The Health Foundation
Inspiring Improvement

What is co-production?

By Alba Realpe and Professor Louise M Wallace

on behalf of the
Coventry University
Co-creating Health Evaluation Team

Contents

Key Message

- Co-production has historical roots in civil rights and social care in the USA. In the UK, co-production in healthcare and social services has gone beyond models of service user consultation towards developing a model of service delivery intended to impact on service users and on wider social systems.

- Collaborative co-production requires users to be experts in their own circumstances and capable of making decisions, while professionals must move from being fixers to facilitators. To be truly transformative, co-production requires a relocation of power towards service users. This necessitates new relationships with front-line professionals who need training to be empowered to take on these new roles.

- Patient centredness describes the relationship between clinicians and patients as a meeting of two experts, each with their respective knowledge and skills.

- There has been far more emphasis on research and practice on elaborating the clinicians' skills in the co-productive consultation than there has been on the skills of the patient.

- This paper presents a descriptive model of the skills of clinicians and patients, and the context and outcomes of co-productive consultations.

Overview

The Health Foundation proposes that co production is central to how the Co-creating Health (CCH) initiative works. This report establishes the origins of co-production in health, economic and social arenas. How the concept is used in relation to people with long-term health conditions, how it can be defined, and how clinicians can capture the quality of co-production in consultations are also discussed.

The purpose of this paper is to establish a working definition of the co-production of health. As a delivery model for health services, co-production is based on the sharing of information and on shared decision making between the service users and providers (Bettencourt, Ostrom et al, 2002; Needham and Carr, 2009). It builds on the assumption that both parties have a central role to play in the process as they each contribute different and essential knowledge (Cahn, 2000).

Introduction

In the 1970s, social policy recognised how users can make a difference to the quality of service they receive when they participate in the delivery of the public service themselves. During the last decade, there have been efforts to explore how client involvement in service delivery can be encouraged and supported by the services themselves (Boyle et al, 2006a and b). One approach, which emphasises the importance of the collaboration between service providers and users, is co-production. It is also known as co-creating services, whereby service recipients are involved in different stages of the process, including planning, design, delivery and audit of a public service (Boyle, Clarke and Burns 2006a; Needham and Carr, 2009).

Historical background

Co-production was first conceptualised by an academic team led by Elinor Ostrom at Indiana University in the 1970s and described the lack of recognition of service users in service delivery. The concept was developed further by Edgar Cahn, a civil rights law professor, who created time banks, a system which relies on the participation of volunteers who are also service users (Boyle, Clarke and Burns 2006a; Needham and Carr, 2009). His work shows how successful collaborative interventions that involve people with long-term psychosocial needs can contribute to improve community links (Boyle, Clarke and Burns, 2006b).

In the UK during the 1980s, Anna Coote, director of health policy at the King's Fund, introduced the concept of co-production as a way to understand the relationship between clinicians and patients in health services.

By the mid-1990s, a combination of factors highlighted the need to attend to alternative models of delivery of services, including co-production (Needham and Carr, 2009). Firstly, the prevalent market model of public service delivery in the UK was found to give a poor return on investment (Boyle, 2004; Coote, 2002; Needham and Carr, 2009). Secondly, new types of knowledge generated by mass media, such as the internet, have challenged the assumption that providers have sole control of the information (Coulter and Ellins, 2006; Needham and Carr, 2009). Finally, more participatory ways of service delivery are actively sought by policy makers within social care and in promoting social capital (Cayton, 2004; Needham and Carr, 2009). Co-production is therefore a model of service delivery intended to impact on service users and on wider social systems.

THE NATURE OF CO-PRODUCTION

Co-production refers to the contribution of service users to the provision of services. Bettencourt and colleagues (2002) argued that this concept is critical in knowledge-intensive business services in the US and UK markets. A similar co-productive approach to the generation of knowledge has been applied in Germany and Spain in the field of biotechnologies (Ferretti and Pavone, 2009), and in community initiatives in Hungary (Bodorkós and Pataki, 2009).

From these examples we learn that co-production derivedfrom knowledge-based industries shows how the model permits the individualisation of service delivery. This delivery is based upon effective information exchange and shared decision making that respond to complex and unique service users' needs (Bettencourt, Ostrom et al, 2002). It challenges the idea of a passive customer by creating the expectation on the part of the service provider and the customer of equivalently active roles in the delivery of the service.

Co-production has also been applied to the provision of public services. In the European context, for example, co-production has been used to describe the relationship between government, private, voluntary and non-profit organisations in the delivery of public services (Pestoff, Osborne and Brandsen, 2006).

In public services, including those provided by not-for-profit bodies, co-production could have three different roles: co-governance, co-management and co-production. Co-governance refers to organisations that help in the planning and design of public services while co-management refers to the production of the service by the third sector organisation in conjunction with the state (Brandsen and Pestoff, 2006).

Co-production, however, is restricted to user involvement in the production of public services directly, with or without state intervention. In this case, the term refers to a certain type of user involvement at an individual rather than organisational level.

Although it is not the only type, it has been taken further as a way to create synergy between governments and citizens (Brandsen and Pestoff, 2006, p496).

Similarly, in a paper about public policy, engagement and participation, Bovaird (2007) placed emphasis on the co-productive relationship, which firstly works within a long-term perspective and secondly assumes that both citizens and government have a contribution to make to the provision of the service.

In the UK, there is growing interest in applying co-production to public services such as social care and health, where the emphasis is primarily concerned with a service to an individual rather than with organisational or community co-production.

CO-PRODUCTION IN SOCIAL CARE

In a research briefing for the Social Care Institute for Excellence, Needham and Carr (2009) proposed that co-production in social care can have a transformative effect on the provision of public services.

Co-production has been applied to the collaboration between a professional or technical provider and a service user. UK government policies, such as person-centred care and individual budgets, are examples guided by this type of co-production (Wilson, 2001).

Collaborative co-production challenges the usual relationship between professionals and service users. It requires the latter to be considered experts in their own circumstances and therefore capable of making decisions and having control as responsible citizens (Boyle, Clarke and Burns, 2006a).At the same time, co-production also implies a change in the role of the professionals from fixers of problems to facilitators who find solutions by working with their clients. This approach promotes the importance of front-line staff to the delivery of a service (Needham and Carr, 2009).

The effect of co-production in a service can go from merely descriptive to recognisable or truly transformative (Needham and Carr, 2009). At a descriptive level, co-production is used to restate how services rely on the users' input to achieve predetermined outcomes. It aims to address the problem of compliance by attaining an agreement between the provider and the service user through shared problem definition and the design and implementation of solutions.

The intermediate or recognisable level of co-production is characterised by the acknowledgement of, and sometimes requirement for, users to be involved in problem-solving tasks and crucially in agreeing outcomes. The delivery system should have structures in place to support users' contributions and be more accommodating to the needs of the individual (Needham and Carr, 2009). However, this stops short of a shift in the power that service providers have in determining how the service is delivered. According to Needham and Carr (2009), when there is a relocation of these power structures, co-production has an even more transformative effect on the service delivery.

Indeed, when co-production is fully assumed, this relocation of power is accomplished by the development of new user-led mechanisms of planning, delivery and management. Also there is a considerable effort to train and empower front-line staff who become crucial to the quality of service delivery.

At an individual level in a research report to the Joseph Rowntree Foundation, Boyle and colleagues (2006b) stated how being involved in co-productive social programmes can make an important contribution to peoples' physical and mental health. They suggested that the creation of social networks working in partnership with services is important for recovery, especially for people with long-term conditions. Similarly, there is an increasing use of co-production in the provision of health services via policy directives (Boyle, Clark and Burns, 2006b).

CO-PRODUCTION
AND HEALTHCARE

In service delivery, co-production is highly individualised to the unique needs of users (Bettencourt, Ostrom et al, 2002). It depends on the development of a long-term relationship between the provider and the recipient where information and decisions are shared (Bovaird, 2007).

Co-production challenges the assumption that service users are passive recipients of care and recognises their contribution in the successful delivery of a service (Cahn, 2000). At the same time, it involves the empowerment of front-line staff in their everyday dealings with customers (Needham and Carr, 2009).

There is also a recognition that setting up co-productive relationships may have positive implications in social and health circumstances (Boyle, Clarke and Burns, 2006a).

The renewed interest in co-production has coincided with the search for new models of delivery of health services in policy, evident in the NHS (Boyle, Clarke and Burns, 2006a; Coote, 2002; Wilson, 2001). The need for change was expressed by the former Secretary of State for Health Alan Johnson in an address to the 2008 NHS Confederation annual conference when he stated that, '[The 19th century] was an age of acute and infectious disease, whereas today, we battle with lifestyle and chronic disease'.

The White Paper Our health, our care, our say: a new direction for community services (Department of Health, 2006) sets out the agenda for user involvement in a whole range of social and health services, especially for those with long-term needs, and encourages greater links between services. Recent NHS quality improvement programmes have positioned patient centredness and patient involvement, as well as self-management interventions for people with long-term health conditions, at the heart of government initiatives (Cayton, 2004).

LONG TERMS
HEALTH CONDITIONS

There are important differences between what is considered to be an acute health condition and what is a chronic or long-term condition (Epping-Jordan, Pruitt et al, 2004; Hall and Roter, 2007; Wilson, 2001). The former tends to be episodic and generally treatable. Long-term conditions, however, are ongoing, incurable and need to be managed for life. This generally implies that the quality of life and the patient's work and family may be affected further than in an episodic event of ill health (Boyle, Clarke and Burns, 2006a; Wagner, Austin et al, 2001).

Long-term health conditions currently affect more than 17 million people in the UK and they fill 80% of consultations in primary care (Department of Health, 2005). It is recognised that systems are not supporting people adequately.

In the USA, for example, the Institute of Medicine's Crossing the quality chasm report states that 'Health care for chronic illness is confusing, expensive, unreliable and often impersonal' (IOM, 2001).

Taking into account the characteristics of long-term health conditions, Wagner (1998) developed a chronic care model, which has been adopted by the NHS as the generic model for long-term health conditions (Epping-Jordan, Pruitt et al, 2004). According to Wagner's model, one of the main tasks for health services should be to support self-management. This is an important area and needs to be embedded in a system that includes activated patients, prepared clinicians and a responsive and flexible administrative structure (Wagner, 1998).

There is strong evidence that suggests that self-management support is more likely to work if transformation in every part of the system takes place instead of the implementation of isolated strategies which have no long-lasting impact (Wagner, Austin et al, 2001). The system should integrate the expertise and skills of the health providers, ensure the provision of health education and support to patients, guarantee the provision of planned and team-based care delivery and enforce the use of clinical registers (Coleman, Austin et al, 2009).

The chronic care model falls short of describing the necessary features of the co-productive relationship between the clinician and the patient in the consultation.

CO-PRODUCTION OR HEALTH AND THE CLINICIAN-PATIENT RELATIONSHIP

With the growing interest in patient centredness, the relationship between clinicians and patients is now recognised to be a meeting of two experts. The clinician has knowledge of diagnosis, treatment options and preferences, aetiology and prognosis and the client knows about the experience of illness, social circumstances, and attitudes to risks, values and personal preferences (Coulter, 2006). When the contribution of each participant is recognised, the consultation becomes relationship centred, and the main purpose is to create a meeting that is informative, receptive, facilitative, medically functional and participatory (Hall and Roter, 2007; Street Jr, Makoul et al, 2009).

At the centre of this relationship is communication between providers and patients (Pawlikowska, Leach et al, 2007). There have been attempts to get agreement on what constitute the essential aspects of effective communication. For example, the 2001 Kalamazoo consensus stated that there are seven essential communication tasks in a medical consultation, namely to:

- build the doctor–patient relationship
- open the discussion
- gather information
- understand the patient's perspective
- share information
- reach agreement on problems and plans
- provide closure.

(Bayer Institute for Health Care Communication, 2001, p391)

These communication tasks give a structure to the consultation which takes into consideration the patient's current situation, not only their symptoms. Additionally the consensus stated that both parties should ideally reach agreement on the problem and the treatment course.

Clinicians require particular skills to achieve these tasks. According to Pawlikowska and colleagues (2007) the skills described in models of consultations include 'establishing rapport, questioning style, active listening, empathy, summarising, reflection, appropriate language, silence, responding to cues, patient's ideas, concerns and expectations, sharing information, social and psychological context, clinical examination, partnership, honesty, safety netting/follow up and housekeeping'. However, there is a change of emphasis in consultations for chronic conditions which are aimed at the co-production of health. These consultations need to support self-management in order to improve user involvement and health outcomes (Coleman, Austin et al, 2009).

Research in the field has suggested that clinicians can perform particular actions in order to support self-management, such as to enquire about the self-management beliefs of the patient and to ask for the levels of confidence and motivation for why the patient feels that they have to take action, such as goal planning, towards better health (Shaefer, Miller et al, 2009). There is also a growing interest in what kind of skills patients can develop in order to obtain the benefits of a good consultation.

PATIENTS' SKILLS IN CONSULTATIONS FOR LONG-TERM HEALTH CONDITIONS

By considering consultations for people with long-term health conditions as an opportunity to co-produce health it is important to explore which skills are expected to be developed in those who receive the service. The Expert Patient Programme (www.expertpatients.co.uk), based on the model for chronic disease self-management developed by Kate Lorig at Stanford University (Wilson, 2001), promotes five core areas of self-management of long-term health conditions, namely:

- problem solving
- decision making
- resource utilisation
- developing effective partnerships with healthcare providers
- taking action in order to make behavioural changes.

(Department of Health, 2001)

The programme encourages patients to increase their health literacy and to participate actively in their care by sharing knowledge of their condition, preferences and concerns with healthcare providers (Wilson, 2001). However, there is little content on the preparation for, and conduct within, consultations.

Figure 1 shows the two sets of basic skills that have been proposed for a good consultation as well as the tasks that need to be achieved. It is important that these skills and tasks are present in a successful clinician–patient consultation. However, it is likely that some are more relevant for those consultations which are designed to co-create health and become opportunities to engage patients in effective self-management.

THE FEATURES OF CO-PRODUCTION RELEVANT TO CO-CREATING HEALTH

As a delivery model for health services, co-production is based on the sharing of information and on shared decision making between the service users and providers (Bettencourt, Ostrom et al, 2002; Needham and Carr, 2009). It is expected to result in the empowerment of front-line staff (Needham and Carr, 2009) and in increasing levels of service user confidence to find suitable solutions to their concerns (Boyle, Clarke and Burns, 2006b).

Co-production aims to highly individualise treatment solutions (Bettencourt, Ostrom et al, 2002). As people with long-term conditions have to change their lifestyle because generally the implications of the condition are wider and permanent (Hall and Roter, 2007), having a proactive professional with a long-term relationship with the patient is a key component of co-producing specific solutions (Wagner, 1998).

Co-production of health in consultations is a crucial part of a system to support self-management (Bodenheimer, Wagner and Grumbach, 2002). However, defining the exact skill set for teaching purposes and for research is a challenge (Street Jr-, Makoul et al, 2009). Few researchers have been able to demonstrate the expected links between the communication processes and better long-term health outcomes. Not only is there the difficulty of clearly showing the connection between the communication and a specific outcome but there are also limited tools to measure this connection.

Additionally, considering a consultation within the framework of co-production may also prove to be a challenge as the solutions achieved are generally individualised and contextually based, as well as presenting a clear picture of what the partnership may look like in clinical consultations.

The first themed paper (Ahmad, Wallace et al, 2009) described early findings from the process observations, surveys and interviews with participants in the CCH programmes. The second annual report (Wallace, Turner et al, 2010) extends this work, showing where there are gaps within and between programmes in building the skills and motivation of patients and clinicians, and the service support for co-productive consultations.

The process observations of the self-management programme and interviews with patients and tutors have already thrown light on the tasks and skills that patients need to apply if they are to be active co-producers of the consultation. The video analysis of observations of consultations in CCH will begin to address some of these issues by developing a model and means of measuring co-production in consultations for people with long-term health conditions.

Figure 1: Co-production of health in consultations for people with long-term health conditions
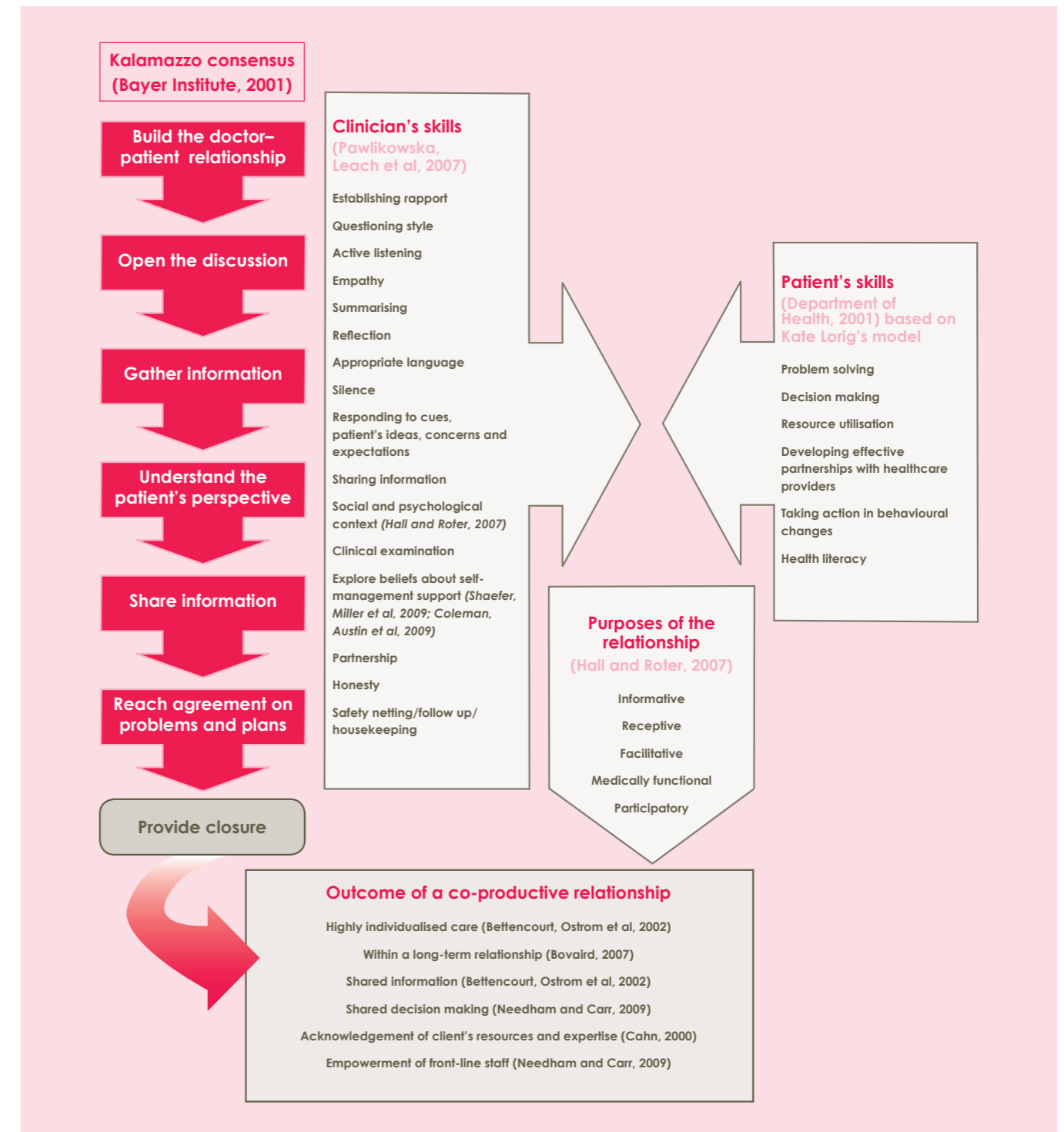
References

1. Ahmad N, Wallace LM and Turner A (2009). Exploring the significance given to the patient's role in CCH: how the patient role is utilised and what this implies for patient empowerment. London: The Health Foundation.

2. Bayer Institute for Health Care Communication (2001). 'Essential element of communication in medical encounters: the Kalamazzo consensus statement'. Academic Medicine: Journal of the Association of American Medical Colleges, vol 76, pp390–393.

3. Bettencourt LA, Ostrom AL, Brown SW and Roundtree RI (2002). 'Client co-production in knowledge-intensive business services'. California Management Review, vol 44, pp100–128.

4. Bodenheimer T, Wagner EH and Grumbach K (2002). 'Improving primary care for patients with chronic illness: the chronic care model, Part 2'. Journal of the American Medical Association, vol 288, pp1909–1914.

5. Bodorkós B and Pataki G (2009). 'Linking academic and local knowledge: community-based research and service learning for sustainable rural development in Hungary'. Journal of Cleaner Production, vol 17, pp1123–1131.

6. Bovaird T (2007). 'Beyond engagement and participation: user and community co-production of public services'. Public Administration Review, vol 67, pp846–860.

7. Boyle D (2004). 'Is this how to end public service failure?'. New Statesman, vol 133, pp2–21.

8. Boyle D, Clarke S and Burns S (2006a). Aspects of co-production: the implications for work, health and volunteering. London: New Economics Foundation.

9. Boyle D, Clarke S and Burns S (2006b). Hidden work: co-production by people outside paid employment. London: Joseph Rowntree Foundation.

10. Brandsen T and Pestoff V (2006). 'Co-production, the third sector and the delivery of public services'. Public Management Review, vol 8, pp493–501.

11. Cahn E (2000). No more throw away people: the co-production imperative. Washington: Essential Books.

12. Cayton H (2004). Patient-engagement and patient decision-making in England. Paper presented at the Improving Quality of Health Care in the United States and the United Kingdom: Strategies for Change and Action.

13. Coleman K, Austin BT, Brach C and Wagner EH (2009). 'Evidence on the chronic care model in the new millennium'. Health Affairs, vol 28, pp75–85.

14. Coote A (2002). Claiming the health dividend: unlocking the benefits of NHS spending. London: King's Fund. Available from: www.kingsfund.org.uk

15. Coulter A and Ellins J (2006). Patient-focused interventions: a review of evidence. London: The Health Foundation. Available from: www.health.org.uk/publications

16. Department of Health (2006). Our health, our care, our say: a new direction for community services. London: Department of Health. Available from: www.dh.gov.uk

17. Department of Health (2005). Supporting people with long term conditions: an NHS and social care model to support local innovation and integration. London: Department of Health. Available from: www.dh.gov.uk

18. Department of Health (2001). The expert patient: a new approach to chronic disease management for the 21st century. London: Department of Health. Available from: www.dh.gov.uk

19. Epping-Jordan JE, Pruitt SD, Bengoa R and Wagner EH (2004). 'Improving the quality of health care for chronic conditions'. Quality and Safety in Health Care, vol 13, pp299–305.

20. Ferretti MP and Pavone V (2009). 'What do civil society organisations expect from participation in science? Lessons from Germany and Spain on the issue of GMOs'. Science and Public Policy, vol 36, pp287–299.

21. Hall JA and Roter D (2007). 'Physician-patient communication' in Friedman H and Silver R eds, Foundations of Health Psychology. New York: Oxford University Press.

22. Institute of Medicine (2001). Crossing the quality chasm: a new health system for the 21st century. Washington, DC: Institute of Medicine.

23. Needham C and Carr S (2009). SCIE Research briefing 31: co-production: an emerging evidence base for adult social care transformation. London: Social Care Institute for Excellence. Available from: www.scie.org.uk

24. Pawlikowska T, Leach J, Lavallee P, Charlton R and Piercy J (2007). 'Consultation models' in Charlton R ed, Learning to consult. Oxford: Radcliffe.

25. Pestoff V, Osborne SP and Brandsen T (2006). 'Patterns of co-production in public services: some concluding thoughts'. Public Management Review, vol 8, pp591–595.

26. Shaefer J, Miller D, Goldstein MG and Simmons L (2009). Partnering in self-management support: a toolkit for clinicians. Cambridge, MA: Institute for Healthcare Improvement.

27. Street Jr RL, Makoul G, Arora NK and Epstein RM (2009). 'How does communication heal? Pathways linking clinician–patient communication to health outcomes'. Patient Education and Counseling, vol 74, pp295–301.

28. Wagner EH (1998). 'Chronic disease management: what will it take to improve care for chronic illness?'. Effective Clinical Practice, vol 1, pp2–4. Available from: www.acponline.org/clinical_information/journals_publications/ecp/augsep98/cdm.pdf

29. Wagner EH, Austin BT, Davis C, Hindmarsh M, Schaefer J and Bonomi A (2001). 'Improving chronic illness care: translating evidence into action: interventions that encourage people to acquire self-management skills are essential in chronic illness care'. Health Affairs, vol 20, pp64–78.

30. Wallace LM, Turner A, Kosmala-Anderson J, Bishop A, Sharma S and Smith A (2010). The second annual report of the evaluation of The Health Foundation's Co-creating Health initiative. London: The Health Foundation.

31. Wilson PM (2001). 'A policy analysis of the Expert Patient in the United Kingdom: self-care as an expression of pastoral power?'. Health and Social Care in the Community, vol 9, pp134–142.

The Health Foundation wants the UK to have a healthcare system of the highest possible quality – safe, effective, person-centred, timely, efficient and equitable. We believe that in order to achieve this, health services need to continually improve the way they work.

We are here to inspire and create the space for people, teams, organisations and systems to make lasting improvements to health services.

Working at every level of the healthcare system, we aim to develop the technical skills, leadership, capacity, knowledge, and the will for change, that are essential for real and lasting improvement.