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*Paradigm shift towards co-production
in the European healthcare? A literature review²*

Summary

Public service delivery has never been the area of a state monopoly, but the process of the “destatization” of public service delivery accelerated with the wave of new public management (NPM). The competition between private suppliers of public services was expected to reduce public expenditures and improve the quality of services. However, current scepticism towards NPM triggered the revival of the idea of co-production, i.e. direct participation of citizens in public service delivery. This paper reviews the practices of co-production in European health care systems. It is based on an extensive definition of co-production, not only including co-delivery, but also co-planning, co-financing and co-evaluation. The existing evidence regarding the effects of co-production is also reviewed.

Key words: co-production, health care, new public management

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***Introduction. Citizens' empowerment in public services systems
— from new public management to co-production***

In the rhetoric of the new public management, citizens' empowerment was one of the most important promises reflected by the famous slogan stating that "the customer (citizen) is always right" (Vigoda-Gadot 2009, p. 137). NPM advocates emphasized that public administration should be transformed into customer-oriented organisation, which adopts the perspective of the customers and focuses on their needs, communicate with them and enables them to participate in the evaluations and revisions of the plans and policies (Barzelay, Armajani 1992, p. 8–9). In this vision the state is a supermarket predominantly responsible for providing citizens as consumers with high quality goods and services (Christensen, Laegreid 2002, p. 281). The main forms of citizens' empowerment in this vision are:

- measuring customers' satisfaction with service provision;
- providing customers with the widest possible freedom to choose public service providers (e.g. via vouchers);
- enabling them to negotiate and individualize the specific conditions of service delivery.

However, declarations of citizens' empowerment under NPM have not been followed in practice. While vouchers did indeed extend the scope of citizens' choice, they are applied only in selected areas of public services. Furthermore, in some of those areas the customer choice is limited by information asymmetry, lack of competition between providers or monopolistic nature of some markets of public services (e.g. water supply). Moreover, while public administration under the influence of NPM agenda began to measure the citizens' satisfaction with public services, such surveys themselves do not guarantee citizens' empowerment since the relevant administrative bodies have still the monopoly to decide on how to utilize feedback from the customers. Finally, individual adjustments of the scope or standard of public services promoted by NPM usually require extra payments and therefore it is not available to all customers.

From NPM's perspective, the citizen is rather a passive consumer than an active partner of the state in service delivery (DeLeon 2005, p. 104). However, there is a growing interest, both in the theoretical discourse and practice of public management, in a concept that strives to ensure more significant and direct citizens' participation in public service delivery, i.e. the idea of co-production of public services. According to the early definitions of this concept, co-production reflects the presumption that citizens may play a meaningful role in production of services that they themselves consume. Co-production blurs the traditional division of labor in public services systems (regular producers — customers) by involving customers in service delivery (Parks et al. 1981; Whitaker 1980). Some scholars extend the scope of co-productive arrangements to citizens' participation in policy design, evaluation and allocation of public resources (Ottman, Laragy, Allen, Feldman 2011; Bartenberger, Sześciło 2016).

This paper aims to develop a conceptual framework for co-production in healthcare as one of the major areas of public services. Current research on co-production is rather

focused on general theoretical considerations, while the sectoral approach to co-production is still missing. Another objective of this study is to review the practices of co-production already developed in European health care systems, including the available evidence on impact of co-production on the performance of health systems. This paper is based on an extensive literature review covering primarily medical and public management journals.

Forms of co-production in healthcare

Although the definition of co-production seems to be clear, specifying available forms of co-production in healthcare is not an easy task. Among researchers dealing with healthcare the concept of co-productions has not gained in popularity. Increasingly, however, medical literature is interested in the empowerment of the patient, which in most cases is synonymous with co-production. According to a study Loukanova and Bridges (2008) covering the period 1990–2005, the number of articles on patient empowerment published in scientific journals dealing with health increased approximately fivefold. Deriving from the notion of patient empowerment, we may identify in the literature the following types of co-production in healthcare.

Patient — Physician: shared decision-making

According to this concept important treatment decisions should be made jointly by the patient and the physician. Shared decision-making does not mean only the formal requirement to obtain the consent of the patient's specific clinical intervention. It reflects a broader vision of empowerment of the patients by ensuring that their knowledge and preferences will be taken into account, and that decisions will be preceded by providing patients with reliable knowledge of optimal methods and treatment strategies (Coulter, Collins 2011; Elwyn, Tilburt, Montori 2013). Co-deciding aims at increasing the knowledge of patients, while reducing the anxiety associated with the treatment process, improving the quality of treatment, and at the same time, ensuring that health care will be provided in a manner more consistent with the expectations, preferences and values of the patient (Oshima Lee, Emanuel 2013).

Shared decision-making might refer to decisions on undergoing certain tests, medical treatment or surgical procedures, as well as taking medication or necessary lifestyle changes (Coulter, Collins 2011). In each of these cases there is some scope for co-deciding, provided that there is more than one available and acceptable variant (Shafir, Rosenthal 2012; NHS 2012). Patients often do not realize how many decisions in the treatment process are undertaken on the basis of selection from a wide range of possible strategies, and a specific diagnosis does not determine the only one treatment strategy. Shared decision-making is excluded in life-threatening situations, when rapid medical reaction is needed or when the patient is in a state of diminished consciousness or has no capacity to take any decision (Loh, Simon, Kriston, Härter 2007; Alakeson, Bunnin, Miller 2013).

The complete process of co-deciding in the treatment process consists of three steps:

- (1) the physician informs the patient about the treatment options, providing the patient with information on their effectiveness, as well as the risks and possible side effects;
- (2) the patient — using patient decision aids — does the “homework” consisting of analysis of their own preferences and expectations concerning the treatment process;
- (3) in the course of the discussion and exchange of information, the patient and physician reach an agreement on the chosen treatment strategy (Alston et al. 2014).

Shared decision-making requires not only enabling patients to express their views and preferences. As in the relationship between patient and physician, there is a natural information asymmetry; patient empowerment might be implemented effectively only if the patient is provided with reliable information which at least partially reduces this asymmetry (Stacey et al. 2014). For this reason, shared decision-making begins with ensuring patients’ access to adequate decision aids. The development of information technology has opened new channels and tools assisting patients by providing them with access to reliable medical information. Typical tools for patients to acquire useful knowledge are not only leaflets and guidebooks, but also interactive web-based tools (Elwyn et al. 2010). For example, the British National Health Service launched a website dedicated to supporting shared decision-making (sdm.rightcare.nhs.uk). Interested patients can — after clarifying their health problem — review the available variants of treatment, express their preferences, compare all the options, and on this basis prepare to discussion with the physician.

The patient as an expert: patient self-management

Jointly-made decisions can be better implemented if the patient’s involvement goes beyond adherence to established guidelines. The more significant role of the patient in the treatment process can also take a form of self-management, which is a set of tools for achieving desired health outcomes through the use of the patients’ ability to control the symptoms of the disease, steer the treatment process and adapt their lifestyle to the requirements of treatment (Cordier 2014). Self-management treatment does not mean that the patient takes full responsibility for the results of the treatment. The physician supports, advises and guides the patient, avoiding authoritative guidelines and indications (Greenhalgh 2009). As pointed out by Anderson and Funnell (2010), a common misconception, especially among physicians, is the perception of patient empowerment as a tool for disciplining patients, i.e. ensuring their adherence to medical recommendations. However, shared decision-making is more about teaching patients to think critically and to make independent decisions based on sound knowledge. For this to succeed, several conditions need to be met. Patients must have access to reliable information, but also to the tools enabling them to monitor their health status (e.g. simple device for measuring blood pressure). The patient’s ability and willingness to make changes in the treatment strategy, as well as a certain type of personality (openness to taking more responsibility for their health) is necessary (Tattersall 2002).

The most popular model for initiatives promoting and implementing self-management is the Chronic Disease Self-management Program for chronic diseases (CDSMP) developed

at the Stanford University in the 1970s. CDSMP consists of a six-week (2.5 hours per week) series of workshops and trainings addressed to patients and conducted by the two trainers (facilitators). At least one of the trainers is a patient, who himself has been struggling with a chronic disease. The training program covers a wide range of issues, including nutrition, techniques for dealing with pain and fatigue, frustration and a sense of isolation, physical exercises to improve strength and endurance, the rules for taking medication, techniques to communicate with physicians and to evaluate the effectiveness of treatment (Bährer-Kohler, Krebs-Roubicek, Ephraim-Oluwanuga 2009, p. 81–82; Carrier 2009, p. 70).

The patient — the patient: peer support

In addition to the activities carried out by individual patients, co-production may also manifest itself in the form of peer support groups for patients. This includes, in particular, the various networks or communities of patients created under the auspices of therapeutic institutions, or as bottom-up initiatives launched and run by patients themselves. Sometimes the patient support groups are formed in opposition to the institutions of health care, or in response to the lack of a satisfactory level of care offered by regular providers. In the UK, a group of psychiatric patients who have been denied access to personal budgets created one of the most vibrant and recognized peer support groups — Personalisation Forum Group (Duffy 2012).

Co-production in European healthcare systems

Drawing from the catalogue of possible co-production schemes in healthcare, we may focus now on examples of their use in the European health systems. The following table shows the results of a literature review covering initiatives and programs aimed at dissemination of co-production in different forms and at different levels of the health system. The table includes only projects that not only attracted attention in the literature, but also have been subject to some form of evaluation indicating their outcomes and outputs. Thus, it is very likely that this is not a comprehensive list. The most important limitation is the availability of academic literature describing examples of co-production. In some cases local initiatives that have been developed and implemented have not been described anywhere and nor have their effects been evaluated.

At first glance we may formulate two general remarks. Firstly, the scale of initiatives is very limited. Chronic Disease Self-Management Program seems to play the dominant role among co-productive arrangements in European healthcare. CDSMP gained a monopoly among the tools supporting patients in self-managing their health. Identification of peer support networks appears to be the most challenging task. Secondly, the United Kingdom is the clear leader in the dissemination of all possible forms of co-production. Moreover, the UK is the only country where co-production has become a part of the national health policy, and not just a local experiment or one-off initiative. Right Care

Shared Decision-Making and Expert Patient Programme have the status of the most prominent co-productive initiatives in the European healthcare systems. These initiatives have also achieved international scope and their positive outcomes have been widely promoted thanks to numerous published reports and evaluations. Despite this success story, however, co-production in the European health systems remains a rather marginal phenomenon. Other countries (e.g. Germany or Sweden) launched some initiatives aimed at developing patient decision aids as a tool supporting shared decision-making. In Switzerland, Austria and Spain, the CDSMP has been successfully implemented; yet it is far too early to declare anything approaching paradigm shift towards co-production in the European healthcare systems.

Table 1. Review of European initiatives promoting co-production in healthcare

Type of co-production	Country	Project	Outputs/Outcomes
<i>Shared decision making</i>	United Kingdom	The Right Care Shared Decision Making	699 health professionals trained; 38 patient decision aids developed; 82% of patients covered by the programme reported they had been fully involved in decision making
	Germany	Training programme for physicians on SDM	Significant improvement of knowledge about shared decision making confirmed by the results of multiple-choice knowledge test; substantially improved SDM self-efficacy
	United Kingdom	MAGIC Programme (Making good decisions in collaboration)	Workshops for 270 health professionals in Newcastle and Cardiff; Ask 3 Questions campaign among patients; communities of practice enabling exchange of information and experience between professionals; elaboration of patient decision aids; HCPs' knowledge and self efficacy increased; patient decision aids disseminated among patients and physicians
<i>Patient self management</i>	United Kingdom	Expert Patient Programme	Decrease of about 10% in general practitioners' consultations, outpatient visits and physiotherapy use; decrease of total cost of services provided per patient; decrease in use of hospitals beds of average of 1 bed day per patient over a six months period; improvement of health-related quality of life; significant improvement of self efficacy
	United Kingdom	Co-Creating Health self management programme	High completion rate among patients who joined the course (around 70%); significantly improved patient activation after completing the programme; significantly improved patients' self management skills; significantly decreased patients' anxiety and depression (measured six months after completing the programme)

Type of co-production	Country	Project	Outputs/Outcomes
	Spain (Catalonia)	Expert Patient Programme	Increase of knowledge (7%) and improvement of habits and lifestyle (9%), and quality of life measured with the Minnesota Living with Heart Failure Quality of Life Questionnaire (7%); decrease in the degree of dependency (7%); reduction in the average of visits per patient (including primary, emergency and hospital admissions) by 40% for patient with chronic heart failure
	Netherlands	Diabetes Interactive Education Program	Interactive tool supporting self management based on web portal (guidelines, handbooks, checklists, forms for preparing questions to physicians and enabling patient to prepare self management plans); increase of knowledge about self management techniques; low use of more advanced functionalities
	Switzerland, Austria	Evivo — Gesund und aktiv mit Krankheit leben	Adaptation of the Stanford's Chronic Disease Self Management Programme; training program for patients led by trained peers; significant increase in declared self efficacy, high satisfaction with the content of the course
<i>Peer support</i>	United Kingdom	Personalisation Forum Group	Significant decrease in planned and unplanned hospital admissions; production of care services of value exceeding £250,000 (savings for regular providers)
	United Kingdom	SUN (Service User Network)	Significant decrease in number of planned and unplanned hospital visits; from respectively, 725 to 596, and 414 to 286; 50% reduction in hospital beds' use

Sources: Bieber et al. 2009; Bujan et al. 2015; Duffy 2012; Haslbeck et al. 2015; Heinrich et al. 2012; Innovation Unit 2014; Nesta 2012; NHS 2012, 2013; Office for Public Management 2013; Ortega 2010; Rogers et al. 2008; The Health Foundation 2012; Turner, Anderson, Wallace, Bourne 2015.

The British case shows that the effective dissemination of co-production requires institutional support and clearly established policy supported by major actors and decision-makers in the healthcare system. A clear shift towards co-production is evident in the government documents and supported by comprehensive programs. Another factor was the support of vibrant think tanks (The Health Foundation, Nesta and the New Economics Foundation), which helped in building know-how, implementation and the dissemination of results of projects listed above.

Concluding remarks. Why so little co-production in the European healthcare systems?

The British experience is definitely not sufficient to declare a paradigmatic shift towards the empowerment of patients in the health care systems by involving them on a large scale in the production of health services. However, since the effects of initiatives already implemented are rather positive, and because specific models of co-production are widely available, and key stakeholders in the health care system agree on the need to ensure stronger position of the patient, why, then, is the impact of co-production still marginal? It is very likely that the potential barriers and limitations could be linked with the attitudes and habits of physicians and patients, but also in the rules governing health systems.

Even if health professionals declare support for patient empowerment, their reluctance towards a more deliberative model of relations with the patient might be one of the factors. Contemporary medicine is organized around the paradigm of expert knowledge. Treatment is a process where expertise (evidence) play a key role in determining clinical decisions. Physicians are the source of this expertise, which gives them a natural advantage over the patients, as well as creating clear relations of power according to which the physician decides and the patient consents, confirms and follows recommendations of the professional. Co-production blurs this scheme by presuming that lay knowledge or the individual patient's preferences are no less important than the expert knowledge of the physician (Dunston et al. 2009). Obviously, co-production cannot be equated to a return to traditional medicine based more on intuitions or superstitions than scientific evidence, but co-production does lead to establishing new type of relations between patient and physician, more balanced, deliberative and reflecting the idea of partnership and the equal position of the parties. It would be too optimistic to expect that every physician will be willing to accept this shift. Some physicians may oppose it as undermining their position and competences based on knowledge and experience. Others may lack communication and interpersonal skills needed for communicating with the patient. The idea of shared decision-making, although easy to explain at the level of general principles, is much more difficult to apply in daily practice (Greenhalgh, Howick, Maskrey 2014). Hence, many physicians tend to believe that a majority of patients prefer not to get involved. As a review of available research conducted by Joseph-Williams, Andrews and Elwyn (2014) showed, in many situations the patient would like to have more influence on decisions made within the treatment process, but the physician assumes a priori that the patient prefers to be "mothered" by the physician.

It is clear that patients' actual willingness and readiness to engage in this process is sometimes inhibited by psychological barriers. For example, many patients presume that their knowledge and experience is inferior compared to the expertise of health professionals. Hence, they are reluctant to share their observations, expectations and preferences. Moreover, some patients want to present themselves as "good patients" who do their best to follow the physicians' recommendations (Joseph-Williams, Andrews, Elwyn 2014). Taking into consideration those complex factors of a psychological nature, it

is does not suffice to announce a shift towards patient empowerment and inform patients that their remarks, questions or doubts are now welcomed. The physician should also be able provide the patient with a sense of psychological security facilitating greater openness. In case of self-management programs, it is also important to provide tools that will be adjusted to patients' lifestyle preferences (Galdas et al. 2014). For example, a web-based self-management program would probably fail if it is implemented among patients deprived of reliable access to the Internet.

Many of those barriers might be eliminated by adequate modifications in the training programs for physicians or information campaigns. This seems neither to be difficult nor too expensive. However, it might be more challenging to other barriers and obstacles associated with the logic of functioning of modern health systems, dominated by the pressure on increasing productivity, optimizing processes and reducing costs. Even if the declared objective of health policies is to improve health outcomes, service providers are under constant pressure to make better use of available resources, financial or human. While the self-management programs seem to contribute to the objectives, the shared decision-making might be in conflict with them. Kaplan (2004) formulated this problem as follows: *Today the average primary care visit is limited to 15 minutes. During this time, a clinician must engage the patient, take a history, perform a physical examination, make a diagnosis, review concerns, and write prescriptions. Within this crowded encounter, when and how will shared decision-making be introduced and completed?* A model according to which the physician is the sole decision-maker and the patient follows the physician's recommendations seems to be more efficient, predominantly less time-consuming. The dissemination of shared decision-making on a large scale would therefore require, at the least, the introduction of incentives into the system of financing and contracting providers. Otherwise, the shared decision-making will remain available only to those patients who are in a position to buy extra time of the physician, needed to complete the full cycle of co-deciding.

The conclusions stemming from the review of the European practices with regard to the co-production of health services are also relevant for other areas of public services, especially human services (e.g. education or social care). In all those areas, co-production has the potential to increase the quality of services and to deliver other positive outcomes. However, it is also needed to identify potential risks and challenges, and to understand that co-production requires "policy stimulation", i.e. promoting and facilitating co-productive arrangements via special institutional, legal and financial mechanisms.

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Cytowanie

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