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Healthcare Co-production and the Indirect Governance Toolkit: Demystifying the Organizational Puzzle

Meeting of the IIAS Study Group on
Coproduction of Public Services

Nijmegen, 8-9 June 2015

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The paper in a nutshell

A literature review on healthcare co-production to explore:

- The importance of management issues in the debate on co-production in healthcare-sector.
- The managerial challenges of implementing co-production practices.
- Knowledge gaps and open issues in extant research.

Outline

- Background
- Research Goal and Design
- Conceptual framework
- Main Findings
- Limitations and further research

Background/1

- Previous research (including: Bovaird 2007; Hunter 2009; Osborne 2010; Pestoff 2006; Pestoff, Brandsen, & Verschuere 2012), has shown that co-production (CP) can help achieve public goals, such as improving public health, reducing inequalities and increasing social inclusion.
- Our research supports these arguments, leading us to believe that labelling CP as a simple delivery model is too reductive . Indeed, we see CP as a tool of public action, i.e., a means to address problems of relevance to the collective, on a par with other policy tools.
- We follow this line of reasoning, also drawing on the “new governance paradigm”, to place CP in the category of “indirect tools of government” (Salamon, 2002).
- As such, CP poses a critical challenge: it is not a self-executing system but requires close **management** and careful oversight.

Defining the term 'management'

- 'Management' can mean one of two things:
 - the people who are responsible for making and implementing decisions within organization settings;
 - the managerial functions that these people perform.

Source: Preston and Post (1975)



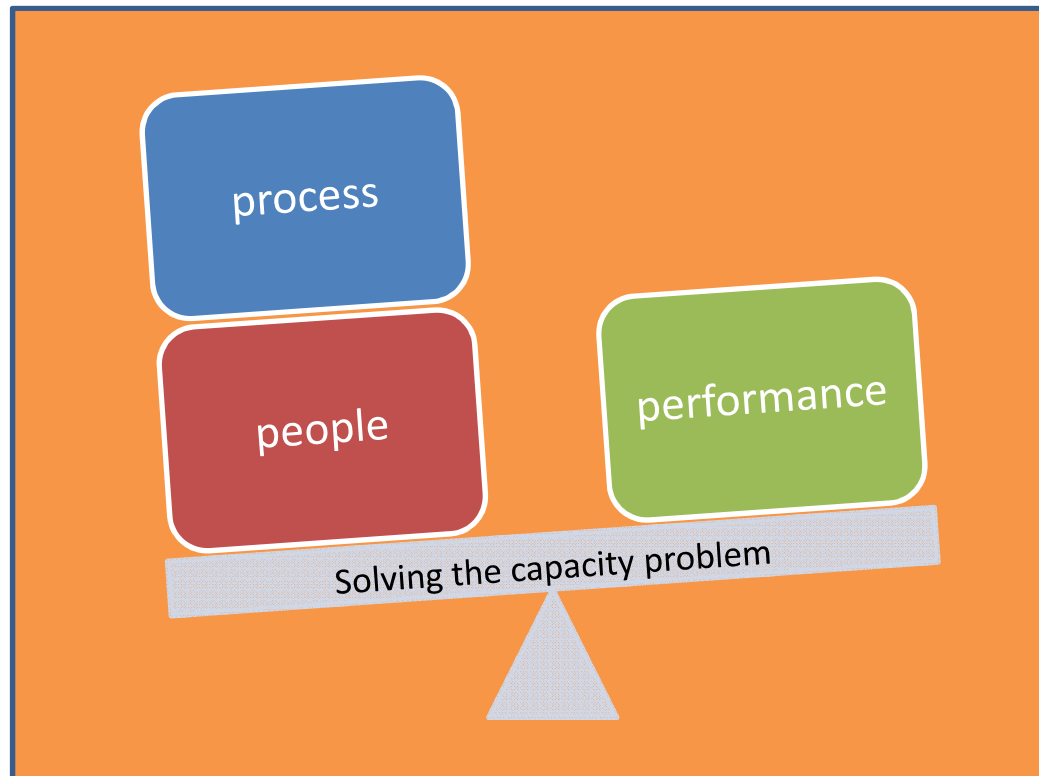
Background/2

- As far as we can ascertain, no review article has systematically addressed the relationship between co-production and healthcare.
- Co-production practices in healthcare need to win two major battles:
 - To *engage the patient*, an ongoing process that calls for this latter to actively participate in their healthcare plan (Coulter, Parsons, Askham, 2008).
 - To ensure that the patient engages with both *their therapy and the hospital organizational system* by managing the interdependency within and between ‘organizational production and client co-production’ (Alford, O’Flynn, 2012, p. 182), in order to govern the healthcare organization’s interactions (Alford, 2009; Brandsen&van Hout, 2008).

Topic, goals and RQs

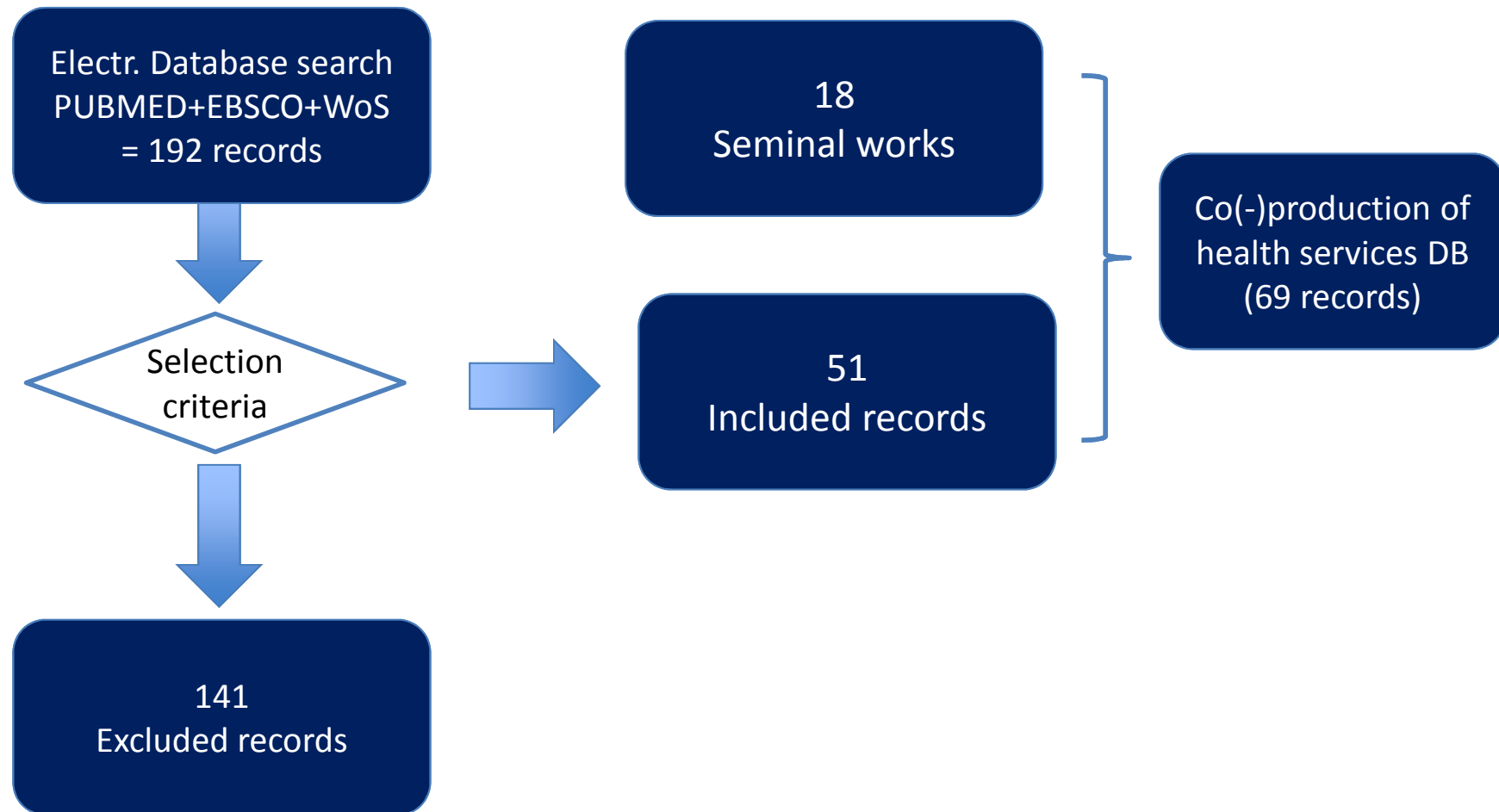
- The research aims are to: (1) map our existing knowledge (*what we know*) of the co-production and healthcare relationship; and (2) highlight any gaps (*what we don't know*) at the organizational/managerial micro-level, i.e., that of the providers – hospitals, trusts, local health communities.
- The three main research questions are:
 1. *Are managerial implications of healthcare co-production considered important in the current CP debate?*
 2. *Which are the most frequent **managerial dimensions** and **challenges** addressed by the research?*
 3. *What **open issues** are not addressed by current CP literature (CPL)?*

The conceptual framework



Authors' interpretation, drawing on: D.F. Kettl, 2002, "Managing indirect government", in L.M. Salamon (ed) *The Tools of Government*, Oxford: OUP, pp. 490-510.

Research method and design



PROCESS

Tracking money

Structuring contracts

Need for highly connected structures and a participatory organizational culture D15

More process transparency required D6

CP must embrace not only the individual encounter of the single person, but also the integration of different providers/patient-centred services C4, B3

CP as a patient-centred service process can increase the quality of care C4, B3

Process fragmentation, expansion of relations D15



Kettl's framework (KF)



Co-production literature (CPL)

Implementing new practices D6
Clinic nurse B18
Heart school B35

ICT structures the ways in which information is produced and shared D12, B18, A10

Technical and administrative quality (service operation) has significant positive relationship with functional value of users C19

Classification of CP activities C20

Redesign the process by treating patients as members of the healthcare team and letting them play an active part in all 4 dimensions (medical, social, cognitive, emotional) of the caring process B35.
The CP of 'informed consent' presumes rational decision-making D20

Micro, and meso-level of interaction D20

Co-produced training program (co-delivery and partnership working with service users – expert by experience and by occupation) to address people with mental disorders B10, B22

Reward system to promote co-production principles and patient-centred care B18

Organization must provide resources and tools to facilitate CP: "CP needs to be integrated into all aspects of the organizations" A2



PEOPLE

Managers need to develop 5 critical skills:

- Goal-setting
- Negotiation
- Communication
- Financial management
- Bridge-building.

Importance of doctor/patient communication to achieve CP and activate informed, engaged and motivated patients B25, A2, A15, D20

Creating boundary-spanning skills D6

MI (motivational interviewing) A15

Importance of the selection criteria used to recruit volunteers D15

Align competencies with existing or new roles to form a local workforce without going over budget D21

Staff need to internalize the philosophical shift D6

Orchestrate formal and informal carers D12; C4, A17 (relational coordination)

Technical competence (staff expertise) is significantly and positively related to the functional value of the users C19

Training and development of HC professionals C4, B18
Revitalized conception of professionalism /front-line staff, responsible autonomy.
Good use of judgement and tacit knowledge; not technical monkeys B28

Worker self-awareness vs. resilience in CP support A2



Kettl's framework (KF)



Co-production literature (CPL)

PATIENTS

Direct involvement of patients in the development of their care plan (self-management support, sharing of decision-making) to co-produce quality of care, social inclusion E1-2; B3, B16, A2 (“I want the service to listen to me”)

Kaleidoscopic nature of the co-producer and development of user skills (Citizen-consumers and Expert-patients) D20

Users must have agency and the ability to shape the methods used for their involvement D21

Citizens need motivating to engage in healthcare service C8

Interdependency between multiple actors does not necessarily imply sharing a common mission/conception of CP value C4; B25
Patient co-production of an avoidance service not perceived as value C19

Patients don't appreciate being addressed as co-responsible agents with own responsibilities D20

Self-efficacy and socio-demographic characteristics as determinants of CP across sectors D44



Kettl's framework (KF)



Co-production literature (CPL)

PERFORMANCE

Design a robust financial accounting system
Outcome measurement

Redefine inter-governmental relationships

User's perception of the quality of care: CP as a tool of actively making quality B3

VALUE IN USE - Definition of customer value co-creation practice styles (role, activities, interactions) linked to QoL measures; service providers must factor in these different approaches and try to influence take-up to raise the QoL - C20

Experiential Value - Value (functional+emotional) creation of model for preventive (avoidance) health service – value as driver for satisfaction/behavioural intentions; importance of customer role in creating emotional value, although organizational factors have greater influence C19

Dangers of malpractice or fraud D15

Influence of volunteers (CHW) on CP sustainability D15

Outcomes are influenced by local contextual factors D21

CP can increase service efficiency (long-term care) but not grant it E20

Increasing role of non-medical aspects (e.g., cost, quality, expected benefits). Patients become cost-sensitive consumers D20

Political self-efficacy influences CP performance D44

Need to integrate CP into regular planning processes D15

Need for a multi-stakeholder governance approach D15

VALUE BASED HEALTH - value co-creation through patient engagement (micro-level) C4

Experience-based co-design as a systematic approach to include patient perspective in quality improvement- A3 research protocol

CP performance is enhanced when governments provide information or engage patients in consultation D44

An unintended consequence in CP practices is that users quite often request expensive HC services for fear of missing out on what is available D20



Kettl's framework (KF)



Co-production literature (CPL)

Co-production through Kettl's framework

	CONVERGENCES	DIVERGENCES: CPL vs. KF	MANAGERIAL IMPLICATIONS (our deductions)
PEOPLE	Recognition of person-centred services. Importance of personal and professional skills.	<ul style="list-style-type: none"> The skills in question are those of the caregivers (not the managers). Highlights the specific and critical role of the skills of the patient and the informal care givers. 	<ul style="list-style-type: none"> Poor focus on managerial skills risks blocking CP development and legitimization. This acts as a drag on ultimate recognition. Need to pay adequate attention to the specific technical/personal skills required for CP practices.
PROCESS	Importance of inter-organizational relations among multiple and diverse actors.	Does not address the problem of the inputs (in terms of economic resources and the organizational effort of coordination and control) needed to sustain the CP process.	When the CP processes are opaque the outcomes are unrelated to the inputs. Becomes hard to obtain the support needed to spread this practice even in cases of success.
PERFORMANCE	Attention to the different dimensions of performance and the role of contextual conditions.	<ul style="list-style-type: none"> Attention mainly on clinical outcomes and the efficacy of the service for the patient (value in use/Experiential Value). Undervalues the importance of economic efficiency. Scant regard for the inter-organizational dimension of performance (with prevalence given to the micro perspective). 	<p>The lack of tools to measure CP performance means it is impossible to evaluate its sustainability. Moreover, this lack impedes:</p> <ul style="list-style-type: none"> - Scaling-up and application in other domains. - Accountability to the stakeholders (user association). - Evidence-based variations/improvements. - Knowledge dissemination.

Source: the authors

Summing up

- CP as both a political and an administrative strategy. Cross-fertilization between public management studies and policy studies is viable and necessary
 - for analytical and diagnostic purposes.
- Pay-offs of Kettle's perspective:
 - It enabled us to map the CP literature addressing healthcare, and revisit the contribution of a number of seminal studies;
 - It can serve as a base to further develop sustainable co-production practices.

Limitations and further research

- Limitations
 - Ongoing research: first attempt to map the literature on co-production in healthcare; need for more in-depth investigation.
- Further research (tentative)
 - Need for a more encompassing definition of Kettl's 3P framework, by 'importing knowledge' from studies addressing CP in public services.
 - Apply Kettl's conceptual framework specifically to HCP (i.e. to include patients as co-producers and service recipients).

*Thank you
for your interest!*



Research method and design

- **Method:** literature review
- **Search strategy**
 - Three electronic databases (Pubmed; EBSCO; WOS)
 - Terms: “coproduction/co-production + health” in title, abstract and/or keywords
 - Timeline: 1980-2015 (1981 publication year of the seminal work of E. Ostrom)
 - Only English written records
 - International peer-reviewed journal articles
 - Seminal papers on co-production in public services.
- **Record selection**
 - Included: works that deal solely and specifically with *healthcare service provisioning*
 - Not included:
 - Co-production of knowledge in healthcare process (academic vs. applied research)
 - Co-production not related to service provision
 - Co-production of health artefacts (drugs, compounds, devices, etc.)
 - Other not relevant, according to the inclusion criteria.