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Value Co-Creation through Patient Engagement in Health Care: A micro-level approach and research agenda

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Abstract

Patient engagement has gained increasing prominence within academic literatures and policy discourse. With limited developments in practice, most extant academic contributions are conceptual, with initiatives in the National Health Service (NHS) concentrating at macro- rather than at micro-level. This may be one reason why the issue of 'value co-creation' has received limited attention within academic discussions of patient engagement or policy pronouncements. Drawing on emerging ideas in the services marketing and public management literatures, this article offers the first elucidation of the importance of studying 'value co-creation' as a basis for further empirical analysis of patient engagement in micro-level encounters.

Key words

Patient engagement, value co-creation, service-dominant logic, micro-level approach

VALUE CO-CREATION THROUGH PATIENT ENGAGEMENT IN HEALTH CARE

A micro-level approach and research agenda

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INTRODUCTION

Patient engagement (also commonly referred to as 'participation' or 'involvement') in the planning, development, and analysis of health care has received increasing attention in the last decade (Armstrong et al. 2013; Bate and Robert 2006). It has variously been proposed as a vehicle for maintaining the sustainability of the National Health Service (NHS); delivering safer health care, managing long term conditions, and improving accountability, health care delivery, and health equity (Coulter 2012; Ocloo and Fulop 2012; Francis 2013; Department of Health 2002; Renedo and Marston 2011). Despite the increasing concern for patient involvement in health care, improvements to practice remain slow and variable (Ward et al. 2011; Ward and Armitage 2012; Ocloo and Fulop 2012; Hor et al. 2013). Additionally, the research evidence base underpinning patient engagement in health care is limited, with the results being difficult to assess or generalize (Staniszewska, Herron-Marx, and Mockford 2008).

In the United Kingdom, there has been an emphasis within the NHS on developing individuals' capacities for patient engagement. The application of this approach has typically ignored the contextual and relational barriers and facilitators to involvement (Renedo and Marston 2011). Academic analysis and practical development of patient engagement has also been hampered, to date, by factors including a lack of agreement about what 'participation' means in practice and when it may be necessary, debates concerning both policy and theoretical rationales for involvement (who to involve, why, and how), varying levels to apply engagement (macro-, meso-, or micro-level), competing perspectives on the validity of knowledge of those involved (e.g., expert vs. lay knowledge), the relationship between professional providers of services and the public they serve, and the number of possible roles that users may assume (Renedo and Marston 2011; Martin 2008a, 2008b, 2009; Greenhalgh, Humphrey, and Woodward 2011; WHO/Europe 2013; LéGaré, Stacey, and Forest 2007; Gibson, Britten, and Lynch 2012; Fotaki 2011).

While recognizing the issues outlined above as crucial to the development of conceptual and practical understandings of patient engagement, our contribution to this emergent field elucidates the importance of 'value co-creation' in furthering understandings of patient engagement in health care at the micro-level. In terms of unit of analysis, we address Coulter's (2012, 7) concern that 'the NHS has put the cart before the horse when it comes to patient and public engagement' by failing to explore participation within individual service encounters. In terms of analytical theme, we draw from services marketing and public management literature (Vargo and Lusch 2004a, 2004b, 2006, 2008, 2011, 2012; Osborne 2010; Osborne, Radnor, and Nasi 2013) to emphasize the importance of examining value co-creation within patient engagement in health care.

This article first advocates a micro-level approach to the investigation of patient engagement in health care, then explicates the potential contribution of 'value co-creation' (a developing body of work in services marketing) to such analyses.

Drawing upon emerging literatures concerning service-dominant logic (SDL) (which emphasizes the co-creation of value and 'customer-centric' services) and the recent application of this approach in public management (Osborne, Radnor, and Nasi 2013), this article suggests that exploring value co-creation through patient engagement at a micro-level is important for health care practice and policy and presents opportunities to enhance 'participation' initiatives at meso- and macro-levels. Given the increasing emphasis on the measurement and creation of value in health care services (Porter 2010; Porter and Teisberg 2006), this article contributes to public management literature in two main ways. First, by specifically framing this discussion within a services perspective and, second, by advocating a micro-level approach to studying value co-creation and patient engagement in health care encounters.

The remainder of this article is structured as follows. First, the wider participation literature and the proposed rationale for a micro-level focus on patient engagement and 'value co-creation' is debated. Second, a brief introduction to the services marketing literature and key aspects of SDL of which value co-creation is a central tenet, are outlined. The application of the services literature to public management, 'public service-dominant approach' is also then explored (Osborne 2010; Osborne, Radnor, and Nasi 2013). Third, the SDL literature concerning 'value co-creation' is applied to the health care arena, and debates concerning conceptualizations of value, value creation, and co-creation are summarized. The usefulness of service interaction spheres (specifically the 'joint sphere') to contribute to the study of value and value co-creation in patient engagement in health care is considered. Finally, the potential implications of applying the SDL approach to value co-creation and patient engagement in health care interactions are outlined. The elements of value co-creation which warrant further analysis within micro-level health service encounters and patient engagement in health care are also identified.

PARTICIPATION, VALUE, AND A MICRO-LEVEL APPROACH

Our attempt to place value co-creation during service encounters at the centre of the analysis of patient engagement arises from arguments that for public management to demonstrate effectiveness, 'it must contribute to the value experienced by its multiple stakeholder groups' (Wright, Chew, and Hines 2012, 441). Patient participation has, for some time, been portrayed as means of delivering such benefits through, for example, improved accountability, enhanced information, lay-involvement in decision making, and more innovative provision (Crawford et al. 2002). There are, however, a number of well documented challenges in realizing such goals. The absence of conceptual clarity and the widespread disagreements concerning the meaning of 'participation' and when it might be necessary have been raised as key concerns in relation to patient and public participation (Renedo and Marston 2011; Martin 2008a, 2008b). There is also substantial debate and disagreement amongst policy makers, health care

professionals, and participants concerning roles and definitions underpinning patient and public participation in terms of who to involve and the rationales for such approaches (i.e., democratic, technocratic, experiential representation), which professionals may reinterpret in response to their own agenda and projects (Martin 2008a, 2008b, 2009; Renedo and Marston 2011). Power, professional status, competing perspectives on knowledge, and resistance within organizational cultures may all also serve to influence the direction and outcomes of involvement initiatives (Renedo and Marston 2011; Gibson, Britten, and Lynch 2012).

Despite variation in the mechanisms and methods for delivering patient participation, the model in health and social care systems according to Gibson, Britten, and Lynch (2012, 531) remains 'fundamentally the same'. Without attention and recognition to diverse forms of expertise and different arenas for knowledge production, Gibson, Britten, and Lynch (2012, 545) suggest that structures and initiatives that are set up are 'likely to become increasingly irrelevant to all those aside the professional involvement industry'. They propose a four-dimensional framework (expressive to instrumental action, weak to strong publics, monism to pluralism, and conservation to change) for analysing the nature of patient and public participation and suggest these provide co-ordinates along which 'new knowledge spaces' for patient and public participation can be constructed. Renedo and Marston (2011) additionally advocate that the nature of interactions between patients and professionals and patient participant identities is considered. Such processes, they outline, may hinder successful participation even where there is an institutional infrastructure to support engagement. The importance of interactions between providers and users of health services in facilitating engagement has also been emphasized in relation to patient safety. It has been proposed that a fundamental shift is required in how patients and professionals view their roles, and that collaborative patient–provider relationships are the key to safe care (The Health Foundation 2013; Hor et al. 2013).

While recognizing the importance of the broader issue of how to engage publics (citizens) in decisions about the development, planning, and provision of health, this is beyond the scope of this article. Rather, we focus on the role of the patient within health service encounters (micro-level). This unit of analysis features concern for issues including health literacy, willingness and desire to participate, professionals being adequately trained in involvement methods, and unclear lines of responsibility for improving patient experience within organizations (see Coulter 2011, 2012 for further commentary). In line with Coulter (2011), we suggest that the needs of patients and public (citizens) are considered separately. From the patient's perspective, the focus is more likely to be on the quality of care and everyday interactions with health professionals. As citizens, this is potentially about the pattern and nature of service provision (Coulter 2011). A view also endorsed by the World Health Organization (WHO/Europe 2013) who acknowledge that engagement can occur at differing levels (macro, meso, micro) and that the design of institutional structures may affect processes for providing care, but advocate a

specific focus on the micro-level. This being viewed as the primary process in health care, where patients are treated and where opportunities may arise for them to co-produce and actively participate in decision making, self-management, and error prevention. Approaches such as shared decision-making have been advocated as a way to lead to treatment choices that improve outcomes that patients 'value' (Coulter 2012; The Health Foundation 2012). Yet progress in implementing shared decision-making has been slow (Elwyn et al. 2010). Emphasis has also not directly focused within such literatures on what 'value' actually means to patients and how this is created. Focusing on the nature of interactions at the micro-level of the medical or service encounter may enable exploration of how 'value' is created and experienced within such encounters.

Value has been viewed by some as 'the dominant paradigm for the NHS for the next decade and beyond' (Right Care 2011, 19). Such statements draw (explicitly or implicitly) on the work of Porter and colleagues in relation to value-based health care and delivery, where 'value' is viewed as health outcomes (patient specific) relative to the cost of that care (Porter 2010; Porter and Teisberg 2006). Failure to measure value is seen as the main reason that health care reform has been so difficult in comparison with other fields (Porter 2010). It should be noted that the definition of 'value' used in the services marketing literature on SDL (and throughout the remainder of this article) differs from that of Porter and colleagues. The emphasis is instead upon the value (benefit to some party) that is co-created in using a service, 'value-in-use', which is always unique to a particular context, 'value-in-context' (Chandler and Vargo 2011; Vargo and Lusch 2012). According to this view, it is the beneficiary (typically the customer) of the service who determines and assesses the nature of the value that is co-created (Vargo and Lusch 2008; McColl-Kennedy et al. 2012). Given the trend towards patient-centred care and the development of patient-related outcome measures, capturing more closely the value created through service experiences may be key in developing more patient-centric measures and services (WHO/Europe 2013). Incorporating the experiential knowledge and perspective that lay persons bring may also 'grant a novel, positioned perspective of value to health service-providers' (Martin 2009, 315).

On the basis of the discussion above, we suggest that further exploration of patient engagement within health service encounters (at the micro-level) and value co-creation is warranted. The subsequent sections draw on emerging literatures in services marketing and public management regarding SDL as a means of exploring value co-creation in the sphere of health.

SERVICES MARKETING, SDL, AND PUBLIC MANAGEMENT

Services marketing literature emphasizes interactions between service producers and service users and the interdependence between these at an 'operational level' (Osborne

and Strokosch 2013, S37). Until recently, the services marketing literature had not featured prominently within public management discourse. However, a developing stream of work undertaken by Osborne, Radnor, and Nasi (2013) has drawn together elements of the services marketing and public management literatures. The work has focused on the application of an evolving body of work in services marketing, namely 'service-dominant logic' to public services and management. The subsequent section outlines the central tenets of SDL as an important way of framing value and understanding value co-creation in service before moving on to discuss its recent application to public management.

Services marketing and SDL

Services marketing emerged initially as a sub-discipline of marketing, and it is viewed as distinct from 'goods marketing' due to differences in characteristics between services and goods (Vargo and Lusch 2004b). Scholars including Vargo and Lusch (2004b) have suggested that the distinctions between goods and services are 'myths' and that academics and practitioners should focus on the commonalities. These authors propose that 'goods are distribution mechanisms for service provision' and that 'economic exchange is fundamentally about service provision' (Vargo and Lusch 2004b, 326). An aligned view is provided by Gummesson (1993, 250) who suggests that 'customers do not buy goods or services: they buy offerings, which render services, which create value'.

On the basis of such arguments, Vargo and Lusch forward an alternative view, termed 'service-dominant logic'. Within the SDL framework, 'service' is viewed as a core feature of both services and products. The SDL approach proposes that goods are not an ends in themselves, with value embedded within them and that value can be added by enhancing or increasing attributes, which the customer benefits from once exchanged in 'value-in-exchange' (Vargo and Lusch 2004a). Rather, all goods provide a service and it is value-in-context of the service provided by the good that is where value continues to be created (Chandler and Vargo 2011; Vargo and Lusch 2012). The ultimate basis of activities performed by parties engaged in business is seen as service, with service being defined as the application of competences (such as knowledge and skills) by one party for the benefit of another (Vargo and Lusch 2004a; Chandler and Vargo 2011). It should be noted that SDL advocates that it is not possible for actors to deliver value to another actor, but they can make 'offers which have potential value and this occurs via value propositions' (Vargo and Lusch 2011, 185). The SDL approach is one which has undergone revisions since its inception and continues to evolve. It is underpinned by ten foundational premises, which are summarized in Table 1.

The centrality of customers is emphasized within SDL as they are viewed as both co-creators of value and also resource integrators (see Vargo and Lusch 2004a, 2006,

Table 1. Ten foundational premises of service-dominant logic (Vargo and Lusch 2008)

Number	*Foundational premise*
FP1.	Service is the fundamental basis of exchange
FP2.	Indirect exchange masks the fundamental basis of exchange
FP3.	Goods are a distribution mechanism for service provision
FP4.	Operant resources are the fundamental source of competitive advantage
FP5.	All economies are service economies
FP6.	*The customer is always a co-creator of value
FP7.	The enterprise cannot deliver value, but only offer value propositions
FP8.	A service-centred view is inherently customer-oriented and relational
FP9.	All social and economic actors are resource integrators
FP10.	Value is always uniquely and phenomenologically determined by the beneficiary

Note: *FP6 was originally 'The customer is always a co-producer' (Vargo and Lusch 2004a).

2008, 2012; Vargo, Maglio, and Akaka 2008; Chandler and Vargo 2011; Lusch and Vargo 2011; Vargo 2007, 2011; McColl-Kennedy et al. 2012). Three of the ten foundational premises are viewed by Vargo and Lusch (2012, 1) as directly involving value, (FP6) 'the customer is always a co-creator of value', (FP7) 'the enterprise cannot deliver value, but only offer value propositions', and (FP10) 'value is always uniquely and phenomenologically determined by the beneficiary'. However, all of the other foundational premises also 'indirectly deal with some aspect of value' (Vargo and Lusch 2012, 1). Within the context of this article and in line with Vargo and Lusch (2012, 1), an additional foundational premise of importance for the consideration of value is (FP9) 'all social and economic actors are resource integrators', the rationale being that this defines the resource creation process underlying value creation.

The four premises outlined above (FP6, FP7, FP9, and FP10) imply that value (or benefit for some party) is co-created through the interactions and activities of customers with service providers. Resources (which may include knowledge and skills) are integrated by the beneficiary of the service, and in doing so value is created. These resources may also include private sources, such as family and friends (Vargo and Lusch 2011; McColl-Kennedy et al. 2012). Resource integration is viewed as an opportunity for creating new potential resources, which during service exchange can be used to 'access additional resources' and create new resources (which can also be exchanged) through integration (Vargo and Lusch 2011, 184). The dynamic nature of value co-creation is further asserted by Vargo and Lusch (2008) in FP10, where each instance of service exchange creates a different experience and benefit (value), which is assessed and determined in relation to, 'if not by', the beneficiary (Vargo and Lusch 2012, 6). The rationale being that each incidence of service exchange occurs 'in a different context involving the availability, integration, and use of a different combination of resources' (Vargo and Lusch 2012, 6).

As can be seen, SDL emphasizes the centrality of customers in service creation in their role as a co-creator of value and resource integrator (see Vargo and Lusch 2004a, 2006, 2008, 2012; Vargo 2007; Vargo, Maglio, and Akaka 2008; Chandler and Vargo 2011; Lusch and Vargo 2011; Vargo 2011; McColl-Kennedy et al. 2012). The issue of integrated resources and experiences has also been raised in the health care sphere by Porter (2010), who implies that value accumulates throughout the cycle of care, which may involve a range of health care providers. In viewing patients as resource integrators, we suggest that the quality of interactions between health care professionals and patients with health care is key, given that these experiences potentially may travel with the patient and be drawn upon in future service encounters. Commenting in the marketing literature, McColl-Kennedy et al. (2012, 375), in a study of value co-creation in two private oncology and haematology clinics, propose that the customer is the 'primary resource integrator in the co-creation of their healthcare management' and that value co-creation can include private sources (i.e., family, friends, peers, etc.). Customer's self-generated activities, such as 'accessing their own personal knowledge and skill sets and through cerebral processes', are also viewed as potential sources which contribute to and become part of value co-creation (McColl Kennedy et al. 2012, 375). Five groupings of customer value co-creation practice styles, team management, insular controlling, partnering, pragmatic adapting, and passive compliance, are also proposed by these authors, with the first two styles associated with improved quality of life. Details are not, however, provided within this article regarding how the inclusion of third parties occurs in practice.

The usefulness of the SDL approach in understanding value creation through engagement in health care service encounters will be considered in the latter sections of this article. Although SDL is increasingly discussed at a service eco-system level (Vargo and Lusch 2011; Chandler and Vargo 2011), we consider its application within micro-level patient health encounters. Before considering such, an overview of its recent application in public services and management is provided.

Public service-dominant approach

A developing stream of work undertaken by Osborne and colleagues has drawn together services marketing and public management literature. In doing so, the authors argue that a new theory to underpin public management is needed. Their work outlines the contribution of service marketing theory, mainly 'service-dominant logic', and advocates the application of a 'public service-dominant approach' to public services delivery and management. This work has also been extended to explore the benefit of 'public service-dominant business logic' to lean methodologies in health care and to enhance typologies of co-production in public services (Osborne 2010, 2013; Osborne, Radnor, and Nasi 2013; Radnor and Osborne 2013; Osborne and Strokosch 2013; Strokosch 2013).

Osborne and colleagues argue that the majority of public goods are best conceived not as 'public products' but rather as 'public services'. Specifically, social work, health care, education, and business support services are all services 'in that they are intangible, process driven, and based on a promise of what is to be delivered' (Osborne, Radnor, and Nasi 2013, 136). They advocate that there is a need to move away from focusing on approaches to service delivery that have been grounded 'in manufacturing' for exploring those within the services sector where consumers are also 'co-producers'. They propose a public service-dominant approach to public services delivery and management, which is viewed as key to having stakeholders as the central focus of services (Osborne 2010; Osborne, Radnor, and Nasi 2013). Osborne and colleagues advocate an integrated typology of co-production, which brings together the two theoretical standpoints of service management and public administration (Strokosch 2013; Osborne and Strokosch 2013).

In developing their case for a 'public service-dominant approach', Osborne, Radnor, and Nasi (2013) explore the capacity of SDL to create new theoretical frameworks and insights for public management. To put flesh on these bones, they examine four themes of public management practice (strategic orientation, marketing, co-production, and operations management) to which SDL could potentially contribute. On the basis of such discussion, they develop a number of propositions to underpin a public service-dominant approach and also highlight important issues and areas for research to consider in taking forward the framework (see Osborne, Radnor, and Nasi 2013 for more detailed discussion), with one of these being to specify the key elements of a public-service dominant, rather than service-dominant approach (Osborne, Radnor, and Nasi 2013). Indeed, a key requirement in studying how marketing works in practice for public services is to identify the dimensions that are significant for relationships for public services and to also carefully consider context when borrowing a good idea from elsewhere (McGuire 2012; Pollitt 2003).

The emphasis on 'co-production' within Osborne and colleagues proposed 'public service-dominant approach' is of importance in this article because co-production between the service provider and customer may also facilitate value co-creation (Grönroos and Voima 2013). As noted earlier, the SDL literature has undergone refinement. The work of Osborne and colleagues draws upon one of the original foundational premises of SDL (FP6, see '*' in Table 1), with users of public services viewed as co-producers. It does not yet, however, directly address the refinement of FP6 that was made in terms of this now being 'customers are always co-creators of value' (Vargo and Lusch 2008). This differentiation was made as the term 'co-producers' was viewed as being too closely associated with goods dominant and production-oriented logic (Vargo and Lusch 2006). In the refined FP6, co-production is viewed as a component of the co-creation of value and is optional unlike co-creation of value, which is not (Vargo and Lusch 2008). Within the SDL framework, co-production relates to participation in direct service provision activities such as service

design, self-service, and new service development (McColl-Kennedy et al. 2012; Vargo and Lusch 2011). Within a health care context, this could include activities such as assisting with drug administration or providing service ideas (McColl-Kennedy et al. 2012). Co-creation of value relates to benefit (unique to a situation and context) created through actors integrating service offerings with other resources (Vargo and Lusch 2011). Examples of co-creating activities in health care include combining complementary therapies, collating information, and co-learning (McColl-Kennedy et al. 2012). This manuscript builds on the innovative work of Osborne and colleagues but differs in that the emphasis is on 'value co-creation' within health care encounters, rather than 'co-production'. The focus is also at a micro- rather than macro-level of analysis.

VALUE CO-CREATION

Despite value creation and co-creation being key concepts in marketing, Grönroos and Voima (2013, 134) argue 'value is perhaps the most ill-defined and elusive concept in service marketing and management'. It is also an area of marketing where there is disagreement amongst scholars concerning how value is created (Chandler and Vargo 2011). In addition to these concerns, it is also argued that the role of customers and providers in value creation has not been analytically specified and requires further theoretical elaboration (Grönroos and Voima 2013). In considering such an elaboration, three dynamic spheres (joint, customer, and provider) are proposed within which the firm's and customer's actions can be categorized. Within the joint sphere, direct interactions are seen to provide a 'platform' for the joint co-creation of value (Grönroos and Voima 2013, 141) and be the only sphere within which value can be co-created. According to this view, value co-creation can only occur through direct interactions, making value creation a process which is dialogical (see also Grönroos 2011; Grönroos and Ravald 2011).

In contrast with mainstream work on SDL, Grönroos and Voima (2013) suggest that the customer is an independent creator of value but can invite others to join in the co-creation process. This view of customers as independent creators of value is not shared in SDL (see Table 1, FP6). Although SDL recognizes that an actor can uniquely evaluate or assess value, value cannot be created by an actor on their own (Vargo and Lusch 2011). It is the latter SDL perspective on value co-creation that is adopted within this article. The article by Grönroos and Voima (2013) is, however, useful in considering spheres within which to consider future investigation of value co-creation (as defined within SDL) empirically and how direct interactions form a basis for value co-creation.

In exploring how value may be co-created by patient and provider, there is a need to recognize that this process is complex within health care and is not necessarily linear.

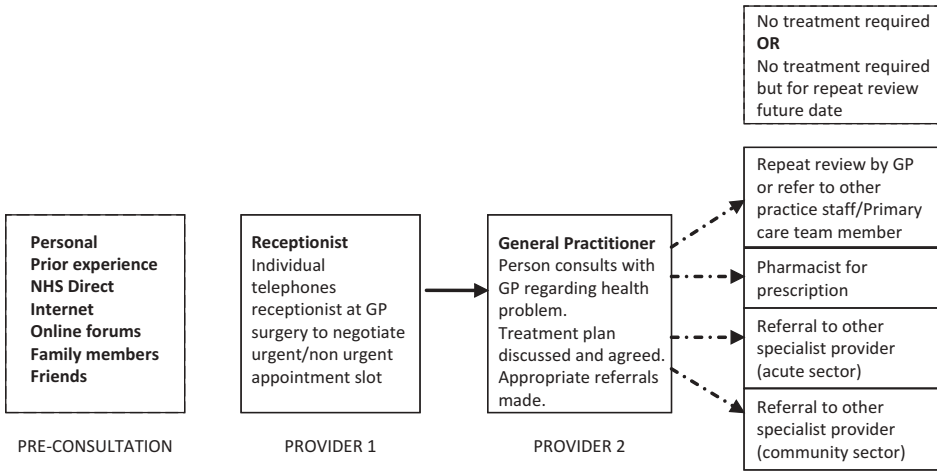

Figure 1. Value co-creation chain in GP consultation

Even in simple health care encounters, there can be a range of providers involved in the service encounter. This is illustrated well by the example of a consultation between a patient and GP (general practitioner, a primary care physician). Within this one service encounter, there is potential to interact with a range of providers, with different roles. This is outlined in Figure 1, which breaks down the GP consultation into a potential 'value chain'.

If we consider an NHS patient's journey, which often begins by visiting the GP, then being referred to a different specialist, potentially within an acute setting, the value chain becomes even more complex. There may be diversity in types and numbers of the health care providers involved. Variation in terms of the range of knowledge and skills that different health professionals and patients exchange during the service encounter might also exist. Given that, SDL defines service as the application of competences (such as knowledge and skills) by one party for the benefit of another (Vargo and Lusch 2004a; Chandler and Vargo 2011), this has particular implications within the sphere of health and for patient engagement in health care.

The vast majority of health care interactions are face-to-face and occur within a 'joint sphere'. Further understanding of what 'value' actually means to patients and how direct micro-level service interactions impact upon value creation may enable insight into strategies that promote engagement and co-creation in health care. It should not, however, necessarily be assumed that there will be direct alignment between patient perceptions of the benefits they will realize from using the service and those of health care providers, or indeed other patients. It has been suggested that SDL assumes inter-dependency between providers and customers who share a common mission. However, when 'multiple actors' are involved, these perceptions may be contradictory and (possibly negatively) impact on value co-creation processes (Fyrberg Yngfalk 2013).

This is of importance to health care given the multiplicity of providers that can be involved in a single health care encounter. Variation in perspectives on 'value' is not necessarily a negative phenomenon as multi-stakeholder value propositions are also viewed as having a key role in co-creation of value 'between stakeholders'. These propositions, being central in aligning value, may then be reflected within the 'service promise' of service organizations (Fyrberg Yngfalk 2013; Frow and Payne 2011; Osborne, Radnor, and Nasi 2013). This is important if we consider that patient engagement can occur at varying levels (micro-, meso-, and macro-) within an organization and with a range of providers with differing roles and professional allegiances.

It should be noted that there has been limited empirical research in relation to value co-creation. The evolving literature in this field has mainly been of a conceptual nature. Only a small number of empirical studies have empirically explored 'co-creation' in health in terms of exploring value co-creation practice styles in cancer services, co-creation of services in community-based aged care, and co-creation of learning in health care (McColl-Kennedy et al. 2012; Gill, White, and Cameron 2011; Elg et al. 2012). This work has not, however, focused directly on patients or service providers' conceptualizations of value-in-context. To tap into such concepts, we suggest that research of an ethnographic nature may be required. This view is emphasized by Nordgren and Åhgren (2013) who analysed patient responses to an in-patient survey to ascertain what patients perceived to be health care values (based on the concept of value creation). They found that patients expressed different values and suggested that it was debatable how service management concepts could be applied simplistically.

Generally, value creation involves a process that increases a customer's well-being, in that the customer becomes 'better off' in some respect (Grönroos and Voima 2013; Grönroos 2008). A service provider's actions could, however, be to the detriment of the customer. In this sense, the value co-creation process can also be negative. This has particular relevance in health care, where there is potential to cause harm. Although service failure, complaints and service recovery are embraced as workable concepts within the services marketing literature as a means of improving services, this is not fully reflected in the sphere of health care research. Co-creating service recovery entails other service options being available (Roggeveen, Tsiros, and Grewal 2012). This may not actually exist in health care. As Nordgren (2008, 510) states: 'when the service management discourse travels into the world of healthcare, discursive tensions between medical, care and management discourses follow'.

Classifying patients as first consumers, then customers creating value raises concerns (Nordgren 2008). Even if the customer in service management discourse is viewed as his/her own agent with power and individual responsibility, 'it is doubtful if people view themselves as customers' (Nordgren 2008, 510). Health care consumers may also be reluctant customers, in that the service may be 'needed' but not necessarily 'wanted' (Berry and Bendapudi 2007). Recent health care research presumes that

patients are seen as wishing to be part of their value creating processes (Nordgren 2008). This has implications given that the responsibilities and tasks of health care professionals are regulated and institutionalized, which cannot necessarily be delegated to patients, as 'a matter of course' (Nordgren 2008, 510). There may also be contextual and relational barriers and facilitators to involvement as highlighted earlier in this article. These are useful points to consider when contemplating patient engagement and value co-creation in the sphere of health.

The next section highlights some of these tensions. Areas for further analysis and empirical investigation regarding a micro-level approach to patient engagement and value co-creation in health care will also be identified.

DISCUSSION AND CONCLUSION

This contribution to the emergent field of patient engagement scholarship is the first to elucidate the importance of 'value co-creation' in the analysis of patient engagement in micro-level NHS encounters. In terms of unit of analysis, we present an early response to Coulter's (2012, 7) concern that NHS policy and practice has failed to explore participation within individual service encounters.

In terms of analytical theme, we draw from services marketing literature to emphasize the prominence that 'value' could play in the design and conceptualization of initiatives aimed at enhancing and studying patient engagement in micro-level health care encounters, particularly in relation to 'value co-creation' during direct service interactions. In furthering understanding of how value is co-created during health service encounters and what this means to patients, there is also potential to develop engagement strategies and more patient-centric measures and services. This is of central relevance given that approaches such as 'value-based health care' focus on patient-specific health outcomes. The increasing trend towards patient reported outcome measures and measures of patient experience potentially being key areas where a clearer understanding of value co-creation at the micro-level may contribute. The SDL framework presented here usefully focuses attention on the patient in health care services and views them as co-creators of value. It also emphasizes the interactional nature of service, which is key in health care given the majority of service interactions are face-to-face. The focus on value co-creation during 'frontline' service interactions in health care we suggest is essential, particularly given the nature of service failures highlighted in the Francis Report (Francis 2013).

Building on Osborne and colleagues' work in relation to the application of SDL to public services more generally, we suggest that the co-creation of value through engagement in health care warrants more detailed exploration. The recent empirical work undertaken by McColl-Kennedy et al. (2012) in services marketing proposing a health care customer value co-creation practice styles typology provides a useful basis from which to explore how value is co-created by customers in the health care sphere.

Further work is required, however, to explore such a typology within the context of a UK publicly funded, rather than private health care setting. Although offering a differing perspective on the role of the customer in value creation than in the mainstream SDL literature, Grönroos and Voima's (2013) article usefully suggests spheres (specifically the joint sphere) within which analysis of value co-creation (as defined from a SDL perspective) could be undertaken and also emphasizes the importance of interactions in service encounters. Focusing upon the joint sphere (where interactions are direct) provides an additional basis from which to consider investigating empirically 'value co-creation' (from a SDL viewpoint) in health care and the roles that patients (potentially also friends, family, and peers) and providers adopt as co-creators of value. These points are especially significant given our argument that much of the extant literature relating to value co-creation is conceptual. Future empirical investigations could productively employ the frames outlined above to examine a number of issues including: perspectives of value from patients, providers, and those managing and organizing health care services and observe how 'value' is co-created and articulated within health care organizations. This will necessitate research of a more ethnographic nature and require a repertoire of methods (i.e., observation, interviews, and documentary analysis).

There are a number of areas that require further elaboration in relation to value co-creation and patient engagement. First, there is an assumption within SDL of interdependency between providers and customers. Health care service encounters are complex and may include multiple providers, with differing skills, roles, and competences. Service encounters often consist of multiple interactions with differing health professionals. These 'multiple actors' may not necessarily share a common mission or conception of value-in-use. Thus, there is considerable potential for interactions of 'multiple actors' to be contradictory (Fyrberg Yngfalk 2013). As highlighted earlier, within health care there may be asymmetry in the knowledge, skills, power, expertise, and capacity of patients to engage in health care. Indeed, if patients feel pressurized to participate in co-production activities, this could have a negative impact on their service experience and value creation. This is an important consideration given that customer perceptions have been found to be negative when they are unwilling co-producers (Bendapudi and Leone 2003). Further insight into the potential barriers and facilitators for value co-creation is required.

Second, given that there are a range of vulnerable patient populations within health care who may not be able to contribute or interact during health service encounters, further exploration of the role of third parties (e.g., carers, friends, and families) in value co-creation in health care is needed. It is unclear how third parties are integrated within the value co-creation process, if they are acting on behalf of or as an advocate for the patient who is unable or unwilling to participate. It could be argued that third parties would bring to the value co-creation process their own experiences, which may not be possible to separate from those of the patient.

Third, it is currently unclear how patients integrate experiences with differing providers and how this impacts on 'value co-creation' throughout the service encounter. Further conceptual and empirical work is, therefore, required to further understanding of the potential for value to accumulate or conversely be destroyed within: (a) individual service encounters and (b) across multiple service encounters. Additionally, there may be competing perspectives in terms of what 'value' means to different stakeholders within health care, which may impact on the service experience. Better understanding of this will be required to effectively pursue the espoused goal of developing patient-centred services in the NHS.

Finally, the extent to which 'micro-level value co-creation', between patient and provider, impacts within and across health care organizations merits attention. How value accumulates for individual patients and the organization and how value co-created in one service area is transported between settings are also issues requiring further exploration. In terms of organizations responding to patients and facilitating value co-creation, the manner in which organizations are able to engage indirectly in value co-creation may also be an area of investigation. Such questions clearly have significant implications for the training and development of health care professionals.

This article has advocated a micro-level approach to looking at value co-creation and patient engagement in service interactions. In doing so, pertinent works within the services marketing literature were considered to elucidate the importance and application of value co-creation to the health domain and the analysis of patient engagement in micro-level NHS encounters. This article underscores that further developmental work concerning the application of SDL to health care is warranted. The article also highlights that a greater understanding of the barriers, facilitators, and supports required for value co-creation are also key policy issues given the importance of direct interactions in health care processes and many other public service areas both in the United Kingdom and internationally.

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