



Co-Production in Service Delivery: Opportunities and Barriers

A Literature Review

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Summary

A literature review of publications concerning the opportunities for and barriers to co-production has been carried out. This review discusses the following themes:

- The theoretical background of co-production
 - The concept was introduced in the 1970s due to research recognising citizens' active role in the production of services
 - The increased focus on co-production, which demonstrated the several, sometimes competing, perceptions of its role in service delivery
 - The debates over what constitutes co-productive activity
 - Co-production can cover co-creation, co-development and co-delivery

- Opportunities for co-production
 - It improves service quality and efficiency
 - It has the potential to address new healthcare challenges
 - It may be particularly effective at dealing with vulnerable groups
 - Focus on whole person or communities overlaying contexts not just service

- Barriers to co-production
 - There are issues of inequality, as those that would benefit most are often those that are less able to engage
 - Organisations may lack certain capabilities that are important for effective co-production
 - The complexity of the service network may result in a lack of co-ordination and management
 - Difficulties in creating a productive partnership between people and professionals
 - Manipulation of the term to continue 'business as usual' or used as only a form of consultation

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1.0: Introduction

A review of the literature on co-production reveals three broad themes which have been broken down into several, more specific, categories. Common in the literature are discussions of the opportunities presented by co-production, which firstly concern its role in increasing service quality and efficiency. Second and third, and of relevance to the healthcare context, are its ability to deal with new healthcare problems, and the improvement of services for vulnerable groups. The literature also highlights barriers to effective co-production. These have been categorised as the following: issues of inequality, staff structure and organisation, and the partnership between the client and the professional. Firstly, though, the theoretical background of the co-production concept is discussed, which uncovers multiple debates. These surround the concept's role in the delivery of public services, as its importance has varied over time and, secondly, the types of activities that fall under the heading of co-production.

2.0: Theoretical Background

The concept of co-production was introduced during the late 1970s in the USA by public administration scholars. They recognised three key factors which destabilised the idea of the centralisation of government; that there was rarely one single producer responsible for the delivery of a service; that actors in the delivery of a service were autonomous and did not act simply as a result of their managements' requests; and that service delivery relied upon the participation of those receiving it (Ostrom, 1996). From its initial introduction, however, the task of defining co-production appears to have been considerably difficult. This section will discuss two major themes which illustrate various points of contention: the gradual increase in focus on co-production and what activities may be considered co-productive.

2.1: The Increase in Focus on Co-Production

From the 1970s, the co-production literature tended to define it as something either requiring recognition as intrinsic to the delivery of services or, from a more economic perspective, as a tool that may be utilised to increase the effectiveness and efficiency of services. This difference is exemplified by Alford (1998) and Parks *et al* (1981). Alford saw that the delivery of some services was impossible without co-production and maintained that, during the 1980s and 1990s, the prioritisation of contracting out and privatisation in the reform of public services had caused co-production to be ignored both in literature and practice. He argued that this had led to 'patchy' reforms. On the other hand, Parks *et al* asserted that technical,

economic, and institutional factors determined the feasibility of coproduction, and therefore recognised it as an additional tool for service delivery.

More recently, this idea of co-production as a new method of service delivery has been emphasised in the literature, as the concept has experienced renewed interest. This provides further insight into reasons for recent advocacy of co-production. There are three key factors that have been identified in the literature from this century: a declining level of trust in government (Fledderus *et al*, 2014), the economic crisis (Buddery, 2015), and greater knowledge and empowerment of citizens (Bovaird, 2007). However, before each of these are outlined, the importance of recognising the context of co-production on a small-scale is repeatedly cited in the literature (for example Needham, 2007; Needham and Carr, 2009; Hoorberg *et al*, 2015). Therefore, whilst the following factors are likely to have had an influence on the broader drive towards co-produced public services, the specific nature of individual co-productive efforts will vary.

It is argued that, during the 1980s and 1990s, trust in government was declining and there were doubts surrounding the efficiency and quality of public services. In an attempt to rectify this, governments used market-based initiatives as they tried to regain the trust of the public. They provided more choice and transparency with New Public Management (NPM) (Fledderus *et al*, 2014: 424-425). However, NPM's success in increasing trust levels was undermined by its focus on control and compliance. Therefore, recently, there has been an effort to foster and mobilise social values, already existent in society, in order to transform citizens into active co-producers of services. Another explanation is offered by Buddery (2015); the economic crisis of 2008. Austerity measures have increased the number of services being delivered through volunteering as traditional service provision has become increasingly difficult to maintain. Finally, the increased knowledge and empowerment of citizens has placed them in a better position to be able to contribute to service delivery (Bovaird, 2007).

2.2: What Constitutes Co-Production?

There has been further debate over what constitutes co-productive activity. Whitaker (1980) considered a wide range of activities to be co-productive, which he divided into three categories. The first was citizens requesting assistance from public agents, which may include, for example, the application for unemployment payments or requests for emergency services. Second, he discussed citizens providing assistance to public agents, such as the effects of parents' inputs into their child's education. Whitaker's final category was

citizen/agent mutual adjustment, whereby 'in some public service delivery situations, agents and citizens interact to establish a common understanding of the citizen's problem and what each of them can do to help deal with it' (1980: 244).

Other scholars, however, are more restrictive in the range of activities they consider to be co-productive, including only instances where formal arrangements allow both the producer and consumer to input into the service delivery (Sharp, 1980). Nevertheless, Brudney and England (1983) emphasise the importance of not strictly defining the range of activities that may be involved, arguing that the nature of co-production is, instead, context-dependent. They maintain, though, that there are several dimensions to the process of coproduction: citizen involvement which is intended to have a positive rather than negative impact, voluntary cooperation rather than compliance, and active rather than passive behaviour (Brudney and England, 1983: 63).

Over time, there have been continued attempts to clarify what constitutes co-productive activity. Some have distinguished between co-governance, co-management, and co-production (Brandsen and Pestoff (2006), whilst others have focused on the varying impacts of individual, group, or collective co-production (Pestoff, 2013). Importantly, though, there appears to be disagreement in the literature over whether volunteers may be considered co-producers. Alford distinguishes between clients, volunteers, and citizens, stating that clients 'receive private value from the service' (2002: 33), whilst volunteers do not individually consume benefit. In terms of citizens, their role is expressing their opinions through political participation, such as voting, therefore they receive public rather than private value. In terms of healthcare specifically, Needham and Carr (2009) listed the factors of co-production that may vary, which included the following: who co-produces, at what stage co-production takes place, what is contributed, and different levels of service transformation. All of these insights clarify that defining co-production is complex due to its use in many different contexts. Pestoff (2013) therefore states that it is necessary to be clear about the specific context of co-production in any discussion of it.

3.0: Opportunities for Co-Production

There are three key factors that have been acknowledged for increasing the feasibility of co-production. The first, increased service quality and efficiency, is broad and is arguably relevant for co-production in a variety of contexts. Its ability to deal with new healthcare challenges and improve services for vulnerable groups, the second and third factors, may be considered particularly relevant to the healthcare context.

3.1: Increased Service Quality and Efficiency

Current research on co-production largely recognises it as important due to its ability to improve the effectiveness and efficiency of services. Vamstad (2013) uses the example of child care in Sweden to emphasise the improvement to service quality as a result of co-production. He observed that parents whose children attended cooperative pre-schools valued the staff higher than those at municipal pre-schools, which was potentially as a result of more effective communication between staff and parents. He concluded that parent cooperative child care services had a better service quality from both the user and staff perspective.

The previously dormant knowledge resources of both users and frontline staff is one factor that contributes to increased quality, as discussed by Needham (2007). Firstly, co-production recognises the voice of frontline professionals which was previously marginalised as the bureaucratic voice dominated. Co-production, however, recognises frontline staff's expertise and importance in shaping the user's experience. Similarly, recognition of users' agency, as opposed to dependence, develops citizen's knowledge and empowerment, which may result in further civic involvement.

3.2: Ability to Deal with New Healthcare Challenges

Buddery (2015) promotes co-production, particularly volunteering, in healthcare. Whilst the healthcare sector does have a history of involving the voluntary sector, he argues that it would be unsustainable to continue with the same level of reliance upon professionally designed and delivered care services. This is due to longer life expectancy and more complex illnesses which place an increased demand on medical resources. According to Buddery, the greatest threat to health is now lifestyle-related disease, the determinants of which are complex and social. Realpe and Wallace (2012) distinguish between the major healthcare challenge in the 19th century – acute and infectious disease – and the present, where we face problems with lifestyle and chronic disease. Therefore, our methods of treatment must be equally 'multi-level and socially oriented' (Buddery, 2015: 11) which is synonymous with the co-production approach.

3.3: Improvement of Services for Vulnerable Groups

Due to an increasing need for new solutions for healthcare challenges, as discussed above, there is also a greater need to find effective methods to help the vulnerable. Fledderus *et al* (2014) give insight into the increase in feelings of self-efficacy and the creation of trust

networks that occur as a result of co-production. Under conventional forms of participation, citizens lack the belief that they have any control over policies and services. They assert that people are more vulnerable to risks if they perceive themselves as unable to control events in their lives. Contrary to this, if an individual, through engaging in co-production, experiences their own actions effecting their daily lives, they gain trust and create social capital. This suggests that co-production may be particularly useful for vulnerable groups, such as the elderly, as affirmed by Gill *et al* (2011).

Realpe and Wallace support this view, but place emphasis on co-production's ability to deal with long-term conditions (2010). Long-term conditions present different challenges to the healthcare system in order to be treated truly effectively. Health services need to support self-management, encourage active patients and prepared clinicians, and have a responsive and flexible administrative structure (Realpe and Wallace, 2010: 11). Taking into account the broader opportunities discussed above, there is evidence to suggest that co-production presents a valuable opportunity to improve health services dealing with long-term conditions.

4.0: Barriers to Co-Production

Three key themes have been identified in the literature which may prevent effective coproduction: issues of inequality, the staff structure and organisation of the providing body, and the nature of the partnership between the patient and the professional.

4.1: Issues of Inequality

In discussing co-production's limitations, Needham and Carr (2009) show that, despite its potential to enhance social capital, it may be less effective at actually building it. Marginalised groups, such as those in poverty, the homeless, ethnic minorities, and the elderly, for example, may need extra support to become involved. Through identifying conceptual issues with the term co-production, Pestoff considers who becomes a co-producer, asserting the importance of the wide range of interests and motives for engaging in co-production (2013). Key to this is the citizen's ability and motivation to engage which they suggest depends upon several factors, such as their distance to the provider, the amount of information available to them, and how the service affects them.

Despite this, Van Eijk and Steen (2013) asserted that these insights were limited in that they failed to sufficiently clarify how knowledge and motivation translated into actual behaviour. Thomsen (2015) went some way in responding to this through her research into parent's

inputs into their child's education. She argues that the more knowledge of how to co-produce and the higher an individual's self-efficacy perception is, the more likely they are to co-produce. She also argues that the relationship between knowledge of how to co-produce and citizen co-production level is likely to vary by different strengths of self-efficacy perception. Thomsen's research revealed that self-efficacy had greater impact on input than level of knowledge. It is suggested that this is due to the likelihood of a highly efficacious person to become more involved in activities and have the confidence to overcome obstacles. Therefore, there is a clear argument that the groups that could receive most benefit from co-production in healthcare are those who may find it most difficult to get involved, therefore co-production has the potential to reinforce inequalities in healthcare delivery.

Nevertheless, this research was carried out in the field of education, therefore there is space in the literature for an assessment of citizens' abilities to co-produce in the context of healthcare. Hoorberg et al (2015) support this, expressing the need for a greater understanding of what conditions support citizen participation and can therefore be linked to more successful outcomes.

4.2: Organisational Capabilities

Certain characteristics of the healthcare system have been identified as counter-productive to co-productive efforts. Sharma *et al* provided the first insight into 'the processes and structures to actively embrace customer participation in the improvement of healthcare services at an organisational or system level' (2014: 180). They conducted research into healthcare organisations in Australia, using dynamic capability theory to address what skills and resources are required for healthcare providers to deal with increased participation from clients. Whereas it has previously been argued that the user controls value co-creation, Sharma *et al* argue that organisations can influence co-creation through their interaction with users. They identify four characteristics which may undermine an organisation's ability to co-produce.

Firstly, they may fail to recognise the importance of the client's knowledge and skills, therefore they must develop 'customer activation' capabilities to acknowledge their competence and individual needs. Secondly, organisational resources may be inadequately developed for co-production, unable to collaborate with cross-functional teams and clients, thus they require 'organisational activation'. Next, organisations' interaction with clients has previously been limited to gaining feedback of the service, however the impact of this is minimal. Sharma *et al* consequently suggest that organisations need to develop 'interaction

capabilities' for 'encouraging dialogue with customers and sensing new opportunities for innovation' (2014: 181). Finally, they suggest that organisations have limited flexibility to adapt to the changing needs of the consumer. They must be able to self-evaluate with 'surveys, discussion forums and other feedback mechanisms' (187) or, in other words, develop 'learning agility' skills. They do, however, recognise a need for further exploration of the capabilities identified in order to enhance the relevance of their research. Specifically, along with Van Eijk and Steen (2013) and Hoorberg *et al* (2015) (who's identification of further avenues for research are discussed above), they suggest investigation into the customer profiles that are most appropriate for participation in co-production.

4.3: Complexity of Service Networks

Similarly, Tuurnas *et al* (2015) assess the effectiveness of the structure of healthcare services, but suggest some more specific organisational limitations. They use the concept of figuration from complexity sciences and apply it within the network context of co-production to show how actors in the network act and make decisions that are interdependent with those of others. They studied networks formed of frontline workers in health and social care, maintaining that coordination and management are essential for the network to function. However, due to a lack of coordination, difficulty agreeing on a service path for clients, complexity arising from different professional viewpoints, and no clear management structure, they observed 'a lot of randomness and diversity in services' (Tuurnas *et al*, 2015: 379). Clients were identified to be moving backwards and forwards between professionals due to different opinions over the correct pathway for them, which prevented value co-creation for the client. They therefore call for further research on co-production in the network setting, specifically that which concerns client's experiences in social and healthcare services. Despite this, they were able to identify the importance of one trusted informant within the network who could support the client and relay information between actors; a potential way of overcoming complexities in co-production.

4.4: The Patient-Professional Partnership

The importance of a co-creating partnership between people and professionals in the healthcare context is emphasised throughout the co-production literature. Whether co-production occurs at an individual, group, or collective level, 'it mainly concerns the one-to-one relationship between the health care professional and the patient' (Palumbo, 2016: 7). However, the nature of this relationship is largely dependent on the individuals involved and, as Hoorberg *et al* (2015) concluded, professionals are often resistant to enhanced patient

involvement. They may doubt the alleged merits of co-production due to the unpredictability of citizens and therefore be reluctant to share control, fearing that their professional status will be undermined.

Other authors have focused on specific problems that may cause turbulence in the patient-professional relationship. Barlie *et al* (2014) discuss the issue of information asymmetry. They strongly believe that information and knowledge sharing is key to the interaction and co-creation between user and provider, and seek to answer how co-creation is 'affected by information asymmetry that has traditionally characterised health care service, particularly the doctor-patient relationship' (Barlie *et al*, 2014: 205). They assert that in co-creation, knowledge sharing may be affected by different views, perspectives, and expectations.

Owens and Cribb identify an example of difficulties arising from different viewpoints; the 'potential problem involved in combining professional and lay conceptions of health' (2012: 268). The professional defines health objectively, as the absence of pathological or anatomical abnormality, whereas the patient's conception of illness is much wider and deeper as they directly experience the 'sensations, emotions, frustrations, and stigmas which accompany a pathological phenomenon' (272). They conceptualise this as a tension between disease-oriented and illness-oriented ideas of health, which may translate into tensions in co-production and, ultimately, threaten the effectiveness of healthcare provision.

5.0: Conclusion

This review has discussed three key themes surrounding the co-production of healthcare. Beginning with its theoretical background, the changing and contended role of co-production was discussed, followed by the debates over what types of activity were considered co-productive. Following this, several opportunities for co-production in healthcare were identified: the ability to improve service quality and efficiency, its ability to deal with new healthcare challenges, and its role in providing effective services for vulnerable groups, such as those with long-term health conditions. Finally, barriers to effective co-production included its potential to exclude already marginalised groups from involvement, whether organisations had the required capabilities to co-produce effectively, the complexity of service networks, and difficulties in creating a working partnership between patients and professionals.

Several gaps in the research, or requests for further research were also highlighted throughout. The first of these was the need for assessment of citizens' abilities to co-produce in the context of healthcare, with a specific focus on what conditions support citizen

participation and therefore more successful outcomes. Secondly, the need for further exploration of organisational capabilities for co-production was noted. Finally, authors discussed the need for additional research on co-production in network settings, particularly those concerning clients' experiences in social and healthcare services.

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