The Medical Encounter: Building Co-creation Capabilities in Healthcare Services

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Abstract
This study explores the conceptual framework on value co-creation within the context of the medical encounter. Based on a synthesis of the literature, this study examines the patterns of capability development with consideration of adding co-creation capabilities through which health care workers can learn from the medical encounter.

Keywords: Co-creation, Medical encounter, Healthcare

Introduction
A customer, under a traditional perspective, is seen as a passive recipient of the companies (Payne, Storbacka and Frow, 2008). However, since the emergence of globalization and the spread of information through the internet, customers are increasingly taking an active and
reflective role in today’s society (Ueda et al, 2009). In addition, patients are increasingly taking a position to participate in decisions about their health, in an active and reflexive stile. (McColl-Kennedy et al, 2013).

The rapid growth of online social networks services has increased the complexity of the health systems. The social networks of patients may compete or supplement the social networks of health staff. The patients are using the social networks to access and to contribute with information about health. The medical encounter is more permeable to the social networks and employees’ networks. There is a potential tendency for the social networks change their patterns of differences on the medical services, the access to the health care, the stability of the provision of caring and a change on the health staff scripts behavior (Griffiths et al, 2012).

On the contrary, the beliefs, attitudes and the behaviors of the health care staff can surpass the patients’ participation on the decisions, taken about his own health. One of the reasons for that goes over the refusing of the health professionals in giving up the old traditional fatherhood standard on healthy assistance and change to the cocreation paradigm. There are others obstacles that can make difficulties on changings between the archetypes of the relation patients/health care staff, such as social rules that define a passive attitude to the patient and an organizational culture for not getting feedback from patients (Longtin et al, 2010).

Under a broader perspective, this paper proposes an environment of networking experience for configuration values on health services based on the triangulation of four models reviewed in the literature of co-creation.

The customer participation on the values creation
From 1960 decade on, we see a globalized tendency of movement from people about his rights of being well informed, heard, getting their points taken in consideration, the right of choosing and security around themselves. On health area, the same movement arises from the patient’s participation over health assistance: diagnoses and treatment, objectives, patient’s education, decision making. The passive patient archetype, traditionally faced as a passive spectator on the health decisions making, adjusts itself to the script of getting involved on the decision making process about health. The patient assumes a new archetype: an active and reflexive customer, empowered of self-wish and determination. As any other customer, the patient starts demanding assistance services with high quality level. (Longtin et al, 2010; Otani, 2010).

On the tradicional view, the customer is a passive recipient, separate and outside the company (Payne, Storbacka and Frow, 2008). This perspective still predominates on health
services (Berry and Bendapudi, 2007). In despite of that, a new paradigm emerges, on bases where the customers can cocreate values with the company and other related people else. (Prahalad and Ramaswamy, 2004 a; Vargo and Lusch, 2004; Schau, Muniz and Arnould, 2009). The customer changes from the passive archetype to the active archetype (Payne, Storbacka and Frow, 2008). The customer becomes endogenous as much as for his own values creation as for the company creation. (Vargo and Lusch, 2008c). The process establishes itself as continuum where the customers assume several active scripts on the provision of services and on benefits performances (Prahalad and Ramaswamy, 2000; Vargo and Lusch, 2004). The service provider is seen as a partial element that provides inputs to the process of creating customer value, among others resources, that includes also the clients own activities (Vargo and Lusch 2004).

The basic premise of the new creation model value is the experience. The experience is created together with the company and the customers. This is the cocreation experience (Prahalad and Ramaswamy, 2003). The experience of innovation involves networks, extensibility, granularity and expandability (Prahalad and Ramaswamy, 2003). There is the demand of network experiences; intelligent services and products; dialog, access and transparence; customers commonwealths; actions on real time, heterogeneity and complexity comprehension, alliances, fast resources reconfiguration. Products and technologies are not objectives themselves, but they work as vehicles of experiences (Prahalad, 2004).

The cocreation generates efficient solutions through multiples interactions among several elements of a global system. The artefact, the people and the society, nowadays, are very close inter-related, on such a way that the creation of the values emerges through these three elements interaction. Therefore, as much as the product creation, the services creation requires comprehension itself under a single perspective of value creation. On the experience of value co-creation, the value of the product or service supplier, as well the value of the customer can not be set up by itself. The separation between both does not fit because they interact to each other (Ueda, Takenaka and Fujita. 2008).

The value can be assigned as a social construction. Therefore, social forces shape the co-creation of values, it is generated in social structures and it presents itself, sometimes, on a no symmetrical shape among the several social players. The players learn and change their scripts into the services dynamics systems (Edvardsson, Tronvoll and Gruber, 2010). The value creation involves two linked concepts: co-production and the cocreation. The co-production refers to the participation of the client in creating a product or service, while the co-creation represents a construct of higher order that captures the idea that value can be created and
defined just by the customer during the product or service consumption. The co-creation can happen with or without co-production (Vargo and Lusch, 2004; 2008c)

**Environment of networking experiences of value configuration in healthcare**

This paper proposes a model for an environment of networking experiences of value configuration in healthcare. This model was developed from the literature review. The paper proposes a triangulation of approaches of Elg et al (2012), Ueda et al (2009), Grönroos (2011) and Payne et al (2009).

Elg et al (2012) describes the co-creation process with the patient and the learning process through these three phases: preparation, execution, and learning.

The preparation phase consists on a stage of selection of care process for the co-creation experience with the patient, on the design of data collection process and on the *media* selection of data collection. (Elg et al, 2012). This phase fits to the analyses phase (collection and selection ) of the model of Ueda et al (2009), that consists on extracting the partial knowledge around the existing body of knowledge available (environomt, people, artefacts).

Therefore, by analogy, so there is product and service development in healthcare, it becomes crucial, initially gathering of knowledge available. In addition, it follows the proper selection of the acquired knowledge for the design oh healthcare services (input model of figure 1).

Considering the model of Grönroos (2011), there is an opportunity of connection of these phases (preparation/analysis) between the supplier and the patient processes. The customer process input starts with products and services research available on the market that can meet their needs and expectations.

On the other hand, the supplier must collect data on patients’ expectations of products and services. Then, it emerges an opportunity for a joint production of values between suppliers and customers (co-development).

The subsequent subprocess of the patient is to assess the usefulness of products and services provided by the supplier. Another opportunity for the supplier select the alternatives that are aligned with the patients’ perspectives (services co-design).
Figure 1 – Environment of networking experiences of value configuration in healthcare.

Source: prepared by the authors, 2013.
A co-creative organization attends the insights originated on the engagement of the customers’ experiences (stakeholders related to the process). Designing and redesigning what value is. (Ramaswamy and Gouillart, 2010), on practice matching (Grönroos, 2011; Payne et al, 2009).

The execution level includes the recruitment of patients and the support to their claims (Elg et al, 2012). There is a correlation with the structuring stage, synthesis phase, of Ueda et al (2009). There is usually multiples possibilities of arrangements or potential solutions that can meet the customers’ requirements. It emerges a composition of a new unit to be made available to the customer. (UEDA et al, 2009).

The organization must align the resource availability to the acquisition by the patients. The available resources, even though having some function, do not aggregate values to the customers. Even the available resources operate properly on the patients’ context; there are few chances that they aggregate value to their own experience (UEDA et al, 2009). The organization can also explores a competitive advantage by opting for coproduction of the resources along the customers.

The way the product or the service is delivered and the way the patient use it are the initial critical phases for the values cocreation and the decisions taken shared on the encounter among the customer and the front-line staff (physician, nurse, technical nurse, physiotherapist, nutritionist, and psychologist, and so on...).

During the high-contact service, among the patient and front-line staff care, arises the opportunities of interactions to cocreate values (value-in-use). For a strong interaction, it is needed the construction blocks, presented by Prahalad and Ramaswamy (2004); dialogue, access, evaluation on the relation risk/benefits, and transparency.

The customer experience is critical for himself getting interested on the cocreation process. We get though into the learning phase of Elg et al (2012). Several ways of learning arises for the cocreation experience. The patients’ ideas can be used as the base for innovation and developing care process; and can identify critical events, positives or negatives, on the care process and can contribute to the holistic patient comprehension perspective on the executed service (Elg et al, 2012).

The encounters are the interactions and transactions that occur during the relationship between the patient and the front-line staff (both integrated resources). The initiative for the encounter itself can be taken by any of the parts. The encounters are represented on the figure 1 by the dotted arrows with double direction. The double direction arrows has the objective of
laying emphasis on the fundamental element of the cocreation and the service dominant logic, i.e. the dialog between the two parts (Payne et al, 2009).

The form and the mix of the co-creative processes are highly dependent on specific contexts, the variation depending on the nature and the extent of the relationship. The co-creative encounters (colored rectangles with dotted borders) influence the patient’s ability, desire and opportunity to co-create with the front-line staff. The brand communication and the attitude toward the brand are two aspects that facilitate the co-creation process (Payne et al, 2009).

The encounters can give support to the cocreation under a cognitive perspective: sense-making (Why should I get involved with this process?) This contributes for the informations sharing and the expertise development. As much as providing emotional support (Payne et al, 2009). The emotional engagement is critical for the loyalty of the patient, by converting him on an active service promoter. Those encounters can be functional support actions else, on such a way that the patient can be engaged on several activities, as sickness prevention campaigns and health promotion.

The service exchange occurs on such large configuration space (rectangle with the traced sides that includes all the dotted arrows). Both parts are embedded on larger networks (networks of employees/networks of customers). On the figure 1, the actors, on each network, are represented on different colors, symbolizing different roles. For example, on the customer network: parents, nurses, carers, friends, medical staff, counselors, pharmacies, laboratories, and so on.

These networks are complex adaptive systems services (Lusch, Vargo and Wessels, 2008). They adapt to changes in the enviroment and they are able to organize their resources to such adaptations. As much as being social systems too, it implicates on interactions between the actors on several social contexts (Edvardsson, Tronvoll and Gruber, 2010). Each service system has its single identity, and a story which the sequence involves interaction episodes versus systems and versus itself. (Spohrer et al, 2008).

The management of co-creation encounters modulates the contents and the experiences which are due to the different interactions phases (Payne et al, 2009), from service delivery, through the customer loyalty, until the service recovery for poor services or damage claims. Identifying and making a map of each of those phases, it can contribute for the comprehension of each of those parts, patient and the front-line staff, living with those interactions.

The customer process represents a succession of activities through which it has an objective to reach: a unique experience. During the front-line staff encounter along the
customers, there is a flow of fantasies, feelings and emotions with more or less awareness (Payne et al, 2009). The front-line staff process must incorporate the wise patient’s experiences with the organization and of how is the engagement of patient with the services or products as time goes by. The organization has a unique opportunity of encouraging the communities of patients by stimulating those using innovations and upgrading services and products for them.

To what extension the effects of patient’s perception of the cocreation process may contribute to it to increase the confidence and commitment with the front-line staff, as much as improving their comfort with interactions, as suggests Grönroos (2011) on business-to-business?

The exploitation of Grönroos model can speculate that on the front-line sphere occurs the values facilitation process (co-development, co-design, customization, co- innovation, etc.), while the creation of values (value-in-use) occurs on patient sphere. Under the creation values perspectives seen, the front-line staffs are invited to engage themselves on the patients’ process, facilitating the value creation to the patients. During the interaction process, the front-line staff get the opportunity to learn with the patient, and influence the flow and the process of value creation.

Those flows present some common senses on each other. However, as Grönroos (2011) suggests, just the existence of an interaction does not mean that the actions of one part influences on the other part itself. The interaction is just an engagement platform, from the perspective of the front-line staff (Ramaswamy and Gouillart, 2010), an opportunity to influence the customer’s process (Grönross 2011).

An organization can do the first attempt to apply the cocreation by planning the engagement plataforms. On early stages, the engagement plataforms are like sand boxes. The term sandbox is used by analogy to describe a space for testing, I mean a space for the people to perform all the necessary tests to meet the best model for the context), an environment where people can plan as a group team along the organization, their future and their interactions modes. That requires experimentation and learning, attempts and wrongs as time goes by (Ramaswamy and Gouillart, 2010).

References


