendices.

Paper I

How the Esther Network Model for Coproduction of Person-centred Health and Social Care was Adopted and Adapted in Singapore: A Realist Evaluation
Lim E. L. P., Khee G. Y., Thor J, Gäre, B. A., Thumboo, J. & Allgurin, M. (2022). BMJ Open,12: e059794. https://doi:10.1136/ bmjopen-2021-059794

Paper II

An Evaluation of the Relationship between Training of Health Practitioners in a Person-centred Care Model and their Person-centred Attitudes
Lim, E. L. P., Ong, R. H. S., Thor, J., Allgurin, M., Gäre, B. A., & Thumboo, J. (2023). International Journal of Integrated Care, 23(4), 11–11. https://doi.org/10.5334/ijic.7564

Paper III

Understanding Service Users' Narratives in Coproduction: A Positioning Perspective
Lim, E. L. P., Gäre, B. A., & Thumboo, J., & Allgurin, M. (Manuscript submitted for publication)

Paper IV

“I use more of active listening skills” - Discourse of Coproduction
Lim, E. L. P., Gäre, B. A., & Thumboo, J., & Allgurin, M. (Manuscript submitted for publication)

Prologue

Career switches are not uncommon, but what is perhaps less typical is the opportunity to play multiple roles within the same organisation - Singapore Health Services (SingHealth) - over three decades. My journey began in the early 1990s as a medical social worker (MSW) in the Singapore General Hospital. At that time, social work was still an emerging presence in the hospital setting— my fellow MSWs and I often work as lone pioneers advocating for patient autonomy and self-determination, and encouraging the inclusion of caregivers as essential partners in care planning. In those early years, we were practising what would later be termed *coproduction*, even if we did not yet recognise the concept by that name. It was a challenging but necessary work, especially within a system that was predominantly medically driven.

The very term *social* work signals that the profession is concerned not only with individual problems, but with the web of relationships, structures, and contexts that shape people's lives. To practise social work is to recognise that illness and recovery are never purely clinical experiences; they are social experiences embedded in family ties, cultural norms, economic conditions, and institutional arrangements. In the hospital, this meant looking beyond diagnoses and treatment plans to understand how social networks, community resources, and systemic barriers affected a patient's capacity to heal and thrive. The "social" called us to connect the medical to the human, to bridge professional silos, and to make visible the social determinants of health that medicine alone could not address.

I have always cared deeply about going beyond the hospital walls to collaborate with community partners. Patients live in the community, not the hospital, and they benefit most from enduring support structures that connect both worlds. This belief led me to pursue a Master's Degree in Evidence-Based Social Interventions at the University of Oxford in 2006, with the intention of not only doing meaningful work but also evaluating what works and documenting it rigorously.

In Singapore, recognition of the need for organisational change gained momentum as healthcare costs rise and chronic diseases become more prevalent. The country began shifting away from a hospital-centric, disease-oriented model toward population health and coproduction with citizens. As part of this transformation, hospitals were reorganised into regional health systems. I was asked to lead patient advocacy and community integration efforts in the southeastern region under SingHealth.

Towards the end of 2014, SingHealth's top leadership team—comprising administrators and clinical leaders—visited Region Jönköping County, Sweden, to learn from internationally recognised models of coproduction. We were introduced to the ESTHER Network, which focused on what matters to patients—known as "Esthers". As part of my patient advocacy portfolio, I was appointed to lead the adaptation of ESTHER Network in Singapore. We launched the programme in June 2016, and within three years, had developed a vibrant network of over 300 Esthers and ESTHER coaches across professional groups, supported by a structured training and development system to sustain improvements through coproduction.

As the leader of the initiative, I recognised the importance of evaluating our work to refine and deepen its impact. At the same time, I received an invitation from my counterparts in Region Jönköping County to undertake a PhD to further explore the learning and transferability of this innovative model. Taking on the dual role of practitioner and researcher presented inevitable challenges, especially in maintaining impartiality and navigating role conflict. However, the opportunity to integrate theory with practice, and to pursue research while actively contributing to organisational change, was too valuable to pass up. This rare practitioner-researcher position allowed me not only to act but also to pause and ask critical questions—prompting deeper organisational reflexivity and learning. Balancing these responsibilities often felt like walking a tightrope—demanding focus, adaptability, and self-awareness—but it ultimately enriched both my personal growth and professional practice. This integration of work, continuous learning, and inquiry became the foundation of my motivation to undertake this PhD journey.

List of definitions and abbreviations

Definition	*Description*
ESTHER Network	Originated from Region Jönköping County, Sweden - a multiprofessional network comprising leaders, health and social care practitioners, patients, caregivers, citizens and other quality and industry partners to focus on coproduction with service users
ESTHER Café	Main feature of ESTHER Network – a platform where Esthers share their care journey with practitioners to enhance mutual understanding and trust between service users and practitioners
ESTHER Coach Training	A four-day workshop for health and social care practitioners, co-lead by champions and Esthers. Objectives are to provide knowledge, skills in coproduction through interactive workshops on journey mapping, solution-focused coaching
ESTHER Advocacy Training	A two-hour condensed version for health and social care practitioners to raise awareness of the key tenets of coproduction
ESTHER Improvement Project	A six to nine-month application phase after the coach training. ESTHER coaches find out what matters to Esthers and work with Esthers from the beginning to the end of the project, to improve care for Esthers

Abbreviation	*Description*
PCC	Person-centred Care
WHO	World Health Organisation
MOH	Ministry of Health
RJC	Region Jönköping County

PPOS	Patient-Practitioner Orientation Scale
IOM	Institute of Medicine
SingHealth	Singapore Health Services
MSW	Medical Social Worker
DOI	Diffusion of Innovation
IAR	Insider Action Research

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1. Introduction

This dissertation is about change. Not only the change I sought to introduce into an organisation, but the change that unfolded within me. It is about the ways change is imagined, translated, and lived—how it shifts relationships, roles, and ways of seeing the world. It is also about the structures and habits that resist transformation even as we speak of innovation.

The change in question is the introduction of coproduction in care, carried from Sweden to Singapore. Coproduction asks us to work differently: to move from "*what is the matter with you?*" to "*what matters to you?*". Coproduction is understood in this study as the relational work of producing health and care *with* rather than *for* people (M. Batalden et al., 2016). Rooted in Ostrom's (1996) foundational conception of coproduction as the joint provision of goods or services by individuals across organisational boundaries, it extends beyond mere participation to shared responsibility and contribution. Within public service contexts, coproduction represents a hybrid form of social organisation situated between state provision and community self-help (Bovaird, 2007), inviting citizens to act as partners in designing and delivering the services they use (Brandsen & Honingh, 2016). It is not a singular event but a continuum of practices—from consultation and co-design to co-delivery and co-assessment—each requiring the redistribution of power, trust, and expertise between professionals and service users (Loeffler & Bovaird, 2016). In this sense, coproduction challenges traditional, managerialist notions of service delivery by recognising that meaningful change arises through relationships and collective learning rather than through top-down implementation alone.

Person-centred care, meanwhile, emphasises understanding the person behind the patient—valuing their preferences, experiences, and contexts as integral to care decisions (Ekman et al., 2011; McCormack & McCance, 2016). It is grounded in the ethical recognition of the person's autonomy and individuality, seeking to align care with what matters most to them.

While coproduction and person-centred care share a common ethos of partnership and respect, they differ in emphasis: person-centred care focuses primarily on the relational and ethical dimensions of the care encounter, whereas coproduction extends this partnership to the design, delivery, and improvement of health systems. In practice, the two are mutually reinforcing—person-centred care provides the moral foundation, and coproduction offers the practical means through which such values are enacted collectively within systems of care. Coproduction in theory, sounds simple; in practice, this shift disrupts routines, unsettles hierarchies, and challenges deeply embedded understandings of professional expertise. Coproduction asks practitioners to share power and service users to claim agency in systems that have not historically been designed for their voices to lead.

The urgency of such change is driven by global demographic and epidemiological trends: ageing populations, rising chronic disease, declining old-age support ratios, and escalating healthcare costs (World Health Organization, 2022). Simultaneously, policy narratives increasingly place responsibility for health on citizens themselves (Osborne et al., 2016). Against this backdrop, coproduction is often presented as a compelling response—a way to achieve sustainability by engaging those who use services in their design and delivery. Improvement science likewise recognises healthcare as a coproduced service in which value emerges from the collaborative efforts of service users, professionals, and institutions (P. Batalden, 2018). Yet coproduction is not the only possible response to these pressures, nor is its promise without risk. As Batalden and colleagues caution, the philosophical appeal of coproduction can mask the difficulty of translating the concept into everyday clinical practice, where professional obligations, safety concerns, and structural inequalities create tensions and ethical dilemmas (M. Batalden et al., 2016). Scholars have also warned of a "dark side" in which coproduction may inadvertently reinforce inequities, shift burdens onto patients, or conceal the exercise of power beneath a rhetoric of partnership (Oliver et al., 2019).

Indeed, what is persuasive at the level of principle may be contradictory in application. The call to share power may collide with legal duties to protect patients, resource constraints, or professional norms of expertise. Coproduction depends on capacities—time, literacy, confidence—that are unevenly distributed, raising questions of equity and exclusion. What begins

as an emancipatory ideal can, if unexamined, reproduce the very hierarchies it seeks to dismantle (Oliver et al., 2019). Taking a concept forged in one socio-cultural and policy environment and applying it to another only deepens these challenges. Moving coproduction from Sweden to Singapore required more than replicating a model; it meant grappling with differences in culture, governance, and professional training, where the philosophical language of partnership met the practical realities of a highly efficient, hierarchically organised health system.

I undertook this work in the context of Singapore's public healthcare system—a system shaped by hierarchical authority, efficiency imperatives, and the influence of both collectivist values and global health policy priorities. Introducing coproduction here meant stepping into a cultural and institutional environment where practitioners are trained to act decisively and have a moral obligation to decide "what is best" for the patient, while service users may defer to medical authority, sometimes perceiving such deference as an expression of trust or even preference (Hiu et al., 2020; Lee et al., 2008). Change in such systems is often driven through top-down mandates (Ministry of Health Singapore, 2020), with less emphasis on the slow and relational work of shifting culture.

From the outset, my position was both privileged and precarious. As the programme driver, I had the platform and mandate to initiate change. As an organisational insider, I carried the expectations, loyalties, and risks that come with working within a system I sought to transform. This dual position meant I was constantly negotiating between loyalty to the organisation and fidelity to the principles of coproduction, between the pace of formal change processes and the slower pace of human change.

This dissertation examines the process of change in introducing coproduction through the ESTHER Network in Singapore, grounded in my insider perspective within the country's largest public healthcare cluster. Over three decades in multiple roles, I witnessed how healthcare is shaped as much by cultural norms, professional identities, and everyday practices as by formal policies and structures. The work was marked by recurring dilemmas: respecting culture without reinforcing disempowerment, sustaining momentum without imposing change, and holding a vision while navigating

compromise. I learned that courage in change is rarely dramatic; it is quiet, persistent, and deeply relational.

This insider vantage point provides both access and insight into how coproduction—an approach that foregrounds collaboration between managers, practitioners and service users—takes root within a system historically dominated by medical logics. The study traces how social relationships, cultural meanings, and organisational conditions interact to enable or constrain change, offering a nuanced understanding of what it takes to embed coproduction in Singapore's health and social care context, while recognising that the very ideals that inspire coproduction can also generate tensions, inequities, and contradictions when translated into practice.

1.1. Rationale and aim

Organisational change depends not only on formal structures and procedures but also on the narratives, meanings, and linguistic practices through which people interpret and enact it (Czarniawska, 2014). This dissertation examines these underlying foundations through the case of introducing coproduction within Singapore's health and social care system.

Coproduction offers a promising shift from provider-led services toward more collaborative, person-centred care. Yet its assumed benefits are not universally self-evident. When transferred across contexts—particularly from Western models such as the ESTHER Network to Asian health systems—the ideals of shared power and partnership often become sites of tension and negotiation. Much of the existing literature on coproduction is grounded in Western experiences, shaped by individualistic orientations, egalitarian relationships, and participatory governance structures. This study extends and problematises those assumptions by examining how coproduction is interpreted, negotiated, and enacted within Singapore's healthcare system, where hierarchical professional cultures, strong state influence, and communitarian norms shape both care practices and the possibilities for change.

By tracing the ESTHER Network's translation over five years since its adoption, this study foregrounds the socio-cultural and relational dimensions,

namely norms, values, identities, and power dynamics. Conducted through insider action research, it aims to enhance the understanding of organisational change as an evolving process, generating both actionable insights and emergent understandings of how transformation takes root within complex systems. This aim is addressed through three research questions:

- **Mechanisms of Change** – What organisational processes, strategies, and interactions facilitated the introduction of coproduction, and how do these mechanisms operate across different levels of the healthcare system?

- **Interpretation and Enactment** – How do various actors—including managers, practitioners, and service users—interpret, negotiate and enact coproduction, and how do these interpretations shape its practical translation?

- **Cultural and Relational Dynamics** – How do cultural norms, professional values, and relational dynamics influence the adoption, adaptation, and sustainability of coproduction within Singapore's healthcare context?

2. Background

Organisational change is frequently framed as a stepwise effort—strategised, structured, and evaluated by outcomes. Classic models, such as Kotter's eight-step framework, frame change as a planned sequence led from the top (Kotter, 1996). While such approaches provide useful tools for coordination and mobilisation, there is less emphasis on the complexity, ambiguity, and negotiation that characterise real-world change in healthcare.

In response, scholars increasingly advocate for understanding organisational change as emergent, situated, and continually in process rather than the straightforward execution of a blueprint. Drawing on an interpretive tradition, Czarniawska (2014) challenges managerialist discourses that present change as controllable and predictable, reframing it as an ongoing process of *organising*. From this vantage point, organisations are not stable entities but continuous flows of practice, where change is embedded in everyday life. She also emphasises the cultural and political dimensions of change, highlighting how actors cope with, narrate, and navigate contradictions. In contrast to approaches that prioritise adherence to a model, Czarniawska (2014) foregrounds practice—what people actually do and how they enact change in their day-to-day contexts. Narrative and translation become essential: innovations are reinterpreted, adapted, and sometimes transformed as they travel across professional, organisational, and cultural boundaries (Czarniawska & Sevón, 1996, 2005).

This interpretive view resonates with developments in improvement science and quality improvement (QI). Batalden & Davidoff (2007) define improvement science as the generation of "generalisable knowledge to improve health outcomes," stressing the interplay of evidence, context, and facilitation. More recent formulations describe a shift from technical fixes (QI 1.0) to process improvements (QI 2.0) and relational and cultural perspectives (QI 3.0) (P. Batalden & Foster, 2021; Lachman et al., 2021). Greenhalgh et al. (2004), in their seminal review of diffusion of innovations in public services, similarly argue that adoption depends on social influence, adaptation, and local negotiation rather than simple implementation of a proven model. These insights align with Czarniawska's emphasis on translation: improvement

travels through people and relationships, not just protocols (Czarniawska, 2014).

The concept of coproduction deepens this argument, but its appeal should not obscure its complexity. First articulated by Ostrom and colleagues in the late 1970s to describe the joint production of public services by professionals and citizens (Ostrom, 1973; Parks et al., 1981), coproduction has since migrated into health and social care. Boyle and Harris (2009) frame it as a partnership where users and professionals design and deliver services together, while P. Batalden et al. (2016) describe healthcare coproduction as the interdependent work of patients and professionals, combining their knowledge, expertise and resources to the process, to create value in health outcomes. Although often presented as a straightforward invitation to collaborate, coproduction requires far more than structural adjustment: it entails deep relational work, sustained dialogue, and shifts in professional identity—changes that can unsettle established roles and power relations.

Empirical studies caution against assuming that coproduction can be simply lifted from one context and applied to another. Much of the literature remains anchored in technical or managerial framings, privileging structures and processes over the interpersonal dynamics that animate complex systems (Gremyr et al., 2021). While coproduction is increasingly recognised as valuable, there is limited understanding of how change processes unfold across diverse organisational and cultural contexts (Brown & Head, 2019; Mulvale et al., 2024). Robert et al. (2024) caution that coproduction is often invoked without the mechanisms—dialogue, documentation, interpretation—needed for equitable practice. Oliver et al. (2019) describe a “dark side” in which coproduction, if uncritically adopted, can reinforce inequities or shift burdens onto service users while masking power imbalances beneath the rhetoric of partnership. Notable exceptions, such as Vackerberg et al.'s (2023) longitudinal study of the Swedish ESTHER Network, foreground boundary-spanning dialogues and continuous learning as strategies to navigate the unpredictability of complex health and social systems, but even these examples underscore the importance of local adaptation and sustained relational effort.

Taken together, these strands of research—interpretive organisational change, improvement science, and coproduction—underscore that change in healthcare is neither uniform nor linear but emergent, contested, and relational. Models such as the ESTHER Network are best understood not as fixed blueprints but as *portable narratives* that mobilise attention and guide action across sites. Their enactment depends on translation work: who tells the story, how it is interpreted, what gets adapted, and how contradictions are managed. In Singapore, with its strong hierarchical structures, collective cultural values, and institutionalised practices, examining these processes empirically offers a unique opportunity to understand not only how coproduction might be meaningfully sustained, but also where its ideals may clash with local norms and generate tensions that require careful negotiation.

2.1. Socio-cultural underpinnings of organisational change

Singapore's nation-building narrative has consistently emphasised communitarian values over individualism, foregrounding collective well-being, shared responsibility, and social cohesion (Chua, 1995). In healthcare organisations, this manifests in policies and practices that prioritise population health outcomes, efficiency, and system sustainability over individual preference. While such collectivist orientations can foster alignment and compliance in change processes, they also risk sidelining patient autonomy or marginalising voices that do not conform to dominant norms. Organisational change initiatives are therefore often framed as duties towards the greater good, rather than as opportunities for pluralistic negotiation.

The socio-cultural emphasis on meritocracy and achievement permeates Singapore's public institutions, including health and social care. Change initiatives are frequently justified through metrics of efficiency, productivity, and excellence (Tan, 2008; Woon & Loo, 2017). This performance-driven orientation shapes organisational change into technocratic projects, privileging measurable outcomes and evidence-based protocols. While such orientations contribute to system reliability and global competitiveness, they may constrain deeper, equity-oriented transformation that requires attention to relational, qualitative, and context-specific dimensions of care.

Singapore's socio-cultural traditions, influenced by Confucian heritage, sustain strong respect for authority and hierarchical order (Retna & Jones, 2013). In health and social care organisations, this shapes both leadership and professional dynamics: change is often top-down, directive, and compliance-focused. While such hierarchical structuring can accelerate progress and reduce resistance, it also risks limiting participatory approaches and silencing dissent, making it challenging to embed more dialogical and coproduced forms of organisational change.

Singapore's governance model has long emphasised pragmatism—valuing what "works" in practice over ideological commitments (Quah, 2010). This ethos translates into health and social care change processes that prioritise feasibility, adaptability, and results. Organisational change is therefore framed as a continuous process of problem-solving and system optimisation. However, this pragmatic stance can constrain critical reflection on underlying values or structural inequities, potentially relegating justice-oriented or transformative change to the margins.

Singapore's multicultural composition necessitates ongoing attention to harmony and cohesion across ethnic and religious groups. In health and social care, this underpins policies of inclusivity and accessibility, but it also means that organisational change initiatives are carefully managed to avoid disruption of consensus. This socio-cultural imperative towards harmony can suppress conflictual or disruptive forms of change, which are often necessary for confronting entrenched inequities or professional hierarchies.

Together, these socio-cultural underpinnings shape health and social care organisational change in Singapore as predominantly pragmatic, collectivist, and performance-driven, enacted through hierarchical authority structures with an emphasis on harmony. Such features enable efficiency, rapid adoption of innovations, and system-wide alignment, but they may limit deeper transformations that demand reflexivity and redistribution of power. For healthcare systems aspiring towards equity and coproduction, the challenge is to navigate these cultural logics—leveraging their strengths while creating spaces for more participatory and justice-oriented change.

2.2. Coproduction and the ESTHER Network

The ESTHER Network, first developed in Sweden to improve coordination and quality of care for older persons asks a simple but powerful question—"*What is best for Esther?*" (Gozzard & Willson, 2011; Gray et al., 2016). **Esther** is symbolic of a patient with care needs who requires the coordination of two or more care providers from the health and social care settings. This question pivots the focus of care to what matters most to Esthers, prioritising their values, circumstances and preferences (Vackerberg et al., 2016).

The transfer of the ESTHER Network to Singapore has involved adaptation rather than simple replication. In its Swedish origin, Esther is an 88-year-old person with complex care needs, created in Region Jönköping County to keep healthcare focused on the question, "What matters to Esther?" In Singapore, SingHealth localised this persona through real stories, most prominently "Mdm Teo," who represents service users from different levels of society and serves as a tangible reference point for coproduction.

A central feature of the ESTHER Network is the **ESTHER Café**, a platform where service users share their care journeys with practitioners. These interactions foster mutual understanding, trust, and collaboration between service users and healthcare teams. The implementation of the network relies on a cadre of **ESTHER coaches and champions**. Coaches, nominated by their Heads of Department (HODs), are typically frontline health or social care practitioners who, besides their normal work, are trained as improvement coaches with the aim of making care better for Esthers. They receive QI training and, following a four-day ESTHER coach workshop, initiate an improvement project that involves coproduction with service users over a six to nine-month period, supported by their head of department as a **sponsor**. Champions are experienced coaches who co-lead the network's activities, including training, scaling of QI initiatives, and facilitating ESTHER Cafés.

The introduction of the ESTHER Network in Singapore was supported by strong leadership endorsement. Following a study trip by a **SingHealth leadership team**, comprising top administrative, nursing, and allied health leaders, the adoption was publicly endorsed in 2016 and aligned with organisational priorities. A local coordinator and pioneering champions were

appointed to build the training faculty and innovation units. A cohort of sixty coaches from the Singapore General Hospital, Sengkang General Hospital, Changi General Hospital, National Neuroscience Institute, National Heart Centre Singapore, National Cancer Centre Singapore, and social service agencies including the Agency for Integrated Care, Social Service Offices, National Kidney Foundation Singapore, and National Trades Union Congress (NTUC) Health formed the early adopters. This group seeded projects that integrated care within and across health and social service settings, establishing the foundation for the ongoing adaptation and expansion of the ESTHER Network in Singapore.

The timeline (Figure 1) and roles (Table 1) below represent the initial starting point, while the process remains ongoing.

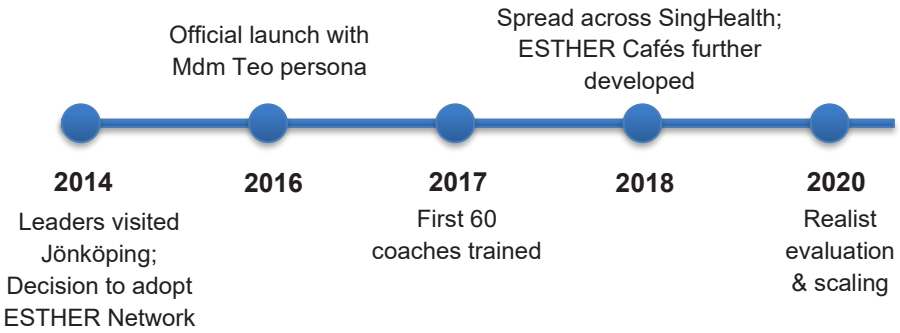


Figure 1. ESTHER Network Singapore - Timeline of Adoption & Adaptation.

Table 1

Key roles in ESTHER Network Singapore

Role	*Description*
Esther	A symbolic patient persona - embodied as Mdm Teo - who has care needs requiring the coordination of two or more care providers. A pivotal question 'What matters to Esther?', guide care decisions toward what truly matters to the person.
Coaches	Health or social care practitioners who, besides their routine work, are trained as improvement coaches to initiate and support organisational improvements with the aim of making care better for Esther.
Champions	ESTHER coaches who advance to become trainers and leaders in the network. They have significant links inside and outside the organisation to connect the macro- and micro-systems. They are typically middle managers who lead teams.
Sponsors	Heads of Department who support coaches' projects, ensuring alignment with organisational priorities.

How ESTHER Network was translated in Singapore is depicted in Figure 2. Structural elements such as the appointment of coaches, champions, and sponsors, and the introduction of ESTHER Cafés, were adapted to fit existing professional hierarchies and the national emphasis on efficiency and integration. Senior leadership endorsement was also vital in legitimising these practices, echoing findings on how organisational innovations are more likely to spread when supported from the top (Greenhalgh et al., 2004).

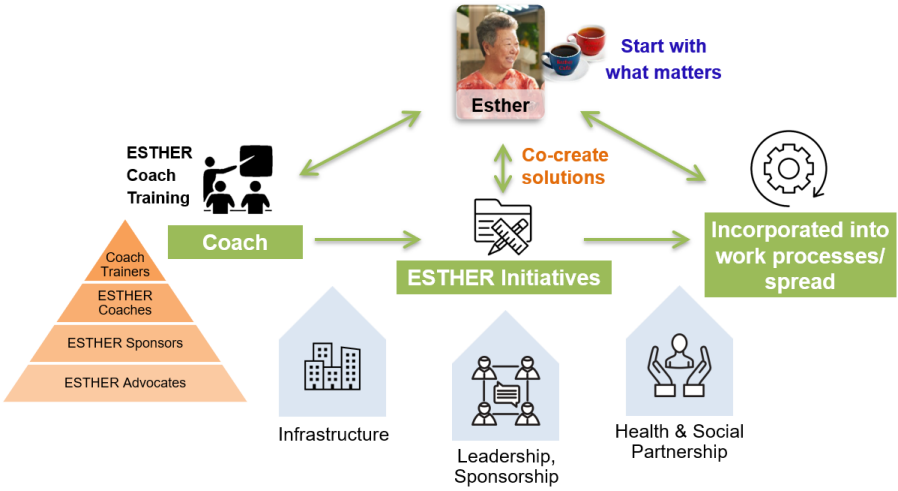


Figure 2. The adapted ESTHER Network Singapore model.

The adaptation of ESTHER Network in Singapore shows that innovations do not arrive as fixed packages but take shape in different ways depending on local histories, professional cultures, and system priorities (Greenhalgh & Papoutsi, 2018). This study views adaptation not as a loss of fidelity but as a process of meaning-making, in which the model becomes usable and legitimate in a new context. Coproduction, as described by P. Batalden et al. (2016), requires rethinking roles, sharing power, and enabling collaboration across boundaries. In Singapore, these ideas were made tangible through local storytelling, structured roles, and new spaces for dialogue. Yet, coproduction remains a contested concept. It is often selectively interpreted, shaped by organisational constraints, or limited by cultural norms of authority and hierarchy. The following discussion illustrates how these dynamics play out in practice. The Singapore experience illustrates both the opportunities and the dilemmas of translating ESTHER Network: while localisation strategies have provided scaffolding for shifts in practice, challenges remain in ensuring that participation is more than tokenistic and that coproduction takes root as a genuine change in relationships and care practices.

While research on coproduction provides substantial evidence of its potential, it also highlights the persistent challenges of translating its principles into everyday healthcare practice (M. Batalden et al., 2016). Studies show that although coproduction can enhance outcomes and patient experience, it

simultaneously generates tensions with professional expertise, organisational imperatives, and the ethical commitments inherent in clinical work. For example, the ImproveCareNow (ICN) collaborative chronic care network for paediatric inflammatory bowel disease demonstrates how patients, families, clinicians, and researchers can jointly design and refine care processes to achieve measurable improvements in remission rates (M. Batalden et al., 2016; Seid et al., 2018). Yet many ICN participants remain unaware of how the chronic care network drives improvements in their care and do not take the opportunity to benefit from it. Similarly, practitioners may not always recognise families who are ready to do more and has trouble devoting time and energy to engage service users. Clinicians remain accountable for safety and evidence-based treatment even as families influence care priorities and introduce variation in practice. Finding the right balance between professional responsibility and patient autonomy remains a challenge that requires continual negotiation of when professional judgement must prevail, and when it is ethically appropriate to defer to patient or family preference.

Similar challenges appear in co-designed outpatient parenteral antimicrobial therapy (OPAT) services, where patients and carers are trained to manage intravenous antibiotic administration at home interdependency (Marsilio et al., 2021). OPAT carries risks and a strong patient commitment coupled by the right dose of attention and monitoring by practitioners is necessary. This underscores the need to coordinate the interdependency (Marsilio et al., 2021). Practitioners must decide how much risk is acceptable when tasks are delegated to patients, knowing that practitioners remain legally and morally responsible for the outcome. These cases underscore that coproduction does not eliminate professional responsibility but complicates it, demanding new forms of relational work, risk negotiation, and institutional support.

Equity and capacity to participate are central to these tensions. Coproduction presupposes that users can contribute time, knowledge, and technical skills, yet such capacities are unevenly distributed. In ICN, participation is easier for families with reliable internet access, flexible schedules, and health literacy, raising concerns that those already advantaged will disproportionately shape priorities (Seid et al., 2018). OPAT similarly requires stable housing, manual dexterity, and the ability to monitor for complications—conditions not equally available to all patients. Without deliberate strategies to lower barriers,

coproduction risks reproducing or even amplifying existing inequities. It is neither feasible nor appropriate to distribute power and responsibility equally between patients and professionals in every context (M. Batalden et al., 2016). P. Batalden (2018) further cautions that improvement efforts grounded in coproduction must therefore be designed for inclusion, providing resources such as translation, flexible meeting formats, and targeted facilitation to ensure that less advantaged voices are not excluded.

Taken together, these examples show that coproduction is not a simple addition to professional practice but a reconfiguration of roles and responsibilities. Professionals must engage with patients as partners while safeguarding standards of care, managing risk, and addressing structural inequities that limit participation. Rather than a stable endpoint, coproduction is a continuous process of negotiation in which ethical dilemmas—about safety, authority, and fairness—are not failures of the model but its inevitable conditions of practice.

3. Theoretical Framework

Underpinning this study is an ontological view of organisations not as static entities but as living, evolving systems constituted through relationships, communication, and continuous interaction (Tsoukas & Chia, 2002; Weick, 2012). From this perspective, organisational life is emergent and processual rather than fixed or object-like. Change is therefore not an episodic event applied to an organisation, but an inherent condition of its existence (Tsoukas & Chia, 2002). This reasoning aligns with Bateson's (1972) ecological view of systems, where patterns of interaction and feedback continuously shape learning and adaptation across multiple levels. Organisational realities are sustained through recursive loops of action and interpretation—what Bateson described as first- and second-order processes of learning and change.

Ontologically, this study assumes that *organisation* is not a thing to be changed but an ongoing accomplishment enacted through everyday practices, dialogues, and relationships (Weick, 2012). This view resonates with social constructionist perspectives (Berger & Luckmann, 1966; Burr, 2015; Gergen, 1999) that understand social systems as continuously produced through interaction. It also echoes the relational pragmatism of Dewey (1938), who conceived reality as unfolding through transaction and experience rather than existing independently of human activity.

Adopting this process ontology has implications for how change is studied. Rather than seek causal explanations of outcomes, the focus shifts to how actors make sense of, negotiate, and co-create new meanings and practices in situ. Insider Action Research (Coghlan, 2019) and Interactive Research (Svensson et al., 2007) are compatible with this ontological stance, as both view knowledge and action as interwoven within the flow of organisational life. Change emerges through collective inquiry and reflection, shaped by the interplay of context, relationships, and feedback.

Within healthcare systems, this ontological orientation foregrounds the importance of relational dynamics and discursive practices that sustain or transform patterns of care. It aligns with the ethos of coproduction, which assumes that meaningful change arises not from top-down interventions but

from dialogical processes through which diverse actors co-construct new understandings of what matters in practice. In this sense, organisational change is not only structural but ontological—it involves shifts in how people perceive, relate, and act within a shared world.

3.1. Theory of change and diffusion of innovation

Building on this ontological grounding, the chapter adopts Gregory Bateson's (1972) theory of change as an overarching lens for understanding organisational transformation. Bateson's distinction between first-, second-, and third-order change offers a framework for examining both surface-level adjustments and deeper cultural and relational transformations. First-order change refers to improvements within an existing system—adjustments to efficiency, processes, or structures that address immediate problems without altering the organisation's underlying logic. Second-order change involves a shift in those deeper frames of reference through which the organisation defines problems, allocates resources, and makes sense of its work. It demands re-examining assumptions about whose knowledge counts and how authority is distributed. Extending this, third-order change involves cultivating a reflexive capacity to question those very logics continuously (Argyris & Schön, 1978; Torbert, 2004). Such change requires tolerance for ambiguity and a culture of dialogue—conditions essential for sustaining coproduction in complex health systems.

Organisational learning theory (Argyris & Schön, 1978) provides a bridge between Bateson's systems thinking and the practicalities of studying change. Their distinction between single-loop learning (correcting errors without questioning governing norms) and double-loop learning (examining and altering those norms) mirrors Bateson's first- and second-order change. Enduring transformation requires the reflexive capacity to "learn how to learn"—precisely the kind of inquiry that coproduction stimulates when it challenges professional hierarchies and epistemic boundaries.

Coghlan (2019) extends these ideas through the framework of insider action research, which legitimises the practitioner–researcher position as a source of situated knowing. Studying change from within, the insider researcher engages in cycles of action and reflection that generate both practical

improvements and theoretical insight. This approach requires navigating complex political, relational, and ethical dynamics, as participation and inquiry are deeply intertwined. Insider action research thus provides both a methodological and theoretical stance on knowledge production in complex systems—viewing change as an emergent, collaborative process echoing Bateson's recursive learning loops and Argyris and Schön's double-loop inquiry (Argyris & Schön, 1978; Bateson, 1972).

Within this overarching framework, diffusion of innovation theory offers a complementary perspective on how new practices are adopted and spread. Rogers' (1995) classic model highlights stages of adoption and the roles of early adopters, champions, and opinion leaders in legitimising change. However, such models tend to treat innovations as stable "objects" to be transferred, overlooking the interpretive work of local actors. Contemporary scholars, such as Greenhalgh et al. (2004) and Greenhalgh and Papoutsi (2018), reconceptualise diffusion as a process of translation rather than transfer—where innovations are adapted and reconfigured through engagement with local contexts, cultures, and identities.

This study draws on both theory of change and diffusion of innovations in service organisations to examine the introduction of the ESTHER Network in Singapore. While diffusion theory helps trace the pathways of adoption and legitimisation, Bateson's framework reveals the deeper cultural and relational shifts that determine whether coproduction remains a first-order adjustment or evolves into second- or third-order transformation. Together, these perspectives suggest that organisational change in healthcare is not merely about spreading innovations but about translating and enacting new logics of care that challenge established assumptions and open space for more coproduced systems.

3.2. Positioning theory

To investigate how innovations like ESTHER Network are reinterpreted and enacted, this study also draws on positioning theory (Davies & Harré, 1990), which examines how people locate themselves and others within conversations and actions. Through positioning, individuals claim and assign rights, duties, and moral obligations that shape what kinds of actions are

possible or legitimate (Harré & Van Langenhove, 1999). Organisational change thus involves discursive positioning, as actors talk about, negotiate, and make sense of their roles in processes of coproduction.

Positioning theory complements Bateson's (1972) and Greenhalgh et al.'s (2004) frameworks by highlighting the relational dynamics through which change is enacted at the micro-level. It illuminates how service users and practitioners negotiate authority, expertise, and expectations, making visible the subtle power shifts that signal deeper cultural transformation. In this sense, the adoption of ESTHER Network is not merely the transfer of a model but a process of discursive negotiation—where service users position themselves as "experience experts" alongside "professional experts."

Taken together, these theoretical perspectives reveal organisational change as a multilayered process of learning, negotiation, and translation. Bateson's systems thinking situates change within recursive feedback loops; diffusion theory explains how ideas circulate and gain legitimacy; and positioning theory exposes the conversational and identity-level processes through which new meanings are co-created. This enables a multi-level analysis connecting the macro- (systemic), meso- (organisational), and micro- (interactional) dimensions of transformation.

3.3. Epistemological and theoretical synthesis

The theoretical framework is underpinned by a social constructionist and pragmatic epistemology. From a social constructionist standpoint (Berger & Luckmann, 1966; Burr, 2015), organisational realities are socially and discursively produced through everyday interactions. Knowledge, meaning, and identity are not fixed entities but relational accomplishments emerging through dialogue and practice. Pragmatism (Dewey, 1938; Morgan, 2007) complements this by emphasising inquiry as a form of action—valuing knowledge for its practical consequences and its capacity to support collective learning. This dual orientation aligns naturally with insider action research, which treats organisational change as a living experiment in reflective practice rather than an externally imposed intervention.

Coproduction theory further enriches this framework by positioning healthcare as a relational and value-driven enterprise rather than a purely technical system. Scholars such as Bovaird et al. (2023) and Osborne et al. (2016) conceptualise coproduction as a hybrid social form that blurs the boundaries between professional service delivery, user self-help, and community action. Its success depends not only on structures and processes but also on shared values, mutual respect, and the recognition of diverse expertise.

Within hierarchical systems like Singapore's, coproduction challenges entrenched logics of authority and efficiency by foregrounding dialogue, empathy, and shared purpose. Organisational change in this context is shaped by deep-rooted cultural norms of hierarchy, meritocracy, and technocratic rationality, which can constrain genuine collaboration. Bateson's (1972) and Coghlan's (2019) emphasis on learning and reflexivity helps to surface and question these underlying assumptions. The adaptation of the ESTHER Network can thus be understood as a process of cultural translation—an effort to align the relational ethos of coproduction with the institutional realities of a system that values control, predictability, and performance.

The theoretical framework therefore integrates systems thinking, relational theory, and socio-cultural analysis to illuminate how change unfolds in practice. The adoption of models like ESTHER Network is not merely a technical challenge but a moral and epistemic one, requiring shifts in how care, expertise, and authority are understood. Change, from this view, unfolds through continuous negotiation between structure and agency, system and story, innovation and identity. What matters is not only whether new practices are implemented but whether they enable people to think, act, and relate differently—to see, in Bateson's (1972) words, "the pattern that connects."

4. Materials and Methods

Grounded in social constructionism and pragmatism, this study adopts an insider action research approach (Coghlan, 2019) to explore how meanings, adaptation, and resistance emerge in practice. This chapter outlines the methodological rationale and the materials and methods used to generate context-sensitive knowledge while engaging directly with practice.

4.1. Study setting: The Singapore health system

Singapore's healthcare system operates on a mixed model comprising both public and private providers. Approximately 80% of tertiary care services are delivered by the public sector, whereas about 80% of primary care is provided by private general practitioners (Ministry of Health Singapore, 2020; Olayiwola et al., 2015). This model is increasingly regarded as unsustainable in light of emerging demographic and economic pressures, including an ageing population, the rise of chronic diseases, a declining old-age support ratio, a shrinking healthcare workforce, and escalating healthcare costs (Chan et al., 2018; Ginting et al., 2022).

To address these challenges, Singapore is undergoing a major health system reform, transitioning from a fee-for-service model to a capitation-based model under the *Healthier SG* strategy (Ministry of Health Singapore, 2023). This shift is intended to reorient the healthcare system towards population health—focusing on preventive care, early intervention, and right-siting care to primary and community-based settings. Public healthcare services continue to operate on a co-payment model, heavily subsidised by the government. Citizens' out-of-pocket payments are supported by co-insurance schemes and compulsory medical savings (Medisave), while additional means-tested subsidies are provided to vulnerable groups to ensure equity in access (Lai et al., 2017).

Against this backdrop, the global shift towards coproduction with service users is gaining traction in Singapore, with the aim towards more collaborative and responsive models of care (Ginting et al., 2022; Lai et al., 2017). Central to this premise is the idea that care should be coproduced with patients,

families, and communities, ensuring that health services reflect not only clinical needs but also the lived experiences, preferences, and values of individuals (Ginting et al., 2022). This model positions patients as active participants rather than passive recipients in the design, delivery, and evaluation of their care.

Coproduction in care is further supported by national efforts to integrate services across health and social care sectors, with the aim of improving continuity and sustainability of care (Olayiwola et al., 2015). However, embedding coproduction into practice remains challenging. Singapore's historically hierarchical healthcare culture, in which medical professionals are viewed as authoritative figures and citizens are perceived as accepting of unequal power, may constrain participatory approaches (Retna & Jones, 2013). Additionally, it is critically important to consider the cultural dynamics when adopting Western concepts to an urban-Asian setting like Singapore (Retna & Jones, 2013).

One significant institutional effort to operationalise coproduction has been undertaken by SingHealth, the largest public healthcare cluster in Singapore, serving around 1.37 million of the people. This integrated network comprises five tertiary hospitals, two community hospitals, five national specialty centres, and ten primary care clinics. Recognising the need to shift from an organisation-centric perspective to coproduction with service users, SingHealth has embedded coproduction into its strategic vision as early as 2016. Its organisational strategy map explicitly prioritises the question, "*What matters to our patients?*"—a core tenet of coproduction. Reinforcing this commitment, the cluster adopted the tagline "*Patients. At the heart of all we do.*" (SingHealth, 2022).

Despite this high-level commitment, there remains no universally agreed-upon definition or system-wide framework for coproduction implementation in Singapore. To address this gap, SingHealth introduced the ESTHER Network as a structured approach to embed coproduction in practice.

4.2. Insider action research and interactive research

This study employs insider action research (IAR) and interactive research to investigate organisational change from within, emphasising iterative cycles of action and reflection. These approaches enable inquiry into both the enactment and emergent understanding of change, resonating with Bateson's (1972) concepts of feedback loops and first- and second-order learning to capture both incremental adaptations and transformational shifts in complex healthcare systems.

Drawing on Coghlan (2019), IAR positions the practitioner-researcher as both participant and inquirer, generating context-sensitive knowledge through engagement in the processes being studied. This insider perspective provides access to everyday interactions, informal dynamics, and tacit knowledge often inaccessible to external researchers. Situated within the broader tradition of participatory action research (Reason & Bradbury, 2013), IAR aligns with the study's epistemology: knowledge as situated, relational, and co-created through cycles of reflection and action.

The Scandinavian tradition of interactive research (Eikeland, 2006; Gunnarsson, 2006; Svensson et al., 2007) complements this by emphasising mutual learning between researchers and participants, particularly relevant in settings where collaboration and coproduction are central to sustainable change (Gibbons et al., 1994). In practice, this involved continuous engagement with practitioners, managers, and service users through feedback cycles, reflective spaces, and co-designed decision-making forums, with the ESTHER Network Executive Committee guiding programme theory and research refinement.

My dual role as programme lead and practitioner-researcher enabled direct observation and participation in organisational transformation, offering rich, embedded insights (Coghlan & Brannick, 2014; Coghlan & Casey, 2001). Potential challenges of this insider position—role conflict, bias, and credibility of interpretation—were addressed through ongoing reflexivity (Alvesson & Sköldberg, 2009), as further discussed under research reflections. Reflective learning cycles, central to both IAR and interactive research, facilitated the co-construction of meaning, adaptive responsiveness,

and multi-level analysis. Coghlan and Brannick's (2014) three-pronged inquiry framework structured this process: first-person inquiry (self-reflection), second-person inquiry (collaborative dialogues), and third-person inquiry (system-level insights).

A single-case study design allowed deeply contextualised examination of the ESTHER Network's adaptation in Singapore, supporting comparison with existing literature and enhancing transferability (Baker, 2011; Yin, 2009).

4.3. Materials

Data collection included qualitative methods (interviews, focus groups, observation, document analysis) and quantitative measures, triangulated to enhance trustworthiness (Creswell & Creswell, 2017; Jick, 1979). An overview of the data collection methods, materials and analyses across the four studies is shown in Figure 3 below:

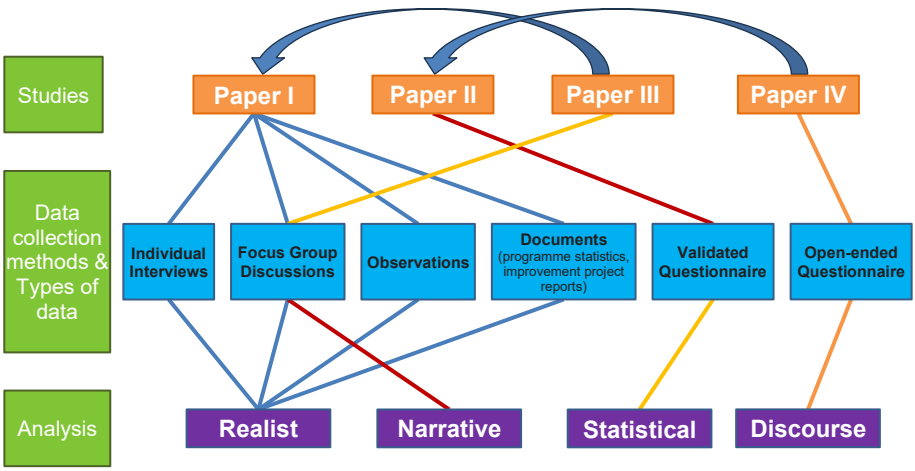


Figure 3. Overview of methods of data collection and analysis.

Data for this dissertation were generated from 2016 to 2021 since ESTHER Network was adopted in Singapore. The four studies shared a common orientation: to examine how coproduction is taken up, practised, and adapted

within health and social care settings (Table 2). I did not begin with a fixed toolbox, but instead drew on and adapted instruments such as semi-structured interview guides, observation templates and codebooks, developed through an international collaboration on coproducing care innovations with vulnerable populations, which included partners from Canada, Sweden, England, Singapore, and Scotland (Mulvale et al., 2024). These instruments were not simply imported; they were reworked with attention to the Singaporean context, often in dialogue with an ESTHER champion on the research team. This act of adaptation reflects my methodological stance: tools are not neutral, but carry the assumptions of the systems in which they were produced. By reshaping them to fit the rhythms and language of local practice, I sought both relevance and rigour. At times this required a balancing act—retaining enough fidelity to enable international comparison, while allowing sufficient flexibility for local resonance.

Table 2

Overview of participants' demographics across the four studies

	Participants	*Gender*	*Years of experience*	*Background*
In-depth Interviews (Paper I)	Policy-makers (4)	M (3) F (1)	21-30 (1) >30 (3)	Administrator
	Programme Implementers (3)	M (1) F (2)	5-10 (1) 11-20 (1) 21-30 (1)	Allied Health
Focus Group Discussions (Paper I, III)	Service Users (7)	M (2) F (5)	5-10 (4) 21-30 (2) >30 (1)	Patients (3) Caregivers (2) Patient & Caregiver (2)
	Care Practitioners (6)	M (2) F (4)	5-10 (1) 11-20 (4) 21-30 (1)	Doctor (2) Nurse (1) Allied Health (1)

				Community Practitioner (2)
Questionnaires (Paper II, IV)	Care Practitioners (437)	M (97, 22.2%) F (340, 77.8%)	<5 (97,22.2%) 5-10 (148,33.9%) 11-20 (138,31.6%) 21-30 (32,7.3%) >30 (22,5%)	Doctor (76,17.4%) Nurse (148, 33.9%) Allied Health (213,48.7%)

Table 3 shows the primary data generated across the four studies. Secondary data, such as programme documents, were mainly used in Paper I and are summarised in Table 4. All interviews, focus groups, and questionnaire sessions were conducted via Zoom due to pandemic restrictions, and recordings were captured in audio-only format. Interviews lasted between 45 and 60 minutes, and focus groups approximately 90 minutes. These constraints shaped the nature of engagement: while online platforms enabled inclusion during a time of restricted movement, they also limited the possibility of observing embodied cues and informal interactions that might have surfaced in physical settings.

Table 3

Primary data generated

Types of Primary Data	*No. of Respondents*	*Amount of Data*
In-depth Interviews (IDIs)	7	188 pages of transcript in word format
Focus Group Discussions (FGDs)	13	62 pages of transcript in word format
Questionnaires (18-item validated scale)	437	1311 questionnaires (repeated at three time-points)

Questionnaires (three open-ended questions)	280	840 responses over 42 pages in excel
Observations	20 (total in 2 observations)	24 pages of fieldnotes in word format

Table 4

Secondary data used

Types of Secondary Data	*Number*
1) ESTHER Network Statistics	
No. of coaches	271
No. of advocates	379
No. of sponsors	171
No. of Esthers	50
No. of community partners	59
No. of outreach events	53
2) ESTHER Projects	
No. of improvement projects	85 (301 pages of project report in Word format)
3) Media Publications	
External	2
Internal	9

Participant recruitment combined purposive and convenience strategies, and here too, choices reflected both opportunity and limitation. Purposive sampling (Papers I and III) allowed me to engage with those whose

perspectives were essential to understanding coproduction—healthcare leaders who shaped policy, practitioners who enacted care, and patients and caregivers whose voices gave texture to these processes. Convenience sampling (Papers II and IV), by contrast, was more pragmatic, drawing on training cohorts and programme participants who were readily accessible. While the former offered depth, the latter provided breadth, though sometimes at the cost of representativeness. For instance, those who attended training sessions may already have been more positively disposed towards new approaches, raising the question of whether critical or resistant voices were under-represented.

The four studies were not conceived as discrete projects but as interlinked cycles of inquiry. Paper III, by deepening understanding of patient and caregiver positioning, retrospectively informed the interpretation of Paper I's structural-focused findings. Similarly, the insights from Paper IV illuminated and extended the findings from Paper II, showing the generative forces of the training that produce effects – whether sustained or constrained—within organisational realities (Bhaskar, 2015). This iterative process reflects the action research logic of cyclical learning (Coghlan & Brannick, 2014), where each phase contributes to refining both practice and theory (Figure 3).

Paper I drew on qualitative methods—in-depth interviews (IDIs) with four top healthcare leaders, three programme implementers, one focus group discussions (FGD) with practitioners (N=6), and two FGDs with a total of seven service users comprising patients and their caregivers (N=4 and N=3 respectively). Other data included direct observation of programme activities, and programme documents of ESTHER Network. Data were collected in English which is the primary working language of the health and social care system in Singapore. Where necessary, clarifications were made in the participant's preferred language to ensure accessibility. The inclusion of key stakeholders—such as senior leaders who had authority to shape institutional priorities—and representative frontline staff was deliberate. It provided a fuller view of how coproduction was understood both "from above" and "from below." Patients were included not as token representatives but as central voices shaping the contours of the inquiry.

In this study, I assumed primary responsibility for interviewing organisational leaders. Given their seniority within the hierarchical structure, I perceived there to be a lower risk of response bias in these encounters. Leaders were accustomed to articulating their views in formal settings and were less likely to feel constrained by my dual role as both researcher and programme leader. Rather, my insider position afforded me privileged access to their strategic reflections, and my familiarity with the institutional context enabled me to follow up on nuanced points that an outsider might have missed. At the same time, I remained attentive to the possibility that leaders might accentuate successes or downplay challenges in order to present the programme in a favourable light, particularly given my visible investment in its implementation (Coghlan, 2019).

In contrast, interviews with service users required more careful consideration of how my positionality might shape the data. As the programme leader, I held authority not only within the organisation but also in relation to the broader trajectory of ESTHER Network. I recognised that service users could feel hesitant to disclose difficulties or negative experiences to me directly, for fear of jeopardising their relationship with the system or of offering what they might perceive as "the wrong answer." To mitigate this, I co-conducted the interviews with another experienced ESTHER coach who was not directly involved in programme implementation. This independent presence introduced an additional layer of neutrality, signalling to participants that their voices were genuinely sought for knowledge creation rather than for programme justification. This way of balancing proximity and distance through shared inquiry enhances credibility (Svensson et al., 2007).

Equally important was the choice of format. For service users, I deliberately employed focus group discussions rather than individual interviews. I reasoned that a group setting could create a supportive environment in which participants could affirm, extend, or gently challenge one another's accounts. The interactions between focus group participants can clarify and enrich understandings of participants' experiences and meanings (Kosny, 2003). In collectivising their narratives, service users were less likely to feel isolated or exposed, and more able to express experiences that might have been difficult to articulate in a one-to-one interview with me. In this way, the focus group served as a protective mechanism against power asymmetry, enabling service

users to speak freely in ways that were less mediated by my role as programme leader (Ryan et al., 2014).

Nevertheless, I remained mindful that my presence—even within a focus group—could still subtly influence the tone and direction of discussion. Participants might unconsciously tailor their accounts to align with what they believed I wished to hear. To address this, I adopted a facilitative rather than directive role in the group discussions, allowing the independent co-facilitator to take the lead in moderating conversation. I contributed primarily by asking clarifying questions or probing for elaboration where appropriate. This distribution of roles helped to balance the benefits of my insider knowledge (enabling me to recognise contextual cues and link emerging themes to broader organisational processes) with the need to minimise undue influence on participants' narratives (Coghlan, 2019).

Through these methodological choices, I sought to harness the advantages of insider access while remaining critically reflexive about the risks of bias and power imbalance. The resulting data were thus co-constructed within a research design that deliberately foregrounded both rigour and ethical sensitivity (Svensson et al., 2007).

Developing the initial programme theory required navigating organisational politics. Early programme documents tended to emphasise success stories and top-down ambitions, but frontline conversations and observations revealed tensions between rhetoric and practice. Iteratively refining the Context-Mechanism-Outcome (CMO) configurations involved negotiating these competing narratives—acknowledging organisational priorities while allowing space for less polished accounts of challenge and resistance. As an insider, I often found myself positioned as both interpreter and negotiator of these dynamics. Transparency meant documenting not just what participants said, but also the politics of how their voices were positioned in relation to each other.

Paper II adopted a single-arm pre–post design using Krupat's 18-item *Patient-Practitioner Orientation Scale* (PPOS) to assess changes in healthcare professionals' attitudes towards person-centred care (PCC) across three time points: immediately before training (T1), immediately after training (T2), and three months post-training (T3). In addition, a five-item self-administered

questionnaire was developed by the study team to capture participants' understanding of person-centred care in their own terms. This was administered at T1 and T2 to complement the PPOS with a context-specific measure.

The choice of a pre–post design was pragmatic and rooted in the applied purpose of the intervention. Our primary aim was not to establish causality under tightly controlled experimental conditions but to explore whether brief person-centred care advocacy training could shift attitudes among a diverse professional group. In healthcare organisations where training opportunities are tightly scheduled and mandatory control groups are ethically and logistically difficult to establish, a single-arm design provided a feasible and ethically responsible compromise. This approach enabled us to measure change over time while respecting the organisational imperative that all interested staff have equal access to the training (Creswell & Creswell, 2017).

The use of the PPOS was deliberate: it is one of the most widely validated instruments for assessing patient-centredness, with demonstrated reliability across professions and cultural contexts. Its two sub-scales: **Sharing**, which captures the extent to which practitioners support shared decision-making and patient involvement in care; and **Caring**, which reflects holistic concern for patients, empathy, and emotional attunement (Haidet et al., 2002; Krupat et al., 1999, 2000), aligned well with the values underpinning the ESTHER Network. At the same time, I recognised that person-centred care is contextually defined and culturally mediated. Hence, the additional five-item questionnaire was included to capture local meanings of person-centred care as expressed by practitioners themselves.

The survey was conducted in English. Reliability was assured through consistency checks across time points, and the established psychometric robustness of the PPOS provided additional confidence. Administered at three time points (pre-training, immediately post-training, and three months later), this survey involved 437 participants. All SingHealth doctors, nurses, and allied health professionals who attended the person-centred care advocacy training between August 2020 and November 2021 were invited to participate in the study. Participation was voluntary. Those who consented provided written informed consent and completed the study questionnaires. Data

collection ran from August 2020 to February 2022. Eligibility criteria were: (i) aged 21 years or above, (ii) completion of the training session, and (iii) ability to understand and respond in English.

The rationale for including all attendees was twofold. First, person-centred care is inherently interprofessional, and its implementation requires buy-in across professional groups (Ekman et al., 2011). Restricting the sample to one cadre (e.g., only doctors) would have missed critical perspectives from nurses, therapists, and pharmacists whose practice significantly shapes patients' everyday experiences. Second, broad inclusion reflected the ecological validity of the intervention: the ESTHER Network was never intended for a single profession but rather to cultivate a shared language and orientation across the system.

Questionnaires were distributed electronically at three time points. At T1, participants completed the PPOS and the five-item person-centred care understanding questionnaire immediately before the start of the training session. At T2, the same instruments were administered immediately after training. At T3, participants received a follow-up PPOS questionnaire three months after training, electronically and via institutional email. Responses were collected anonymously; no personal identifiers were linked to the surveys to ensure confidentiality and reduce social desirability bias.

The decision to use anonymous self-administered surveys was particularly important given the hierarchical nature of healthcare organisations in Singapore. By removing identifiers, I sought to create a safe space for honest expression, reducing the likelihood that participants would respond in ways they believed were expected by management or programme leaders.

Ethical approval was obtained from the SingHealth Institutional Review Board (Reference number: 2021/2064). Informed consent was secured from all participants, who were reminded that their participation was voluntary and that their decision to participate—or not—would not affect their standing within the organisation.

Despite these safeguards, several limitations must be acknowledged. First, the single-arm design does not allow for strong causal attribution. Observed changes may be influenced by broader organisational reforms or external

events (such as the COVID-19 pandemic, which overlapped with the study period). Second, while anonymity reduced the risk of response bias, it also meant I was unable to track individual changes across time points with certainty. Attrition at T3 further complicated longitudinal interpretation.

Third, the reliance on self-reported questionnaires meant that findings reflected practitioners' attitudes and understandings, not necessarily their behaviours in clinical practice. Finally, the PPOS, although validated internationally, has known psychometric limitations (e.g., lower alpha values for subscales in some contexts). To mitigate this, I complemented it with the locally developed questionnaire, but this instrument itself has not undergone formal validation.

From a reflexive standpoint, I was conscious of the dual role of being both researcher and programme leader. Although I was not involved in collecting or collating the questionnaire responses directly, my position could have shaped how participants perceived the training and their willingness to respond positively. The use of anonymous data collection and independent research support staff was intended to reduce this effect, but it cannot be entirely ruled out.

Paper III employed narrative analysis to explore how service users articulated their experiences within Singapore's healthcare system. Narrative research assumes that the stories people tell do more than recount events: they provide insight into how individuals construct meaning, situate themselves in relation to others, and make sense of vulnerability, suffering, and power (Gabriel, 2004; Greenhalgh et al., 2016). In healthcare contexts, illness narratives often reveal not only personal trajectories of pain, recovery, and resilience but also the social structures and cultural norms that shape these experiences (Kleinman, 1988). Storylines and metaphors are rarely individual inventions; they are socially and culturally inflected, conveying how relationships with professionals, institutions, and family members are understood and negotiated (Campbell & Grønbæk, 2018).

The study focused on the voice of service users—patients, caregivers, and those in dual roles—who were directly involved in the ESTHER Network, and leveraged on the focus group discussions (FGDs) conducted with seven service users in Paper I. FGDs were selected over individual interviews

because they allowed participants to co-construct narratives: resonating with, contrasting against, or building upon each other's stories. This group format provided a collective dimension that mirrored the coproduction ethos, surfacing how experiences were relational rather than purely individual. Participants were briefed on the principles of coproduction and were asked to reflect on:

- Their understanding of coproduction and how it was enacted within the ESTHER Network.
- Memorable moments in their care encounters.
- Suggestions for future development of the ESTHER Network.

The FGDs were co-facilitated by an ESTHER champion and the primary researcher, ensuring both insider knowledge and shared facilitation to mitigate potential biases. In line with interactive research traditions, the researcher adopted a practitioner–researcher stance, which emphasised responsiveness to participants and iterative sense-making (Svensson et al., 2007). This reflexive positioning was essential, as my dual role as both programme leader and researcher created risks of participants tailoring responses to perceived authority. The group setting helped mitigate this by allowing participants to find mutual support in collective storytelling, thereby diluting hierarchical dynamics.

Despite being strangers initially, participants quickly developed rapport once the study's aims were explained. Storytelling flowed organically, with rich emotional sharing and mutual empathy dominating much of the discussion. While I attempted to steer focus toward coproduction specifically, participants often remained immersed in recounting personal encounters with the healthcare system. It was only toward the latter part of the sessions that participants explicitly linked their experiences back to questions of coproduction. This reflects both the primacy of lived experience in shaping meaning and the challenge of introducing abstract policy concepts into the embodied realities of care.

All discussions were audio-recorded, transcribed verbatim by two team members, and returned to participants for member checking to ensure

accuracy. The COREQ guidelines (Tong et al., 2007) were used to enhance rigour and transparency in reporting.

Paper IV was designed to extend the findings of Paper II by shifting the focus from *measurement* of attitude change (through the PPOS) to the *language* practitioners used to describe their own practice after training. Whereas Paper II quantified shifts in person-centred care orientation, this analysis sought to unpack how practitioners articulated these shifts in writing, and how their choice of words reflected underlying meanings about responsibility, agency, and care. The approach was therefore interpretive and discursive: less concerned with whether practitioners "did" coproduction in observable terms, and more focused on how they described, justified, or hesitated around it in language.

The study was situated within SingHealth, a context that provided fertile ground for examining discourse because of its deeply embedded cultural tensions: high patient loads, hierarchical professional structures, and longstanding traditions of paternalism in medical practice (Hiu et al., 2020; Lee et al., 2008). Analysing written reflections allowed us to observe how practitioners negotiated these tensions in words—whether by adopting, resisting, or reframing the rhetoric of coproduction.

The participants had attended a two-hour training session on coproduction, delivered through the ESTHER Network. A total of 17 sessions were held across SingHealth, reaching doctors, nurses, and allied health professionals (namely physiotherapists and pharmacists). The brevity of the training reflected organisational pragmatism: to seed ideas of coproduction widely without overburdening practitioners already working under heavy time constraints.

After the training, practitioners were given a three-month period to integrate the concepts into their everyday practice. At the end of this period, they were invited to complete a written reflection questionnaire (T3). This delay was intentional—it allowed for experiential application, moving beyond immediate recall toward discursive accounts of how ideas were sustained, resisted, or transformed in practice.

All 437 practitioners who completed pre- (T1) and post- (T2) reviews of the training were invited to contribute at T3. A total of 280 practitioners (64%) submitted written responses, yielding 840 individual answers to three open-ended questions:

- What did you do differently?
- How did it impact patients?
- Personally, what was your experience making the change?

Responses ranged from two-word fragments ("listened more") to extended accounts of almost 300 words, generating a heterogeneous dataset compiled into 42 Excel sheets. While 280 participants returned reflections, demographic information (collected only at T1) was available for 249, enabling partial analysis of variation across gender, profession, and experience.

The sampling approach was inclusive, with all trained practitioners invited to contribute. This ensured broad interprofessional coverage—nurses, allied health professionals, and doctors were represented. However, participation was voluntary, meaning that the voices captured may have disproportionately reflected those who were either highly motivated by coproduction, or conversely, strongly resistant to it.

The decision to use written reflections rather than interviews or focus groups was both pragmatic and culturally attuned. In Singapore's hierarchical healthcare culture, speaking candidly in group settings may be inhibited by deference to authority and fear of reputational risk (Chua, 1995; Quah, 2010). An anonymous, written format lowered this barrier, enabling practitioners to articulate doubts, frustrations, or ambivalences that might not have surfaced in oral formats.

Equally important, the written responses lent themselves to discourse analysis. They captured not only what practitioners said they did, but also how they chose to frame their actions and experiences in words—whether through hedging, assertive claims, moral justifications, or appeals to patient needs. This linguistic attention allowed us to see how practitioners positioned themselves in relation to patients, colleagues, and organisational expectations.

The written format, however, carried clear limitations. First, variability in length meant that some responses offered rich discursive material, while others were little more than gestures toward compliance. Second, the absence of probing limited opportunities to clarify ambiguity or pursue silences; some practitioners engaged deeply, while others withheld their perspectives. Third, restricting responses to written English inevitably excluded practitioners less comfortable with this mode of expression, potentially narrowing the discursive field to those more linguistically confident. Finally, the mandated nature of the training raised the possibility of socially desirable responses, even in anonymous form.

Despite these limitations, the approach offered a valuable window into how practitioners voiced, resisted, or negotiated the ideals of coproduction. In this sense, the study did not claim to capture "practice" directly but to reveal the conditions under which practice was imagined, justified, and constrained.

Taken together, the four studies offered different vantage points on the phenomenon of coproduction. Paper I provided depth through rich, contextualised accounts, exposing the tensions between organisational rhetoric and frontline realities. Paper II, by contrast, offered breadth and measurability, tracing attitudinal change across a large cohort of professionals but raising questions about the translation of numbers into practice. Paper III shifted the focus to patients and caregivers, where storytelling and semantic polarities revealed the layered, sometimes contradictory positions actors inhabit in navigating care systems. Paper IV then captured how practitioners discursively positioned themselves through anonymous reflections, surfacing voices that might otherwise remain muted in hierarchical settings.

The coherence of these studies lies not in their uniformity but in their complementarity. Where one approach illuminated organisational processes, another captured lived experience; where surveys suggested shifts in orientation, qualitative accounts revealed the complexity of enacting such shifts in practice. At the same time, their juxtaposition revealed tensions: between measurement and meaning, between collective narratives and individual voices, between insider authority and participant autonomy. These tensions are not weaknesses but integral to the methodological story of this

dissertation. They demonstrate that studying coproduction requires multiple lenses, each partial, each necessary, and each open to contestation.

4.4. Analysis

4.4.1. Realist evaluation

Paper I employed a realist evaluation approach to make sense of how and why the ESTHER Network was adopted and adapted within Singapore's healthcare system. Realist evaluation, at its heart, is not only about asking what works but about probing *for whom, in what circumstances, and why* (Pawson & Tilley, 1997). This lens was particularly suited to the ESTHER Network, which was introduced into an already complex ecosystem of healthcare reforms, leadership expectations, and frontline practices.

The analysis moved iteratively between theory and data. I began with Initial Programme Theories (IPTs), drawing on existing literature, policy documents, and early stakeholder accounts. These IPTs reflected the "hoped-for" functioning of the ESTHER Network—for example, the assumption that patient stories would inspire cultural shifts towards coproduction of care. Yet early data quickly complicated these neat assumptions, surfacing questions about organisational readiness and competing priorities. This iterative tension between expectation and experience underscored the value of a realist lens, which insists that programmes never operate in isolation but are always mediated by context (Pawson, 2013).

To structure data collection and analysis, an interview guide, observation guide, and preliminary codebook were developed using Greenhalgh et al.'s (2004) *Diffusion of Innovations in Service Organisations* framework. This framework was chosen for its explanatory strength in service systems: it offered not only a taxonomy of factors influencing adoption, spread, and sustainability, but also foregrounded the roles of actors, networks, and contextual layers in shaping outcomes. Its emphasis on system complexity was particularly resonant for SingHealth, a cluster spanning diverse professions, institutions, and patient groups.

All interviews and focus groups were transcribed verbatim, resulting in approximately 250 pages of textual data. In line with Creswell and Creswell's (2017) guidance on enhancing qualitative credibility, transcripts were returned to participants for validation, reinforcing the interactive ethos of this research (Svensson et al., 2007). The initial codebook was piloted by two independent coders on two transcripts, then refined to simplify and improve consistency. Thereafter, all interviews, focus groups, and observations were deductively coded in NVivo V.12.

At the same time, the analysis retained space for new themes to be added to the codebook when existing categories proved insufficient, treating the diffusion framework as a sensitising heuristic rather than a rigid template (Greenhalgh et al., 2004). Contextual factors were further classified across macro-system, meso-system, and micro-system levels, enabling us to examine how organisational hierarchies and local practices intersected.

The realist triad of context, mechanism, and outcome (CMO) provided the backbone of interpretation. Codes and themes were mapped against this structure to develop explanatory configurations. For instance, one CMO Configuration (CMOC) showed how leadership endorsement (context) activated practitioner confidence and legitimacy (mechanism), resulting in greater willingness to experiment with patient-partnered improvement initiatives (outcome). Another highlighted how competing organisational reforms (context) dampened frontline engagement (mechanism), leading to slower diffusion of ESTHER Network principles in practice (outcome). In this way, CMOCs moved the analysis beyond description, allowing us to surface causal patterns across system levels.

Rigour was strengthened through collaborative coding. Four transcripts—one from each major informant group (decision-makers, programme implementers, service practitioners, and service users)—were coded by a subgroup of authors. Thematic patterns were then refined collectively with all co-authors. Documentary sources, including ESTHER Network reports and statistics, were analysed in parallel to triangulate findings and corroborate or challenge emergent CMOCs.

Conducting analysis as an insider researcher brought both affordances and risks. My familiarity with ESTHER Network enabled me to perceive nuances

and implicit references that might elude an outsider. Yet this same familiarity risked blinding me to alternative interpretations or privileging narratives that resonated with my own leadership experience (Coghlan, 2019). Collaborative coding and regular discussion with co-authors were therefore essential safeguards.

The use of the Diffusion of Innovations framework also posed tensions. While it provided a valuable starting point, its conceptual categories risked imposing linearity on a process that in reality was messy, iterative, and relational. I had to consciously treat it as a heuristic device rather than a prescriptive model (Greenhalgh et al., 2004). Similarly, the construction of CMOCs required inferring mechanisms that were not directly observable. This inferential leap was intellectually generative but also precarious, requiring careful grounding in participant quotations and iterative validation with the research team (Pawson, 2013).

Finally, the timing of data collection during the COVID-19 pandemic complicated attribution. Shifts in practice could not always be neatly attributed to ESTHER Network, as broader system-level upheavals shaped behaviours and priorities in profound ways. Acknowledging this limitation was necessary, as it reflected the "real-world" complexity that realist evaluation insists on grappling with rather than smoothing away (Pawson & Tilley, 1997).

In sum, the analytic process was systematic yet reflexively aware of its limits. By weaving together diffusion theory with realist CMO logic, the analysis sought to generate both explanatory depth and practice-relevant insights, while remaining attentive to the positional and contextual dynamics that shaped how knowledge was produced.

4.4.2. Quantitative repeated-measures

Paper II assessed the impact of ESTHER Network person-centred care training on practitioners' attitudes using the Patient–Practitioner Orientation Scale (PPOS) (Krupat et al., 2000). The PPOS was chosen because it provides a compact, validated measure of person-centred care orientation across two

theoretically meaningful subscales: Sharing and Caring (Haidet et al., 2002; Krupat et al., 2000).

I adopted a single-arm, pre–post analytic strategy because the primary purpose of this study was pragmatic: to examine whether a brief advocacy training could shift attitudes among busy, multi-professional practitioners in a mandated organisational context. A randomized controlled design was neither feasible nor ethically straightforward, as withholding training from certain staff would conflict with institutional priorities and risk inequity. The single-arm design, by contrast, allowed us to assess change over time while maintaining inclusivity and ecological validity (Creswell & Creswell, 2017).

An important cultural consideration shaped interpretation of the PPOS subscales. While both Sharing and Caring are integral to person-centred care, Caring is particularly aligned with Singapore's socio-cultural norms. In a society influenced by communitarian values and Confucian traditions, professional virtue is often expressed through duty, benevolence, and attentiveness to others' wellbeing (Chua, 1995; Quah, 2010). Consequently, practitioners may more readily endorse Caring items—such as attending to patients' emotions and treating them holistically—because these behaviours resonate with prevailing expectations of "good" professional conduct. By contrast, Sharing, which emphasises negotiation of power and explicit patient autonomy, may encounter more tension within hierarchical healthcare relationships. Recognising this cultural alignment was critical in interpreting score changes, as improvements on Caring may reflect both attitudinal and socially reinforced norms, whereas gains in Sharing could be more contingent on organisational structures and professional hierarchies.

Given that the original PPOS thresholds were derived from a predominantly White, New England physician cohort (Krupat et al., 2000), applying them directly to the Singapore context risked cultural mismatch. To ensure local relevance, we ranked baseline Overall PPOS scores and split them into tertiles (High ≥ 4.50; Medium > 4.06 to < 4.50; Low ≤ 4.06), following the distribution-based approach used in early validation studies. This stratification served multiple purposes: it supported ordinal modelling for longitudinal analysis, provided interpretable categories for organisational stakeholders

(e.g., “movement from Low → Medium”), and embedded the analysis within the local professional culture.

The analytic pathway combined conventional and contextualised steps. Descriptive statistics established participant profiles and baseline person-centred care orientations, including subscale scores. Paired-sample t-tests examined changes across the three time points (pre-training, immediate post-training, and three months post-training). Subgroup analyses further explored potential differences by profession, sex, and work experience. Statistical significance was set at $p < 0.05$.

While results showed statistically significant and seemingly encouraging improvements in PPOS scores, interpretation required caution. Higher scores indicated a shift in attitudes toward person-centred care, but did not necessarily translate into changed behaviours in daily practice. Several participants reflected that they had learned “what to say” on surveys but remained uncertain about enacting these principles amid constrained clinical routines. From a reflexive standpoint, the analysis was therefore understood not as definitive evidence of behavioural change but as an indicator of receptiveness to person-centred care principles—a first step toward fostering the relational and coproduced practices central to the ESTHER Network (M. Batalden et al., 2016; Ostrom, 1996).

4.4.3. Narrative analysis using positioning theory

Narrative analysis provides a complementary focus on how stories generate shared understanding and moral meaning. Drawing on Kleinman (1988), narratives are seen as interpretive acts through which people make sense of suffering, care, and relational obligations. Stories are not passive reflections of reality but active frameworks that shape how experiences are understood and acted upon. In healthcare contexts, illness and care narratives reveal not only personal trajectories of pain, recovery, and resilience but also the social structures and cultural norms that organise these experiences. Extending this perspective, De Fina and Georgakopoulou (2011) conceptualise narratives as *interactional practices*—co-constructed in everyday talk rather than confined to neatly bounded stories. From this view, the “small stories” told in ESTHER Cafés, team meetings, and project discussions illuminate how actors locally

interpret and adapt the model, negotiating tensions between rhetoric and practice, or between tokenistic and genuine enactments of coproduction. It was particularly appropriate for this study because it made visible how entrenched hierarchies of power and deference—longstanding features of Singapore's medical culture—shaped lived realities of coproduction. Participants' stories did not simply recount experiences but offered insight into how voice, silence, and negotiation were produced within encounters.

Positioning theory provided a powerful analytical framework for this task. Rather than treating narratives as transparent accounts, positioning theory attends to how narrators locate themselves and others within webs of rights, duties, and identities (Davies & Harré, 1990; Harré & Van Langenhove, 1999). In this study, it allowed me to see how participants actively constructed roles for themselves—sometimes affirming dominant norms of medical authority, and at other times unsettling them by asserting claims to recognition and voice.

The analysis unfolded across three levels (De Fina, 2013).

- **Story-world level**: Here, I examined how participants positioned themselves within their narratives. For instance, a caregiver described being "talked over" during consultations, which positioned her simultaneously as silenced (a passive recipient of medical authority) and as resistant (an advocate insisting that her father's care should reflect her perspective). These positionings illuminated how patients and caregivers oscillated between deference to expertise and assertion of agency.

- **Interactional level**: At this level, I traced how participants positioned themselves within the focus group exchanges and in relation to the facilitators. In one case, a patient softened criticism of hospital bureaucracy by prefacing his point with alignment to another participant: "Like what she said, I also felt small." This revealed how solidarity and caution were coproduced, with participants carefully negotiating authority even in peer settings. My role as researcher was also implicated; participants sometimes subtly invited alignment or shared critique; other times, they deferred to me.

- **Macro-system level**: The above reflected broader cultural scripts of respect for authority and the desire to avoid open contestation. Narratives were also read against cultural discourses of collectivism, and medical paternalism in Singapore (Chua, 1995; Hiu et al., 2020; Lee et al., 2008). These wider frames influenced how participants positioned themselves: some reinforced the normative expectation that doctors "know best," while others unsettled it by foregrounding their right to co-determine care. The ESTHER Network provided a space in which such counter-claims could be voiced, albeit within the enduring pull of hierarchical traditions.

To deepen this analysis, I used semantic polarities (Coghlan, 2019) as a heuristic to map the shifting positions participants occupied—for example, moving along axes such as dependence–independence, passivity–agency, or silence–voice. This helped reveal how participants navigated contradictory pulls: on one hand, cultural norms that valorised deference; on the other, their own lived imperatives to advocate for loved ones and to be recognised as partners in care.

Member checking was incorporated to strengthen interpretive validity, though even this process reflected positioning dynamics. Some participants deferred to my interpretations rather than challenge them, underscoring how cultural respect for authority shaped the co-construction of meaning. The ethical tension, therefore, was not only about accuracy of representation but also about whose interpretations were legitimised and whose hesitations remained unspoken.

In this way, positioning theory did not simply help categorise narratives but illuminated how identities and responsibilities were actively negotiated within stories and within the broader socio-cultural terrain of Singapore healthcare.

4.4.4. Discourse analysis

Discourse analysis explores the shared repertoires of meaning through which participants make sense of their practices (Potter & Wetherell, 1987). Language here is not merely descriptive but *constructive*—it creates the very realities in which decisions are made and actions taken. Analysing talk about Esthers, ESTHER Cafés, and improvement projects reveals how new

meanings around care, professional identity, and power are produced and contested. These discursive practices expose the contradictions and tensions inherent in translating a Western-originated model of coproduction into Singapore's socio-cultural context.

Paper IV turned to the written reflections of 280 practitioners, gathered anonymously through open-ended questionnaires three months after training. In total, 840 texts were generated. The respondents spanned professions, including nurses, allied health professionals and doctors. This interprofessional spread was central to the analytic intent: discourse analysis seeks the *shared repertoires of meaning* through which participants make sense of their practices (Potter & Wetherell, 1987). Discourse analysis was chosen because it enabled me to move beyond "what" practitioners claimed to have done differently, to *how* they used language to frame responsibility, agency, and the feasibility of coproduction in the Singapore healthcare context. In a system marked by hierarchical relations and deference to authority (Chua, 1995; Quah, 2010), the words practitioners selected—whether hesitant, assertive, or metaphorical—offered a window into how change was imagined, legitimised, and at times resisted.

The analysis unfolded in several phases. First, I engaged in repeated close readings of the texts, distinguishing between longer narrative accounts (descriptions of specific encounters with patients or families) and shorter opinion statements (general perspectives on coproduction). At the outset, I sorted reflections by professional group, anticipating differences between doctors, nurses, and allied health professionals. However, as the analysis progressed, occupational distinctions proved less salient than the discursive patterns that cut across roles. This realisation prompted me to regroup responses thematically rather than professionally.

The next phase involved detailed linguistic attention. Following Potter and Wetherell's (1987) framework, I noted:

- **Keywords and metaphors**: Practitioners frequently drew on the language of "bridges" and "barriers," metaphorically casting coproduction as a journey requiring passage across obstacles.

- **Pronouns and verbs**: Shifts between "we" and "they" were especially telling, as in the formulation "We try to involve them, but they don't always understand." Such phrasing aligned practitioners with professional logic while positioning patients as outsiders to that world. Verbs such as "listening," "talking," and "explaining" dominated, suggesting that communication was viewed as the core site of change.

- **Attributes and roles**: Practitioners described themselves as "guides," "supporters," or "decision-makers," while patients were variously positioned as "partners," "learners," or "dependents." These attributions revealed the implicit rights and duties assigned to different actors within care encounters.

- **Emotion words**: Expressions of frustration, hope, pride, and fatigue punctuated the reflections, underscoring that coproduction was not experienced as a neutral technical adjustment but as affectively charged work.

As I moved iteratively between immersion and analytic distancing, contradictions and tensions began to surface. Practitioners often voiced enthusiasm for coproduction in principle, but this was tempered by accounts of conflict, hesitation, or systemic barriers that rendered ideals difficult to realise. This interplay of affirmation and constraint became central to the mapping of interpretive repertoires.

Three dominant repertoires structured the practitioners' accounts:

- **Communication as change**: The most pervasive repertoire cast coproduction primarily as a matter of communication—listening, talking, explaining, and sharing information. Change was thus discursively reduced to shifts in style and dialogue, rather than structural redistribution of power.

- **Emotional labour**: Practitioners framed coproduction as emotionally demanding, requiring patience, empathy, and resilience. While many valued this as "good care," they also described it as draining and difficult to sustain amid heavy workloads.

- **Practical constraints**: Repeated references to time pressure, workload, and bureaucratic rigidity served to qualify commitments to coproduction. Here, structural constraints were mobilised discursively to temper ideals with pragmatic realism.

The decision to privilege written reflections was both enabling and limiting. On one hand, the anonymity afforded candour: practitioners could voice frustrations and scepticism that might not have surfaced in interviews or workshops, given cultural norms of deference. On the other, the format precluded probing; silences and brevity remained uninterrogated, leaving some meanings only partially accessible.

Ultimately, discourse analysis did not yield a tally of supportive versus resistant voices but illuminated the patterned ways practitioners articulated coproduction. These repertoires revealed the tensions—between ideals and routines, empathy and exhaustion, empowerment and constraint—that constitute the lived complexity of embedding coproduction in Singapore's healthcare system.

Across the four studies, analysis did not proceed in isolation from politics, culture, or my own role as insider-researcher. Each method brought particular affordances: realist evaluation structured explanatory logics; statistical tests offered measurable shifts; positioning theory illuminated identity work; and discourse analysis exposed collective sense-making. Equally, each method had limitations—partiality, potential bias, or interpretive dilemmas. Rather than seeking to smooth over these differences, the analyses together narrate the complexity of studying coproduction: a phenomenon that is never reducible to numbers, stories, or texts alone, but must be approached through their interplay.

4.5. Ethical considerations

A central ethical challenge I grappled with throughout this action research journey was maintaining impartiality and managing the potential for researcher bias. As the primary driver of the programme, I was emotionally invested in its success—an investment that could cloud my judgment, reinforce implicit assumptions, or lead me to overlook areas of difficulty

(Svensson et al., 2007). This tension was compounded by my leadership role within the ESTHER Network, which created the risk of response bias, as participants—particularly healthcare practitioners and service users—might have felt compelled to provide overly positive feedback.

To address these risks, I anchored the research in the ethical principle of safeguarding credibility and trustworthiness (Hsieh & Shannon, 2005). Several strategies supported this aim. In Paper I, supervisors unaffiliated with the ESTHER Network were engaged as external researchers, providing outsider perspectives that counterbalanced potential internal bias—a form of investigator triangulation. Participant validation was another key measure: interview transcripts were shared with participants, whose feedback and amendments were welcomed and incorporated. Emerging findings and programme theories were also presented at ESTHER Network meetings, where they were critically reviewed by ESTHER champions and service users to ensure that themes reflected lived realities rather than researcher assumptions. In Paper II, I further minimised bias by delegating questionnaire administration to team members not directly involved in delivering the training, thereby separating intervention delivery from data collection and reducing the likelihood of social desirability in participants' responses.

Reflexivity was a constant thread throughout both studies. I used journaling as a core practice, critically examining how my dual position shaped interpretation. Before analysing data, I recorded my assumptions (e.g., "service users will describe ESTHER Cafés as beneficial"; "training will improve practitioners' knowledge"). Making these explicit helped me recognise contrasting findings as meaningful rather than dismissing them as outliers. My reflexive journal contained two parallel streams: coordinator notes (tasks, strategies, challenges) and researcher notes (observations, insights, emotional reactions). This separation highlighted when professional commitments seeped into interpretations. Regularly sharing emerging analyses with supervisors and colleagues not involved in ESTHER Network offered further checks on whether my interpretations leaned towards advocacy rather than critical examination. Such practices acted as mirrors, deepening self-awareness and grounding my ethical commitment as a researcher (Dodgson, 2019).

Beyond individual reflexivity, I came to recognise that ethical insider action research requires foundational conditions: adequate experience, prolonged engagement, sufficient resources, and institutional support (Svensson et al., 2007). In my case, because the research was concurrent with the running of ESTHER Network, I benefitted from deepening knowledge as engagement unfolded. Yet each condition also presented dilemmas. For example, prolonged engagement blurred boundaries between clinical care and research, raising questions of informed consent; institutional support offered legitimacy but created subtle pressure to present findings in ways aligned with organisational expectations. Without such conditions, action research risks being ethically compromised or practically unsustainable.

Conducting research within one's own organisation also brings vulnerabilities beyond formal protocols (Buchanan & Boddy, 1992). Everyday decisions carried ethical weight: how to manage conflicts of interest, navigate power dynamics, or report sensitive findings without jeopardising organisational trust. At times, I wrestled with whether to present results that might cast the organisation in a difficult light, or to soften them in the interest of loyalty. As (Coghlan, 2019) observes, ethical action research demands courageous leadership—the willingness to ask uncomfortable questions, challenge the status quo, and act with authenticity while remaining politically astute. For me, this meant acknowledging personal discomfort, being open to critique, and reframing resistance not as failure but as a site of organisational learning.

Working with patients added another layer of ethical sensitivity. Service users often shared deeply personal experiences of suffering and vulnerability. In my dual role as practitioner and researcher, I was mindful of interpreting these stories with care. Here, triangulation with co-researchers who were not programme drivers helped ensure that participants' accounts were analysed respectfully and rigorously. Balancing advocacy and inquiry required constant attention to subjectivity and relational ethics (Banks & Brydon-Miller, 2018). At times, this balance was difficult to sustain; I experienced periods of uncertainty, even burnout. Yet these struggles became sources of growth, teaching me that the proximity of insider research, while fraught, also enables profound learning about change processes as they unfold in practice (Mockler, 2014).

The longitudinal nature of this study underscored the complexity of both organisational and personal change. Initially motivated by structural improvement perspectives, I was challenged to re-examine my work through a social work lens. This shift created space for theoretical enrichment, for example, the use of positioning theory in Paper III to illuminate how service users and providers attribute roles and identities to one another. Such spirals of learning reflect the maturation of both the research and the researcher, and demonstrate how reflexivity and ethics are interwoven in action research.

Finally, in accordance with standard ethical research practice, approval was obtained from the SingHealth Centralised Institutional Review Board (Reference numbers 2020/2341 and 2021/2064). All participants were fully informed about the research purpose, procedures, risks, and their rights. Information was communicated verbally and in writing, in line with the Declaration of Helsinki. Participation was voluntary, with assurances that declining or withdrawing would not affect care or standing in the healthcare system. Written informed consent was obtained prior to data collection. Confidentiality and anonymity were maintained, with data stored securely and personal identifiers removed to protect privacy.

5. Summary of the Findings

The four studies together provide a layered account of how coproduction was introduced, interpreted, and enacted within Singapore's healthcare system through the ESTHER Network. They capture the interplay of policy imperatives, organisational processes, practitioner attitudes, and patient experiences, while also reflecting on the researcher's role as an insider in shaping the process.

5.1. Paper I

The idea for this first study grew out of several premises central to this dissertation: that coproduction is never introduced into a vacuum, that its meanings are shaped in dialogue between policy, organisational priorities, and everyday practice, and that cultural and relational dynamics profoundly affect how it is taken up. Building on recommendations from prior research, I sought to examine how a Western innovation, the ESTHER Network, travelled into the Singapore healthcare system, and what happened when it encountered the local realities of hierarchy, performance orientation, and collectivist cultural values.

The research was guided by a realist evaluation framework, allowing me to attend to how contextual conditions activated particular mechanisms of change across macro-, meso-, and micro-levels. This approach was not only methodological but also conceptual: I was interested in how "coproduction" was being constructed at different levels of the system, and what implications this had for the possibility of it in Singapore.

The analysis revealed that, at the **macro-level**, national demographic shifts and health policy priorities created a receptive space for the introduction of ESTHER Network. The model's emphasis on patient involvement and outcomes aligned with Singapore's ageing challenge and the government's shift toward community-based care. Leadership endorsement amplified this resonance, but it also framed ESTHER Network largely as a solution to systemic pressures, sometimes obscuring its more relational and dialogical ambitions.

At the **meso-level**, organisations translated policy aspirations into structured roles and processes. The establishment of ESTHER coaches and formal training was instrumental in connecting policy ideals with practice realities. These initiatives produced a sense of ownership among staff and encouraged cross-disciplinary collaboration. Yet, this structuring also raised questions: did formalisation preserve the spirit of coproduction, or risk narrowing it into another managerial programme?

At the **micro-level**, the everyday practices of storytelling and ESTHER Cafés created openings for genuine dialogue between patients and professionals. These spaces allowed relational trust to develop and positioned patients not as passive recipients but as partners in care. Patients' stories, particularly the figure of "Mdm Teo," humanised systemic challenges and made coproduction emotionally resonant. Tangible improvements, such as reduced hospital stays, were reported. Yet even here, tensions surfaced—between professional authority and patient's voice, between enthusiasm for new practices and the weight of existing norms.

The study identified the interplay of structural supports, narrative practices, and leadership endorsement. It showed how leaders, practitioners, and patients understood coproduction differently, producing both alignment and friction. Attending to cultural and relational dynamics, it revealed how hierarchy and deference shaped participation, while also showing how storytelling could make coproduction locally meaningful. Finally, reflexive insights emerged as I navigated my insider position: balancing polished institutional narratives with less comfortable accounts of resistance, and reflecting on how my role mediated which stories gained prominence.

This first study thus anchored the dissertation. It showed that the adoption of ESTHER Network in Singapore was not a technical import but a negotiated cultural translation, one that highlighted both the possibilities and dilemmas of introducing coproduction in a hierarchical and performance-driven context. The insights developed here set the stage for the subsequent studies.

5.2. Paper II

The second study turned its focus to the professional side of coproduction, investigating whether a short person-centred care advocacy training could shift practitioners' attitudes in the SingHealth system. At stake here was an important dimension of the dissertation's aim: whether the introduction of coproduction required not only new structures and processes but also attitudinal change among those tasked with delivering care.

Using a repeated-measures design, 437 participants completed the Patient-Practitioner Orientation Scale (PPOS) before, immediately after, and three months following the training. This scale assessed two dimensions central to coproduction: *Caring*—treating patients as whole persons, and *Sharing*—involving patients in decision-making. Results showed clear, if uneven, movement. Immediately post-training, significant improvements were observed in both dimensions, though gains were more marked in *Sharing*, suggesting that training could begin to shift long-standing professional assumptions about expertise and power. Yet, by the three-month follow-up, some of these improvements had diminished, pointing to the fragility of attitudinal change in the absence of broader cultural reinforcement.

The findings spoke directly to the dissertation's sub-questions. Paper II revealed that short-term interventions can spark attitudinal shifts, but sustaining these shifts requires ongoing organisational and cultural support. Variations across gender and professional role showed how coproduction was differently understood and internalised: female and allied health professionals were more receptive to relational and participatory dimensions, while others remained more resistant. These patterns highlighted the influence of cultural and relational dynamics, as hierarchical traditions within Singapore's healthcare system constrained the sharing of power even when practitioners were willing. Reflexive insights emerged as I confronted the limits of training: the enthusiasm generated in workshops contrasted with the slow-moving institutional realities I observed elsewhere in the system.

Paper II demonstrated that while education can act as a catalyst for change, it cannot by itself dismantle entrenched hierarchies or sustain relational transformation. Its contribution lies in revealing both the potential and the

limits of training as a mechanism for change, underscoring the necessity of structural and cultural supports if coproduction is to move beyond momentary enthusiasm. From a realist perspective, however, the mechanism at work is not the training event itself but the *generative forces* it sets in motion—such as reflection, recognition, and motivation—which, under particular contextual conditions, give rise to the observed effects (Bhaskar, 2015; Pawson & Tilley, 1997). Recognising this distinction is crucial for understanding how interventions interact with deeper social structures. Building on this insight, Paper IV extends the inquiry by examining how these generative mechanisms unfold over time.

Dichotomising the PPOS to empirically derived cut-offs contextualised findings to the population but reduces statistical precision and comparability across studies. The rationale was to align to previous work (Krupat et al., 1999). On reflection, modelling the PPOS as a continuous outcome e.g. using linear or ordinal mixed models, would yield more precise estimates and avoid arbitrary thresholds. The PPOS scores at different timepoints are based on separate waves that were followed over time. There were no overlapping samples between waves.

5.3. Paper III

The third study shifted the lens towards patients and caregivers, asking how they related to professionals and positioned themselves in the coproduction process. If Paper II highlighted the practitioner side of transformation, Paper III underscored the necessity of recognising patient voices—not as abstract "stakeholders," but as individuals whose lived experiences shaped their willingness and capacity to engage in shared change. Here, the positioning process itself became the unit of analysis, tracing how patients and caregivers constructed, negotiated, and sometimes resisted the identities and roles made available to them in coproduction encounters. This focus revealed not only how participants articulated their own agency but also how professional discourses and institutional norms constrained or enabled particular forms of participation.

Findings revealed a layered process. At the first level, patients and caregivers often began by recounting personal stories marked by frustration, hurt, or

disempowerment. These emotionally charged accounts showed that meaningful coproduction could not be expected without first acknowledging and validating such experiences. At the second level, participants described tensions in knowledge and authority. The question of "who knows best"—professionals with technical expertise or patients with experiential knowledge—surfaced repeatedly. At the third level, some participants moved beyond their individual experiences, repositioning themselves as advocates for collective change. This shift from personal trauma to collective agency signalled the transformative potential of coproduction, but also its complexity: not everyone reached this stage, and the journey depended on recognition, trust, and relational openness.

The findings revealed that mechanisms of change include not only structural supports but also emotional validation and recognition of lived experience. Patients demonstrated that their engagement was shaped by prior experiences and the openness of professionals to treat them as equal partners. Cultural and relational dynamics were again central: in a hierarchical system like Singapore's, patients required safe dialogical spaces—such as those provided by the ESTHER Cafés—to voice perspectives that would otherwise remain unheard. From a reflexive standpoint, the study reminded me that inviting patient participation is insufficient without creating the relational conditions for trust; as an insider, I had to ensure these spaces did not reproduce tokenism but enabled genuine dialogue.

Paper III thus underscored that coproduction is neither automatic nor evenly distributed. It requires emotional work, structural scaffolding, and cultural negotiation to move from individual storytelling to collective action.

5.4. Paper IV

The fourth study examined how healthcare practitioners themselves made sense of coproduction in their everyday work. If Paper II captured attitudinal shifts and Paper III explored patient engagement, Paper IV revealed the discursive practices through which practitioners enacted—or limited—the meaning of coproduction.

The analysis identified three dominant themes. First, coproduction was often understood as a *communicative strategy*: practitioners equated it with improved listening, showing empathy, or "being nicer," without necessarily shifting power or decision-making. Second, it was framed as an *emotional change*: practitioners described satisfaction and reward from positive patient reactions, but often in ways that reinforced their own control. Third, coproduction appeared as an *individual struggle*: practitioners who tried to adopt it faced systemic barriers such as bureaucracy, time constraints, and professional norms. Success depended heavily on individual commitment and patient characteristics, raising questions of equity and sustainability.

Paper IV showed that discursive practices themselves acted as mechanisms—both enabling and constraining coproduction. Practitioners' accounts revealed that coproduction was often reduced to communication style rather than shared power. The study also highlighted cultural and relational dynamics: entrenched hierarchies and systemic inertia meant practitioners internalised the burden of change, resulting in emotional highs, burnout, or frustration. From a reflexive perspective, I recognised how rhetorical endorsement of coproduction at leadership levels contrasted with its limited enactment in practice, raising uncomfortable questions about whether the initiative risked becoming performative.

Overall, Paper IV illuminated the tension between rhetoric and reality. While coproduction was widely celebrated in discourse, its practice remained constrained, often reinforcing rather than dismantling hierarchies of care. This underscored the dissertation's central argument: that the translation of coproduction depends not just on training or policy alignment but on deeper cultural and relational transformation, supported by structural change.

6. Synthesised Results: A Meta Process of Change Model for Coproduction

Synthesising findings across the four studies, the process of introducing coproduction through the ESTHER Network in Singapore culminates in the *meta-process of change model for coproduction* (Figure 4). This model extends Bateson's concept of higher-order learning to illustrate how healthcare systems adapt, learn, and self-transform over time (Bateson, 1972).

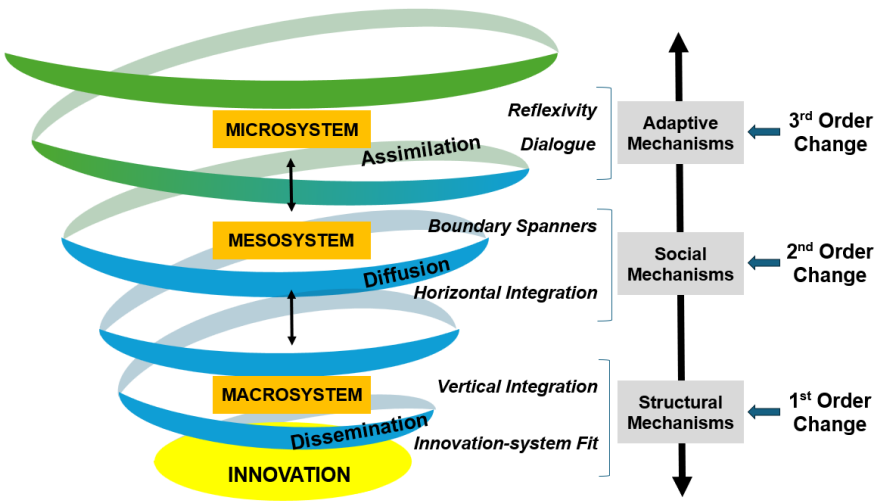


Figure 4. A meta-process of change model for coproduction.

6.1. Vertical and horizontal integration

The study found that both vertical and horizontal integration were applied in the change process. Vertical integration was evident in the top-down

dissemination strategies during the early adoption phase, including the establishment of clinical champions, training programmes, project sponsors, and administrative teams, with the goal of aligning all institutions within SingHealth under a unified structure. Empirical findings illustrated these: *"we have more sub-committees and different people looking at different aspects […] this is one of our strengths because then there are dedicated attention and manpower to look into different aspects of this big network"* (Paper I, programme implementer/Allied Health). This reflects Goodwin's (2016) notion of shifting from passive recognition to active coproduction, where system-level leadership initiates structural reforms that pave the way for meaningful collaboration. However, as Brandsen & Honingh (2016) argue, true coproduction emerges when managers, service users and frontline professionals actively shape the service through shared learning and localised decision-making: *"when […] they first presented the concept of ESTHER Network […] I see it as the birth of ESTHER Network in SingHealth […] it encapsulated what we had been hoping to achieve […] and not just what we have been doing all these years, kind of assuming we knew what patients needed. That point of learning about this together […] was a big "aha" moment to me. […] That all of us saw it, felt it, heard it, wanted it, believed in it"* (Paper I, decision-maker/Health Administrator). These elements are more aligned with the study's horizontal integration efforts. The adaptation phase marked a deliberate turn toward this bottom-up model, incorporating feedback loops, dialogue, and self-organisation supported by advocacy training, thereby empowering ground teams to tailor the innovation to local contexts and challenge their own assumptions: *"one thing I remember vividly about the training was, we were asked to shadow the Esthers to identify their pain points […] So this is a bit different from the norm where we come in with ideas, we assume we know the answer.[…] But in the end, it was very enlightening. You feel better because you know you churned out solutions with the input of the people that you are trying to help. And you're more convinced that you will probably make an impact because you get a voice from them"* (Paper I, practitioner/Doctor). While the vertical approach provided necessary scaffolding for consistent implementation, it risks overlooking the nuances of ground-level dynamics without mechanisms for sustained dialogue. In contrast, the horizontal approach fostered adaptability and ownership among stakeholders: *"the part about meeting like-minded people encouraged all to*

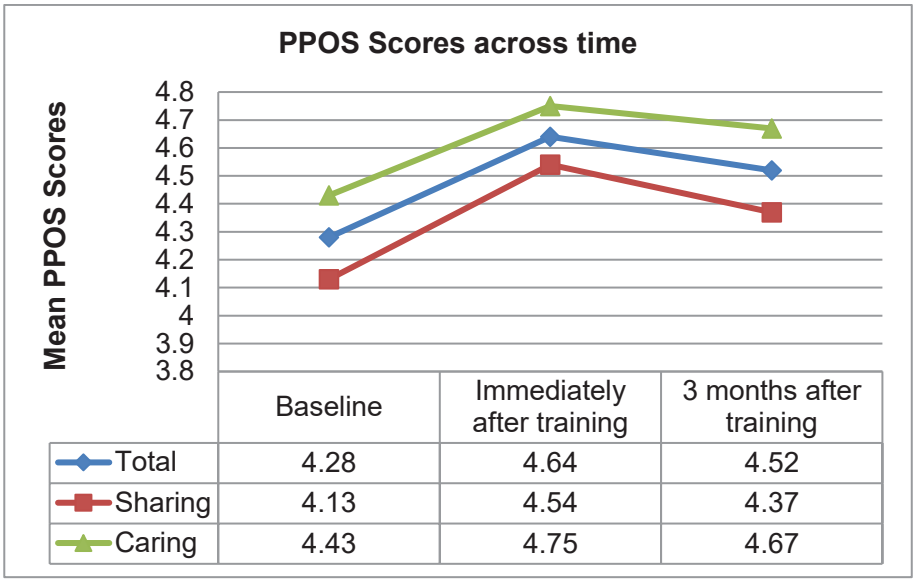
come together to work through all these things" (Paper I, programme implementer/Allied Health). The study contributes new knowledge by demonstrating how both integration strategies can be sequentially and complementarily deployed to balance systemic coherence with contextual sensitivity.

6.2. Innovation-system fit

Despite efforts toward both vertical and horizontal integration, achieving a robust innovation-system fit remains a persistent challenge in this study. Greenhalgh et al. (2004) emphasize that sustainable innovation depends on a dynamic process of mutual adaptation between the innovation and the system into which it is introduced. The innovation was selected because of the clear fit: *"the thing about ESTHER is there was a convincing story […] this is what we want for the people"* (Paper I, decision maker/Health Administrator). ESTHER Network was also deemed a "powerful", "explicit" concept – the "simplicity of it" resonated with our people (Paper I, programme implementer/Allied Health). While the study revealed considerable adaptation of the innovation itself, there was less evidence that the system had reciprocally adapted in response. This was shown in service user's feedback: *"so far, the ratio of importance is not given to the patient"* but *"aimed at productivity"* (Paper III, Case 2/Patient). Leadership expressed a clear commitment to coproduction; however, entrenched cultural norms—such as a continued reliance on performance targets, standardised practices, and legacy benchmarks—served to reinforce existing ways of working.

This tension between aspirational reform and deeply embedded institutional behaviours is not unique to this context but represents a universal challenge across healthcare systems. Greenhalgh et al. (2004) acknowledge that even in the presence of visionary leadership, legacy performance frameworks can obstruct the meaningful translation of innovation into practice. Similarly, M. Batalden et al. (2016) argue that transitioning from provider-centric systems to coproduced models of care is frequently hampered by organisational inertia and established routines: coproduction was described as needed *"muscle rewiring"* to do (Paper IV, practitioner/Doctor). It demonstrated that coproduction required substantial re-learning – it is not a concept that

practitioners were immediately familiar with or trained for. This was corroborated by findings from Paper II where short-term structured training showed potential for change in person-centred orientation of practitioners immediately after training, but there was attenuation of the scores after three months (Chart 1). Although the scores were still significantly higher than baseline (prior to training), they triggered reflections that beyond learning, what kinds of un-learning and re-learning need to be conducted for coproduction to proceed.



	Baseline	Immediately after training	3 months after training
Total	4.28	4.64	4.52
Sharing	4.13	4.54	4.37
Caring	4.43	4.75	4.67

Chart 1. Relationship over time between PPOS scores (Overall, Sharing and Caring) and the advocacy training. #PPOS = Patient-Practitioner Orientation Scale.

Another participant described coproduction as "*a bit more work and a little less reward because there will be less statistics [to meet target workload]*" (Paper IV, practitioner/Allied Health). In the UK, Boyle & Harris (2009) observe that despite widespread support for coproduction, the dominance of managerialism and target-driven governance often undermines efforts to devolve power to service users. These examples highlight that without intentional strategies to confront and reshape cultural norms, leadership

commitments to coproduction risk remaining rhetorical rather than resulting in genuine transformation.

The study's findings further suggest that while horizontal integration enabled local adaptation, it did not fully bridge the gap between high-level structural frameworks and the lived realities of care delivery—where innovation either takes root or falters. Paper I painted an ideal picture but patients and caregivers showed the actual enactment of coproduction where the care path is still experienced as "*set in stone the moment you are diagnosed*" (Paper III, Case 6/Patient). Practitioners echoed this reality, that the public system *"has way too much red tape to get through…"* (Paper IV, practitioner/Allied Health) and even then, when applied, coproduction was understood as a means to an end, towards efficiency and treatment adherence: *"It makes our care [process] smoother and easier…"* (Paper IV, practitioner/Nurse) and *"patient was more approachable and more open to suggestions…"* (Paper IV, practitioner/Nurse). This points to the need for more than implementation infrastructure; it calls for the cultivation of a learning health system that aligns scientific evidence, organisational culture, and incentive structures to support sustained behavioural change (Institute of Medicine (IOM) Roundtable on Value and Science-Driven Healthcare, 2011).

Importantly, Greenhalgh et al. (2004) also highlight that innovation is more likely to be assimilated when its meaning aligns with the values, beliefs, and experiences of its users. Reflecting this insight, the study evolved to explore how these principles played out in day-to-day care encounters involving service users and practitioners within the micro-system. This micro-level analysis revealed that alignment often occurs through small, relational moments, in which innovation is interpreted, adapted, or even resisted based on local context and lived experience. In doing so, the study not only applies but extends Greenhalgh's framework—offering new insight into the critical role of meaning-making, relational work, and bottom-up adaptation in enabling more responsive, grounded, and ultimately sustainable innovation strategies.

6.3. Boundary spanning roles

Boundary spanners are individuals who operate at the interface between different levels, communicating, understanding, and collaborating across these boundaries (Greenhalgh et al., 2004; Williams, 2002). In this study, the boundary spanning function was particularly evident in the expanded and enhanced role of the champions—specifically middle managers—whose placement in this role was not incidental, but rather strategically aligned with their unique position within the organisational hierarchy. These champions were well-suited to bridge the gap between top-down mandates from senior leadership in the macro-system and the lived experiences of service users and practitioners within the micro-system. Practitioners attest to it and appreciated their bridging role in making a difference: *"the importance comes from the sponsors' ability to provide resources, garner support and just allow things that deviate from the norm to happen"* (Paper I, programme implementer/Allied Health). They played a critical role in translating strategic goals into operational language and in bringing the insights, concerns, and innovations of the frontline back to the leadership. This bi-directional exchange exemplifies boundary spanning learning, which became a key mechanism through which the system adapted and evolved. More critically, they look beyond the traditional silos which was observed by and highlighted by service users: *"I think it's the effort. You all are looking at things from different perspectives [holistically]. You are a pharmacist and yet you can look into other things and I think that is very important"* (Paper I, Caregiver).

Coaches and champions in this study leveraged ESTHER cafés—where service users share their stories of the care journey, which can sometimes be met with disagreements from care practitioners. Service users observed that *"the ESTHER cafés were not so much like getting something out of you"* (Paper III, Case 7/Patient) and see hope through the ESTHER café: *"however, for the ESTHER café, I believe that with everyone coming in together, we can change the future or the trajectory for patients, for caregivers"* (Paper III, C6/Patient). Rather than suppress tensions, these boundary spanners used them as opportunities for reflection and coproduction, echoing Greenhalgh & Papoutsi's (2019) view that well-managed conflict can spark innovation and deeper system learning. Adopting an open systems perspective, the study showed that training programmes, project structures, and ways of working

evolved iteratively, shaped by feedback and learning facilitated through these roles. This process strengthened stakeholder identity, ownership, and engagement—key features of effective coproduction. Ultimately, the study extends the boundary spanning concept by illustrating how strategically placed middle managers can foster adaptive capacity and relational infrastructure essential for sustaining innovation in complex systems.

6.4. Dialogue

This study found that stakeholder dialogue played a critical role in advancing both individual and organisational understanding of coproduction. Drawing on positioning theory (Harré & Moghaddam, 2003), dialogue is viewed not merely as an exchange of ideas, but as a dynamic social process through which individuals negotiate and re-negotiate their identities, roles, and power relations. In the context of this study, spaces such as ESTHER cafés and project meetings served as dialogical platforms where these negotiations occurred in real time: *"how I see the ESTHER café is […] coming up with a new trajectory for patients, a new alternative. […] to keep people out of it [health system] as much as possible […], give them the best possible chance they can have"* (Paper I, Patient & Caregiver). This was concurred by practitioners: *"that by giving Esthers a platform to share and having their voices heard, they just feel like the care improved […] that in itself is quite empowering…"* (Paper I, programme implementer/Allied Health). These settings enabled service users, practitioners, and middle managers to reflect on their positions, articulate lived experiences, and challenge traditional professional boundaries. This ongoing positioning supported the emergence of more collaborative and relational identities, central to the practice of coproduction.

As stakeholders engaged in these dialogical spaces, their narratives evolved, allowing for discursive shifts that disrupted dominant managerial or professional scripts and opened possibilities for shared ownership and mutual responsibility: *"the one main important role of patients' stories is they tug at the heartstrings and give people reason and motivation to relook at the way they have been doing things for patients"* (Paper 1, programme implementer/Allied Health). These new discourses created a foundation for

rethinking relational dynamics within the system, enabling individuals to move beyond fixed roles and institutional silos.

6.5. Third-order change: A reflexive model for adaptive working

Analysis of data from the four interrelated studies led to the development of a **reflexive model for adaptive working**. The model was derived from the empirical material and reflects the iterative, self-examining nature of insider action research (Coghlan, 2019). It represents how reflection, action, and relational engagement unfolded between service users and practitioners in the context of introducing coproduction through the ESTHER Network in Singapore. The findings highlight that change occurred through situated interactions shaped by specific socio-cultural conditions—factors that often determined whether new practices were assimilated or resisted (Greenhalgh et al., 2004).

Table 5 shows the contrasting orientations of service users and care practitioners observed in this study. Drawing from empirical data, **five dimensions** of **Time**, **Change**, **Discourse**, **Positions** and **Identity** were identified. From the **temporal and positional dimensions**, service users were generally anchored in their past experiences and adopted a longer-term perspective of their care journeys. They tended to be hopeful, emotionally engaged, and deeply invested in organisational change (Paper III). In contrast, care practitioners focused primarily on future risks—such as worsening medical conditions and long-term outcomes—and, faced with high caseloads and episodic contact with each service user, often adopted a professional stance that was more emotionally detached (Paper IV). These divergent orientations partly reflect the influence of systemic structures and professional socialisation.

Table 5

A reflexive model towards adaptive working - understanding the roles and tensions in coproduction

Dimensions	*Service Users*	*Care Practitioners*	*Adaptive Capabilities*
Time (III, IV)	Past *Defined by past interactions*	Future *Clinical outcome-focused*	Present *Healing and new interactions*
Change (I, III, IV)	Better practitioners *Who listen and acknowledge*	Better patients *Who adhere to treatment plans*	Intermediaries *Identify boundary spanners*
Discourse (I, II, III, IV)	Experience *Good health outcomes should not negate effects of the care experience*	Communication *Way of talking, convincing and persuading*	Knowledge *Way of knowing is bi-directional that supports un-learning and re-learning*
Position (II, III, IV)	Personal *Engaged and vested*	Professional *Distant, influenced by professional practice*	Re-positioning *Reflexivity of individuals and organisations*
Identity (I, III, IV)	Vulnerable *Recognise user and professional vulnerabilities*	Vulnerable *Has power but is vulnerable at the same time*	Systemic environment *Enable right conditions and environment in an open system*

Despite such differences, both groups expressed a shared willingness to collaborate. However, their expectations regarding the **outcomes of change** diverged. Service users hoped for *"better practitioners who prioritised the patient's emotions and physical comfort […] she puts herself in our shoes"* (Paper III, Case 3/Caregiver). Practitioners, conversely, aspired for "better patients" who are *"more approachable […] and more open to suggestions and discussions"* and who *"have an understanding of their medical condition"* (Paper IV, Nurse; Allied Health). Implicitly, coproduction seems to call for a

mutual role shift: service users are invited to become more informed and proactive, while practitioners are encouraged to become more emotionally attuned. Yet such shifts are demanding and cannot be achieved through technical fixes alone. The prevailing model—where service users expect practitioners to provide solutions, and practitioners are trained to maintain emotional distance—is self-reinforcing. Overcoming this dynamic requires long-term cultural change that begins with early education about health, empathy, and shared responsibility in care.

From the **discursive dimension**, coproduction was framed by service users as a matter of "good experience" (Paper III) and by practitioners as "good communication skills" (Paper IV). The quantitative findings in this study (Paper II) further indicated that practitioners were more inclined to express care through interpersonal competence than through sharing power or control with service users. Clarifying the distinct roles, expectations, and relational dynamics between these actors is therefore crucial to enabling complex change processes such as coproduction. Emotional undercurrents—anxiety, guilt, fear, and blame—frequently shaped these interactions yet remained largely unacknowledged. Addressing these emotional dynamics, alongside structural inequalities, is vital for supporting both those who experience harm and those who may unintentionally perpetuate it.

The **dimension of identity** revealed that both actors occupy positions of vulnerability. Service users described their healthcare experiences as *"full of suffering and pain"* (Paper III, Patient), while practitioners spoke of the emotional strain of balancing relational fulfilment with workload pressures: *"[Coproduction is] fulfilling, but at the same time, it was more time-consuming, so after that feel-good moment, I had to pick up the pace to clear the backlog of patients waiting"* (Paper IV, Doctor). Here, coproduction is portrayed as an individual struggle that is difficult to do without sacrifice. Change, therefore, is challenging for all involved, regardless of positional power. Both groups require tailored support to navigate the personal and professional demands of coproduction.

7. Discussion

This dissertation examined the process of change involved in introducing coproduction through the ESTHER Network in Singapore. Drawing on findings from four interrelated papers, it traced how change evolved across different phases and levels of the system. In the early stages, formal mechanisms and training interventions (Papers I and II) produced visible effects, establishing foundational awareness and structures for coproduction of care. As engagement deepened, closer inquiry with service users and practitioners (Papers III and IV) revealed the socio-cultural underpinnings that shaped how coproduction was interpreted, negotiated, and enacted in everyday practice. These later studies illuminated the contrasting orientations of practitioners and service users, highlighting the cultural, relational, and linguistic dimensions that influence how collaborative practices take root.

The following discussion with put focus on the interpretations of the findings, practical and theoretical implications, reflections, contributions and limitations.

7.1. Interpretation of the findings

Across the four papers, the dissertation's sub-questions find layered answers.

Paper I established the broader context, tracing how ESTHER Network was adopted and adapted across macro-, meso-, and micro- levels. It demonstrated that coproduction was made possible through alignment with national policy, organisational structures such as coaching roles, and participatory practices like storytelling and cafés. Yet it also showed that tensions between rhetoric and practice were ever-present. This study provided the programme-level framing, foregrounding the mechanisms and contextual conditions through which coproduction entered the Singapore system.

Paper II shifted the lens to individual practitioners' attitudes, exploring whether short advocacy training could reshape orientations towards care and decision-making. It revealed the potential of training to act as a catalyst, but also its fragility in the face of hierarchical traditions and cultural norms.

Compared to Paper I, which emphasised structures and processes, Paper II highlighted the personal and attitudinal dimensions of change, underscoring that mechanisms of coproduction must be reinforced by cultural supports if they are to be sustained.

Paper III introduced the voices of patients and caregivers, demonstrating that coproduction could not be assumed but had to be earned. By surfacing lived experiences of frustration, trauma, and resilience, it revealed that meaningful engagement required emotional recognition and structural scaffolding. This study highlighted how patients moved, at times, from individual grievance to collective advocacy, offering insight into how lived experience could be transformed into a resource for systemic change. It complemented Papers I and II by bringing to the fore the relational and emotional foundations of coproduction.

Paper IV turned once more to practitioners, but with a focus on discourse and practice rather than attitudes. It showed that coproduction was frequently interpreted as improved communication or emotional satisfaction rather than shared power. When enacted more ambitiously, it often remained fragile and dependent on individual effort, constrained by systemic inertia and entrenched hierarchies. Where Paper II suggested the potential of attitudinal change, Paper IV revealed its limits when not accompanied by structural transformation.

The above indicates that mechanisms of change are multi-dimensional, encompassing structural innovations, training, discursive framings, emotional validation, and relational trust. Interpretations and enactments of coproduction varied widely, shaped by role, experience, and institutional context. Cultural and relational dynamics—particularly hierarchies, professional traditions, and the legacy of past experiences—proved to be decisive forces, at times enabling, at times constraining. Reflexively, the research journey illuminated my own role as insider, both facilitator and interpreter, navigating between institutional rhetoric, frontline realities, and patient voices. Sustainable change, therefore, requires alignment across multiple levels—policy, organisation, practice, and lived experience—and that without structural reinforcement, coproduction risks remaining rhetorical or performative.

Building on this synthesis, the findings extend theoretical understandings of change in complex systems. Drawing on Bateson's (1972) distinction between first- and second-order change, first-order change—reflected in diffusion and adoption of innovation (Greenhalgh et al., 2004)—occurred through alignment with policies and organisational mechanisms. Second-order change, in contrast, required shifts in meaning, identity, and relationships, interpreted here through positioning theory. At the micro-level, discourse and narrative analyses highlighted how language and stories of care shape power relations and possibilities for mutual recognition.

Derived from the findings, the **reflexive model for adaptive working** revealed that practitioners and service users engaged in ongoing, often subtle negotiations of authority, expertise, and vulnerability in daily interactions. These exchanges highlighted the relational complexity of coproduction, where professional and experiential boundaries are continually challenged and redefined. Developing adaptive capabilities—both individual and collective—emerged as central to sustaining collaborative work (Greenhalgh & Papoutsi, 2018, 2019, 2021).

At the **interpersonal level**, the data illustrated the emotional and relational work required of both practitioners and service users. For instance, Paper III showed that service users often needed space and time for healing before meaningful participation. Recognising this temporal and affective dimension of readiness is crucial for authentic collaboration. In the same vein, ESTHER coaches and champions served as intermediaries, bridging perspectives, languages, and expectations of practitioners and service users (Paper I). They facilitated the circulation of experiential and professional knowledge across organisational boundaries. Yet knowledge exchange remained largely unidirectional, with professionals often positioned as transmitters rather than co-learners.

At the **individual and collective learning level**, evidence from Papers II, III, and IV indicated that genuine coproduction required substantial unlearning and relearning. Practitioners needed to question habitual hierarchies and control-oriented practices, while service users re-learned to see themselves as active contributors rather than passive recipients. Adaptive capacity,

therefore, depends on willingness to reflect, reposition, and engage in continuous learning.

At the **organisational and systemic level**, structures, incentives, and processes could both enable and constrain coproduction. Synthesising insights from the four studies, five interrelated dimensions—emerging from the reflective actions of practitioners and service users—highlighted tensions in micro-systems, including the negotiation between professional authority and experiential knowledge and the interplay of differing discourses of coproduction.

Coaches and champions further facilitated discursive reframing, using feedback, tensions, and disagreements as resources for reflection and learning. This aligns with Campbell and Grønbæk's (2018) view of dialogue as generative and transformative, supported by local evidence emphasising the role of dialogue in organisational learning under cultural adaptation (Retna & Jones, 2013). Over time, these processes fostered an adaptive organisational discourse, better reflecting inclusion, responsiveness, and co-ownership.

These discursive and dialogical developments strengthened the system's capacity for a robust "innovation–system fit" (Greenhalgh et al., 2004). While structural integration was important, sustained change depended on the negotiation of meaning through everyday interactions (Greenhalgh & Papoutsi, 2019).

The **meta-process of change model** highlights change as dynamic, iterative, and multi-level. It shows that change is driven not only by formal interventions but also by generative mechanisms—recognition, motivation, and responsiveness to context. Boundary-spanning roles act as catalysts, fostering shared understanding and alignment across hierarchical and professional boundaries. Coproduction emerges as context-dependent, shaped by the interplay of individual, organisational, and systemic factors.

In sum, transformation towards coproduction is not achieved through linear implementation of models or interventions, but through recursive cycles of reflection, dialogue, and adaptation across multiple system levels. Change unfolds as a reflexive and relational process, requiring emotional readiness, facilitation, and discursive negotiation. Together, the reflexive model for

adaptive working and the meta-process of change model illustrate how individuals and organisations can learn into change, continuously negotiating meaning, identity, and practice.

This understanding provides a foundation for the following section, which discusses the broader implications of the study for theory, practice, and policy in advancing coproduction within complex health and social care systems.

7.2. Practical and theoretical implications

The study demonstrates that stakeholder dialogue—when approached as a dynamic social process through the ESTHER cafés rather than as a procedural tool—can catalyse deeper shifts in organisational identity, professional roles, and relational norms. Drawing on Harré and Moghaddam's (2003) positioning theory, and Campbell and Grønbæk's (2018) framework of dialogic positioning, the findings show that change unfolds not only through structural interventions but through the co-construction of meaning in everyday interactions. This research contributes to the growing body of evidence that positions dialogue, particularly within ESTHER cafés, as central to systemic transformation. Unlike stepwise change models, this study highlights how ambiguity, disagreement, and emotional tensions can become productive forces for learning and adaptation. Dialogical spaces such as ESTHER cafés and project meetings enabled stakeholders to reflect, reposition, and reconstruct their identities—supporting more collaborative modes of working and relational forms of leadership.

The findings affirm that people respond to change not merely through rational or technical reasoning but through relational, emotional, and contextual positioning (Campbell & Grønbæk, 2018). For healthcare leaders and change agents, this suggests the importance of cultivating **dialogical spaces** that invite reflection, embrace multiple perspectives, and acknowledge the emotional dimensions of change as integral to improvement. Stakeholder dialogue thus emerges not as a supplementary communicative activity but as a generative mechanism (Bhaskar, 2015), through which the meanings and practices of coproduction are constructed and sustained. By creating conditions for participants to articulate experiences, question assumptions, and negotiate professional and personal positions, ESTHER cafés fostered

collective reflection and realignment. In doing so, they enabled the emergence of more collaborative identities and shared understandings of care. Investing in and maintaining such dialogical infrastructures is therefore vital for deepening coproduction—providing the relational capacity required for meaningful and sustainable system change.

Secondly, the discursive practice and shifts observed in this study further underscore the critical **role of language** in shaping institutional realities, a dynamic well established in institutional studies (Potter & Wetherell, 1987). By revealing how particular ways of speaking opened or constrained possibilities, the findings illustrate that language is action. Change is continually constructed and negotiated through everyday talk (Potter & Wetherell, 1987). How discourse constructs social reality was vividly illustrated in the way stakeholders' narratives evolved over the course of the process. As participants reframed care, power, and professional roles, they were able to challenge dominant managerial scripts and craft alternative narratives centred on mutual responsibility and shared ownership. These findings highlight that discourse is not a passive reflection of organisational culture but an active mechanism for transforming it.

The implication is that strategic investments in facilitation, coaching, and narrative development can amplify such discursive work, fostering a more inclusive and responsive organisational culture. This begins with attention to how **knowledge** moves around. In practice, knowledge exchange is not merely one-directional—where experts teach and others learn—but inherently two-way, emerging through dialogue and mutual interpretation. The boundary-spanning roles of coaches and ESTHER champions exemplify this dynamic, as they make sense of, translate, and connect knowledge across organisational silos. Through these interactions, double-loop learning is enabled (Argyris & Schön, 1978), allowing the system to question underlying assumptions and values rather than merely adjust strategies or procedures. These learnings often take shape through recognition of tensions between roles, contradictions between intended and observed outcomes, and the ambiguities inherent in collaborative work. The organisation's capacity to engage with—rather than control—the unpredictability of such knowledge flows creates opportunities for deeper transformation aligned with core organisational and societal values (Bateson, 1972; Coghlan, 2019). This

orientation resonates with adaptive mechanisms of change (Greenhalgh & Papoutsi, 2019), suggesting that organisational developments move beyond traditional mode of training toward ongoing reflexive practice that supports unlearning and relearning. Similarly, change was driven not by the training activity itself, but by the **underlying generative mechanisms**—such as increased empathy, and struggle—that activated the process and produced observable outcomes (Bhaskar, 2015; Pawson & Tilley, 1997). Examining how interventions like training engage with and trigger these deeper social structures helps to reveal how more profound and sustained transformation becomes possible.

Supporting such transformation calls for a learning health system that brings together diverse actors, perspectives, and models (Cribb, 2017). Such a system must be responsive and context-aware—capable of engaging with individuals while remaining attuned to broader social dynamics. It requires not only new thinking but also the unlearning of ingrained habits, supported by environments, processes, and resources that sustain ongoing change. Finally, stronger inter-organisational discourse and mechanisms for knowledge exchange are essential (Greenhalgh et al., 2004). The discourse of coproduction is inherently complex and often marked by contradictions between micro-level practice and macro-level systems. By examining the relational and social mechanisms involved—including power, trust, and identity—this study not only identifies what needs to change but also illuminates *how* transformation in public service can occur (Muir & Parker, 2014). This helps explain why transformation is typically incremental and why lasting progress depends on continual, collective effort (Loeffler & Bovaird, 2016).

7.3. Socio-cultural underpinnings in translating ESTHER Network in Singapore

The translation of the ESTHER Network from Sweden to Singapore highlights the dilemmas of applying Western-derived ideas of coproduction in an Asian healthcare context. Coproduction, rooted in egalitarian and individualistic traditions in Western countries, assumes that service users and professionals can participate as equal partners in designing and delivering care

(M. Batalden et al., 2016). Yet, in Singapore, socio-cultural norms of hierarchy, deference to medical authority, and collectivist orientations complicate the straightforward transfer of these ideals. A potential contradiction lies in the valorisation of professional expertise alongside rhetorical commitments to "empowering" patients—an imbalance that can lead to tokenistic involvement rather than genuine coproduction (Ocloo & Matthews, 2016). Moreover, the performance-driven imperatives of Singapore's healthcare system risk reducing coproduction to a strategic communication tool to foster adherence rather than a deeper restructuring of relational practice.

The ESTHER Network Singapore sought to mitigate these tensions through a careful process of localisation. The adoption of a culturally resonant persona—"Mdm Teo"—anchored coproduction not in abstract patient rights but in lived stories that professionals and families could identify with. Structured roles such as coaches, champions, and sponsors embedded coproduction within existing hierarchies, giving legitimacy to bottom-up initiatives while maintaining alignment with leadership priorities. ESTHER Cafés, where patients and professionals converse as equals, created dialogical spaces otherwise scarce in a top-down system, providing opportunities to surface and negotiate contradictions between professional authority and patient experience. These adaptations allowed a Western concept of coproduction to gain traction in Singapore by translating it into culturally acceptable forms of participation and improvement.

Nonetheless, significant dilemmas remain. The reliance on leadership endorsement raises questions about sustainability if priorities shift, while the formalisation of roles may inadvertently reproduce hierarchy rather than dismantle it. Equally, while stories like Mdm Teo's humanise the system, they risk being instrumentalised as symbolic devices without altering entrenched power dynamics. The Singapore case therefore underscores both the possibilities and the limitations of translating Western concepts of coproduction into Asian healthcare: success depends less on wholesale transfer and more on continuous negotiation of tensions between relational ideals and institutional realities.

7.4. Researcher reflections and methodological learning

The relational findings of Paper III offered a counterpoint to the professional perspectives in Paper I, expanding the understanding of coproduction from both sides of the care relationship. In turn, Paper IV clarified the underlying contextual mechanisms that underpinned or constrained the attitudinal shifts first observed in Paper II. These recursive linkages across studies illustrate the dissertation's methodological coherence and the evolution of understanding through iterative cycles of reflection and action.

This study was embedded within my own organisation and built upon a programme I lead, using an insider action research approach (Coghlan & Brannick, 2014). My positioning as programme driver, practitioner, and researcher provided unique opportunities: deep contextual access, the ability to act swiftly on insights, and credibility within pre-existing relationships (Coghlan & Shani, 2014). Yet, these very advantages also introduced methodological, ethical, and epistemological complexities. I grappled with the tensions of being both an insider and a critical researcher, having to navigate organisational loyalty while maintaining academic rigour and reflexivity (Alvesson & Sköldberg, 2009).

My privileged access to real-time practices enhanced the depth of the data, but also heightened the risk of bias, blind spots, and complicity, especially when insights ran counter to established norms or internal logics (Coghlan & Casey, 2001). Courage, in this context, was rarely a grand act. It was the repeated choice to speak when silence might have preserved relationships. It was the willingness to remain in difficult conversations when avoidance would have been easier. It was inviting colleagues to question their own long-standing habits, knowing it could strain trust. It was presenting an idea that was still taking shape to leaders expecting polished certainty. It was choosing to stay in the discomfort of change rather than retreat to the comfort of routine. One of the key moments of learning occurred early in the process, when I realised that our team—myself included—was engaging with participant feedback at a surface level. I was inadvertently "dancing around" the deeper mechanisms at play, a dynamic that echoed Bateson's (1972) theory of repetitive, unconscious relational patterns and von Bertalanffy' (1969) systems thinking.

Recognising this mirroring between our team dynamics and those I was studying marked a turning point. It challenged me to look beyond immediate observations and explore the relational and systemic forces that sustained the status quo.

To support this shift, I began employing a practice of alternating between "zooming in" on micro-level interactions and "zooming out" to consider broader institutional and cultural structures (Bateson, 1972). This reflexive oscillation was facilitated by one-on-one supervision with my primary supervisor, who helped me delve into granular interpretive work, as well as through collective discussions with the wider research team, where I interrogated macro-level patterns. Over time, this iterative movement enabled a progression from first-order learning (adjusting behaviours), to second-order learning (challenging underlying assumptions), and eventually to third-order learning (questioning epistemological frames). The action research process, therefore, became not only a means of producing knowledge, but also a space for my own transformation—revealing how deeply I was implicated in, and shaped by, the systems I sought to study.

This reflexive journey was further catalysed by the complex dynamics of working in a cross-national, interprofessional supervisory team. Comprising members from Sweden and Singapore, and spanning disciplines such as medicine, social work, and improvement science, the team exposed me to diverse epistemological standpoints (Marshall et al., 2013). At times, the differing emphases—between theoretical contribution and organisational relevance—led to tensions or delays. However, these frictions ultimately became generative. Negotiating across divergent perspectives strengthened my capacity for critical engagement and enhanced the theoretical depth of the research. Importantly, the team functioned as a counterbalance to insider bias, surfacing blind spots that I might otherwise have missed.

For example, I initially assumed that certain terms, such as "coproduction," would be resisted within my organisation, whereas "person-centred care" might be more acceptable. Yet, my supervisors challenged these assumptions, prompting a more nuanced understanding of the rhetorical and political functions of language. Their outsider perspectives helped me identify how taken-for-granted organisational narratives might conceal or reinforce existing

power dynamics. Through cycles of disagreement, sense-making, and eventual alignment, I developed more robust interpretations that integrated both health and social care logics. These interactions sharpened not only the conceptual rigour of the research but also my own scholarly voice—reinforcing that intellectual discomfort can be a vital site of learning.

Throughout this journey, my background in social work emerged as a critical boundary-spanning resource (Coghlan & Brannick, 2014; Williams, 2002). The profession's grounding in concepts of power, vulnerability, and relational meaning allowed me to approach improvement work with a critical sensibility. Rather than treating change as a purely technical exercise, I was attuned to the subtle, often invisible, emotional and social dimensions of practice. This sensibility was particularly valuable in the interpretive phases of Papers III and IV, where I drew on social work theory to analyse practitioner-service user interactions. My clinical experience helped me detect hidden dynamics of marginalisation, co-construct more inclusive inquiry processes, and generate interpretations that were both grounded and theoretically informed.

This boundary-spanning role was not merely a functional advantage—it had epistemological significance. By integrating the structured, systems-oriented lens of improvement science with the critical, relational lens of social work, I was able to produce knowledge that bridged technical and humanistic domains. The process of research thus became an exercise in epistemological integration: not simply about combining methods or frameworks, but about cultivating the ability to inhabit and transverse across different ways of knowing.

Taken together, these experiences illustrate how action research, when conducted from an insider perspective and enriched by interdisciplinary collaboration, can serve as a powerful vehicle for both organisational insight and personal transformation. The methodological and relational complexities demanded sustained reflexivity, theoretical agility, and emotional honesty. I came to understand that organisational change is multi-faceted and rarely tidy, and that genuine learning often emerges from ambiguity, contestation, and impasse.

7.5. Contributions

This dissertation investigates the process of introducing coproduction through the ESTHER Network in Singapore. It begins by examining how organisational structures, strategies, and leadership shaped the early stages of adoption, while revealing the deeper socio-cultural foundations that influence how managers, practitioners, and service users understand, enact, and sustain change. The analysis underscores the critical role of culture, values, shared meanings, and language in shaping organisational transformation. Ultimately, recognising the socio-cultural and linguistic dimensions of organisational life offers leaders and practitioners a more nuanced perspective on change—one that sees transformation not only as something planned or implemented, but also as something *talked into being*.

Theoretically, this study extends diffusion models by incorporating discursive and relational dimensions of change, showing how coproduction unfolds through situated meaning-making. By examining how actors discursively claim or resist roles, and negotiate authority, it reframes organisational change as an emergent discursive process—constituted through language and interaction rather than the implementation of prescribed best practices (Greenhalgh et al., 2004). Language emerges not just as a medium of communication, but as a form of social action that both reflects and constructs care practices (Potter & Wetherell, 1987). Narrative analysis further reveals the diverse ways service users engage with coproduction—some as co-creators, others constrained by professional dominance or systemic inequities (De Fina & Georgakopoulou, 2011; Kleinman, 1988). These findings illuminate the contingent nature of engagement and the need for reflexive, context-sensitive strategies to support coproduction practices.

Practically, this research provides actionable insights for healthcare leaders, policymakers, and practitioners seeking to introduce coproduction in contexts where entrenched professional hierarchies and cultural norms may resist change. It highlights strategies for balancing respect for local culture with the need to challenge disempowering practices, showing how leaders can create spaces where service users and professionals collaborate meaningfully without erasing contextual realities. Policy-wise, it suggests investment of time, trust and structures that support relational work.

A key output is the reflexive model for adaptive working—a framework of five interrelated dimensions that support dialogue, alignment, and shared decision-making between service users and practitioners. This model offers practical guidance for navigating the tensions, misalignments, and emotional labour that often hinder coproduction, particularly in complex healthcare systems. By emphasising meaning-making, relational work, and the emotional dynamics of change, the study underscores that sustaining coproduction requires more than technical fixes. It calls for ongoing reflexivity, deliberate trust-building, and leadership practices that legitimise uncertainty and create the conditions for adaptive, context-sensitive change.

Methodologically, this study advances the practice of insider action research by demonstrating its value for examining complex organisational change within healthcare systems. It enables an iterative, reflexive engagement with practice, allowing the study to follow the unfolding process of coproduction as it is negotiated, adapted, and embedded across multiple organisational levels. At the same time, the research highlights the challenges and ethical complexities inherent in insider engagement. These include managing role conflicts, balancing advocacy with critical distance, and maintaining reflexivity to mitigate bias. Navigating these dilemmas requires deliberate methodological transparency, structured reflection, and ongoing negotiation of positionality, ensuring that insider insight does not compromise analytical rigor.

By articulating both the strengths and tensions of insider action research, this study contributes to methodological knowledge on how to study organisational change in situ. It illustrates how insider researchers can generate actionable insights while ethically and rigorously capturing the emergent, and relational dimensions of change in complex healthcare settings.

By bringing together **improvement science**'s systematic, problem-solving orientation with the critical, interpretive perspective of **social science**, this study shows how flexible, interdisciplinary approaches can tackle complex real-world problems with both rigour and nuance. It contributes to the literature on health and social care change by demonstrating that coproduction operates not only as a set of practices but also as an epistemological stance—a way of knowing, relating, and acting within organisational systems. The

combination of social work's relational ethos and improvement science's structured methodologies enabled a richer, multi-layered understanding of how change unfolds.

Improvement science is interdisciplinary and continually evolving, drawing on diverse fields (Marshall et al., 2013). This parallels developments in QI practice, progressing from QI 2.0 to QI 3.0, where relational and contextual dimensions are increasingly emphasised (Lachman et al., 2021). Both the improvement science and the practice of QI are moving toward crossing boundaries and combining ways of knowing. This dissertation contributes to that trajectory by advancing a methodology that is epistemologically and practically attentive to the interplay of structure, culture, and meaning in organisational change.

The findings underscore that coproduction is not a static goal but a dynamic, contested process, requiring humility, reflexivity, and sustained attention to both interpersonal and systemic dynamics. They further highlight the enduring impact of ESTHER Network in Singapore, which, since its adoption in 2016, has continued to foster coproduction through ongoing training and improvement initiatives. The model's sustained relevance and effectiveness validate the study's insights and suggest their broader applicability to other health and social care contexts. This research extends the limited body of longitudinal studies examining how innovations are assimilated within public services (Greenhalgh et al., 2004). By providing direct empirical evidence of the adaptive processes through which coproduction is enacted and sustained, it advances understanding of change as an emergent, socially constructed process of learning and adaptation. In doing so, it bridges theory and practice—showing that transformation in complex systems is less a matter of implementation than of continual sense-making, negotiation, and co-evolution across levels of the system.

8. Limitations and Future Research

While this study offers significant theoretical and practical contributions to the understanding of coproduction in health and social care, several limitations must be acknowledged. First, the concept of coproduction. As Greenhalgh et al. (2004) observe, innovations that are simple and clearly advantageous tend to diffuse readily, whereas those requiring cultural transformation, emotional labour, and systemic reconfiguration—such as coproduction—are inherently more complex to embed. This raises an important question about whether coproduction places unrealistic expectations on practitioners. This research was conducted through an insider action research approach within a single organisational setting in Singapore, focusing on ESTHER Network. Although this positioning provided deep contextual access and enabled a nuanced understanding of relational, cultural, and adaptive mechanisms, it also introduced risks of bias and role conflict. Despite rigorous reflexive practices—including supervisory triangulation, critical dialogue within an interprofessional research team, and methodological transparency—my dual role as practitioner and researcher may have influenced participant interactions and interpretive framing. Second, the study's findings are shaped by a specific health and social care context—namely, Singapore's healthcare system and its ongoing efforts to integrate coproduction practices. Although it is a single-case focus, the conceptual and theoretical transferability is strengthened by the use of theories and established frameworks such Bateson's theory of change (Bateson, 1972), Greenhalgh's diffusion model (Greenhalgh et al., 2004) and positioning theory (Davies & Harré, 1990), to identify mechanisms which can be applicable and tested in other contexts. Having said that, further cross-national studies would be valuable to test whether the observed mechanisms of assimilation and adaptive working hold in other cultural, organisational, or policy environments.

Third, while insider action research offers deep access and reflexive insight, it also risks confirmation bias, selective attention, and role conflict—for example, balancing organisational responsibilities with critical analysis or negotiating participant candour given the researcher's dual role. Fourth, organisational change and cultural adaptation are long-term processes. The

study's timeframe may have captured only an early or transitional phase, leaving longer-term sustainability, unintended consequences, or "second-order" cultural shifts less visible. Lastly, while the study sheds light on the enabling role of organisational champions as boundary spanners between micro- and macro-systems, it does not fully explore how to systematically develop, support, or sustain such roles over time. This remains an important area for future exploration, particularly in settings where professional silos and hierarchical norms remain strong.

Looking ahead, future research could deepen and extend the insights generated by this study in several important directions. One promising avenue is to explore how coproduction improvement models, such as the ESTHER Network, evolve over time and adapt within differing policy regimes, particularly as health and social care systems undergo structural and cultural shifts. Longitudinal studies could shed light on how these models are sustained, scaled, or reinterpreted in changing organisational landscapes. Another key area of inquiry involves examining the long-term trajectories of organisational champions—those individuals who act as relational and operational bridges across system boundaries. Investigating how these champions influence systemic change over time, and how their roles are cultivated, supported, or institutionalised, could yield valuable insights into the mechanisms that underpin sustainable change.

Further research is also needed to investigate how coproduction can be meaningfully embedded at scale across fragmented health and social care systems. This includes examining the policy, cultural, and leadership conditions that enable or constrain coproduction across service boundaries. In addition, testing and refining the reflexive model for adaptive working—developed in this study—across other organisational settings, professions, and service contexts would help assess its relevance, utility, and transferability. Such research could clarify how practitioners and service users navigate tensions, align perspectives, and co-create care under varying conditions.

By building on the insights and limitations of this research, future work can contribute to a stronger evidence base for relational, context-sensitive approaches to assimilating coproduction in everyday care. In doing so, it can

help reimagine not only what care looks like, but how change itself is understood, practised, and sustained.

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The Process of Change in Introducing Coproduction

- the Case of the ESTHER Network in Singapore

Organisational change is often driven by strategy, structure, and leadership. Yet beneath these mechanisms lie the cultural and relational foundations that shape how change is understood and sustained. This dissertation explores these foundations through the introduction of coproduction—specifically the ESTHER Network—within Singapore's public healthcare system. Originating in Sweden, the ESTHER Network represents a shift toward collaboration and shared responsibility between practitioners and service users, offering a lens to examine how coproduction is interpreted and practised in a hierarchical, efficiency-oriented context.

Using an insider action research approach, the study investigates how managers, practitioners, and service users make sense of and negotiate coproduction in their daily work. Drawing on interviews, focus groups, observations, document analysis, and survey data, the research captures how change unfolds at structural and relational levels.

Findings show that coproduction in Singapore is at an early stage, often understood as better communication to encourage treatment adherence. Early "first-order" changes—such as structures to strengthen coordination, and training—helped build readiness. Yet service users' past experiences revealed emotional and relational barriers to authentic collaboration. Signs of deeper "second-order" change appeared through the bridging role of ESTHER coaches and champions. Intentionally designed spaces like ESTHER cafés fostered dialogue, mutual understanding, and new ways of thinking about care.

Viewing change as a social process, the study presents a Reflexive Model for Adaptive Working comprising five interrelated dimensions that promote learning, and collaboration. This model offers a practical framework for organisations to work adaptively when navigating complex changes such as the coproduction of care.

ESTHER LIM is the chief allied health professional in Singapore General Hospital, SingHealth. Trained in social work, and family and marital therapy, she also holds a Master of Science in Evidence-Based Social Intervention from the University of Oxford. Since 2016, she has championed ESTHER Network in Singapore. Her professional and research interests include leadership development, organisational learning, and system change. This dissertation explores the process of change involved in introducing coproduction in Singapore.

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