THESIS FOR THE DEGREE OF LICENTIATE OF PHILOSOPHY

Toward Equity and Value Co-creation in Healthcare

Insights from a study on cervical cancer screening and a study on complaints regarding cancer care

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ABSTRACT

The prevailing inequities within the Swedish healthcare system constitute a major challenge, not the least in cancer care. An international comparison shows that outcomes for Swedish cancer care score highly. Even so, the process of *how* care is delivered to its customers has been questioned, with particular emphasis on disregarded groups of the population. Using the notion of value co-creation, the process of service delivery is highlighted. Moreover, the collaborative and relational elements are considered crucial in service interactions, giving the customer an active role in engaging in various activities to co-create value with service providers and others. However, value co-creation has not been thoroughly investigated in a healthcare context.

This thesis addresses the current situation for segments of healthcare customers and explicitly aims to increase equity in healthcare. To achieve this goal, barriers that groups of healthcare customers face during the service delivery process are illuminated, as are the various activities in which they engage to co-create value. The thesis also explores the kinship among various domains; particularly the theories of quality management, value co-creation, and social construction, as well as the methodology of action research.

The empirical material draws from two studies that took place in the Western Region of Sweden. The first study explored how a participatory action research approach may contribute to raising awareness about preventive health services, thus increasing the number of participants in a cervical cancer screening program among foreign-born women. The second study investigated complaints of cancer patients and their relatives by focusing on the interpersonal aspects of service delivery and by applying a gender lens.

The results underline the importance of *how* healthcare services are provided, particularly the collaborative, interactional, and relational aspects that enable customers' value co-creation processes. Incorporating social construction theory into value co-creation offers a collective dimension; the unique knowledge and skills of customer segments should be used more productively, thus enabling healthcare providers to offer more tailored value propositions that better meet the needs and expectations of particular groups.

In line with value co-creation ideas, policy makers and practitioners must realize that a need exists to move beyond the two-party sphere of provider–patient by including other actors from the customer's network, such as family members and civil society. By adopting an action research approach and tools from quality management, disparities may be revealed and quality may be improved to contribute to increased equity in healthcare.

Keywords: Equity, value co-creation, social construction, quality management, action research, healthcare

To Vinga

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Hönö, February 28, 2014

Erik Olsson

LIST OF APPENDED PAPERS

Paper I WHEN ONE SIZE DOESN'T FIT ALL:
USING PARTICIPATORY ACTION RESEARCH TO CO-CREATE PREVENTIVE HEALTHCARE SERVICES

Olsson, E. and Lau, M. (2013)

Under review for publication consideration.

Previous versions of this paper were presented at the conference *Reconfiguration of the Eco-System for Sustainable Healthcare*, Como May 14–15, 2012, and at the *Academy of Management Annual Meeting*, Boston August 3–7, 2012.

Paper II COMMUNITY COLLABORATION TO INCREASE FOREIGN-BORN WOMEN'S PARTICIPATION IN A CERVICAL CANCER SCREENING PROGRAM IN SWEDEN: A FOCUS GROUP STUDY

Olsson, E., Lau, M., Lifvergren, S. and Chakhunashvili, A. (2014)

Submitted for publication consideration.

Previous versions of this paper were presented at the *European Health Management Association Annual Conference*, Milano June 26–28, 2013, and submitted for nomination for the award *Guldskalpellen*, 2012.

Paper III INTERPERSONAL COMPLAINTS REGARDING CANCER CARE THROUGH A GENDER LENS

Olsson, E. (2014)

Submitted for publication consideration.

A previous version of this paper was presented at the *European Health Management Association Annual Conference*, Milano June 26–28, 2013.

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1 INTRODUCTION

This thesis starts with a presentation of the Swedish healthcare system and its challenges, with an emphasis on the prevailing inequities. The importance of the collaborative, interactional, and relational aspects of healthcare and the notion of the active customer, rather than the passive patient, follow. Next, the purpose and interest of the research are expressed. A brief description of the contexts of the included studies follows with an outline of the thesis ending this chapter.

1.1 Background

In the decentralized Swedish healthcare system, services are primarily financed through county council and municipal taxes. Revenues also come from out-of-pocket fees and national government grants on the basis of demographic, geographic, and socio-economic indicators (Anell, 2005). A reformation of the Swedish healthcare sector began in the 1980s. More market-orientated reforms were introduced in the 1990s, such as the implementation of purchaser-provider models and the primary healthcare reform that made more room for private actors (Green-Pedersen, 2002). Some of these reforms were criticized for being too focused on costs and neglecting issues *between* different organizational units. In reaction, the last decade was characterized by process-oriented techniques and methods and a focus on perceived quality from the customer's point of view (Eriksson, Holgers and Müllern, 2013).

Despite reforms and new models, the healthcare sector faces massive future challenges: costs are rising and patients are aging, as is the population as a whole (Socialstyrelsen, 2013). The challenge may be particularly harsh in services for complex diseases, such as cancer care. Today, at least every third Swede will be diagnosed with cancer during her or his lifetime (Socialstyrelsen and Cancerfonden, 2013), and by the year of 2030 the predicted number of people developing and living with cancer in Sweden is expected to double (SOU 2009:11). In addition to the increasingly older population, improved diagnostic methods, screening programs, and increased awareness about cancer among the population help to explain this prognosis (SOU 2009:11). The pattern of an increasing number of cancer patients is not exclusive to a Swedish healthcare context (see, e.g., Jemal *et al.,* 2011; Mistry *et al.,* 2011). Sweden scores highly in cancer survival rates compared with other European (Gatta *et al.,* 2000) and Western (Coleman *et al.,* 2011) countries. However, an international comparison shows that Swedish patients with complex care needs, such as cancer patients, are least likely to report positive interactions with healthcare staff (Schoen *et al.,* 2011). The National Cancer Strategy (SOU 2009:11) highlights the lack of patient focus in Swedish cancer care. The importance of appropriate information and communication between patient and healthcare provider, and involving the patient to participate in the care, are stressed as essential for both the well-being of the patient and the results of the care (SOU 2009:11).

Swedish healthcare is regulated by law (SFS 1982:763). Because this healthcare act offers only a frame, it is complemented by regulations offering more detailed interpretations and directives. The National Board of Health and Welfare, a government agency in Sweden, constitutes six dimensions of the healthcare system essential to provide quality in healthcare (Socialstyrelsen, 2005): *patient-centered*, *knowledge-based*, *timely*, *safe*, *efficient*, and *equal/equitable*. Naturally, the last dimension is particularly central to this thesis, and the six dimensions should be viewed as reinforcing. Indeed, the extent to which healthcare is judged as patient-centered and knowledge-based is regarded by the government agency as important to achieving the goals of equality/equity (Socialstyrelsen, 2011).

As in the previous discussion, the concepts of equality and equity are often used interchangeably in official documents.[1] Macinko and Starfield (2002) conducted a literature review of equity in health, and found that researchers *too* are inconsistent in their use of terminology. The dictionary definition of equality and equity are “the state of being equal, especially in status, rights, or opportunities” respectively “the quality of being fair and impartial” (Oxford dictionaries, 2014). Similarly, previous research recognized that equity is fair, normative, and value-based, whereas equality is not necessarily so (Braveman and Gruskin, 2003; Carter-Pokras and Baquet, 2002). Whitehead (1990) highlighted this ethical dimension of inequity as “… differences which are unnecessary and avoidable but, in addition, are also considered unfair and unjust” (p. 5). Another suggested distinction is the emphasis on *need* within the notion of equity:[2] “Equity does not mean that everybody should […] consume the same amount of health service resources irrespective of need” (Whitehead, 1990, p. 15). Equality does not necessarily consider these different needs. For instance, because of biological differences, equal healthcare for men and women is not always desirable (Payne and Doyal, 2010). An example of equality is that everybody should have equal access to healthcare services, whereas equity means that people’s differences and needs should be considered for them to have equal access. Hence, equity may lead to equality. Central to this thesis are gender differences and such things as language skills, which may hinder equal access to healthcare services.

The National Board of Health and Welfare declared that, “… care and treatment should be offered on equal terms and with equal encounter to everybody regardless of residence, age, gender, disability, education, social status, country of birth, ethnical or religious affiliation, or sexual orientation” (Socialstyrelsen, 2011, p. 3, my translation). Both concepts of equality and equity are covered by adding on the Swedish Health and Medical Services Act (SFS 1982:763), which stipulates that

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[1] In a Swedish context, the fact that one word (*jämlikhet*) covers both concepts may add to the confusion.

[2] Expanding the need-aspect of equity, a further distinction is offered through the notion of *vertical* and *horizontal* equity (Starfield, 2011; Macinko and Starfield, 2002); the former includes preferential treatment for those with greater health needs, whereas the latter indicates equal treatment for equivalent needs.

those with the greatest needs should be prioritized. Adding to the mentioned challenges, research suggested that Swedish cancer care is neither equal nor equitable. Disparities are shown in the survival rates between men and women in non-sex-specific cancers (Socialstyrelsen, 2011); lower participation in mammography screening among immigrants (Lagerlund *et al.,* 2002); geographical variation in incidences of prostate cancer (Stattin *et al.,* 2005); and higher mortality rates for patients with low education (Socialstyrelsen, 2011).

Traditionally, the patient has been regarded as a recipient of medical care rather than a partner (Tariman *et al.,* 2010; Holman and Lorig, 2000). One explanation may be the patients' knowledge disadvantage vis-à-vis the healthcare staff concerning clinical decisions (Kang and James, 2004; Marley, Collier and Meyer Goldstein, 2004). Nevertheless, research suggested that *how* healthcare is provided receives the most attention from patients (Fiala, 2012), not the least of which are interpersonal matters including interactions and relationships with healthcare providers (Dagger, Sweeney and Johnson, 2007). The interactional and relational aspects are further emphasized in the notion of value co-creation (Vargo and Lusch, 2004a; 2008) for which customers are regarded as partners working together with service providers in their joint effort to create value (Vargo and Lusch, 2008; Prahalad and Ramaswamy, 2004). In fact, the partnership does not need to stop there; other actors may be included in a value-creating network (McColl-Kennedy *et al.,* 2012; Normann, 2001). Adopting the value co-creation logic, healthcare customers ought to be regarded as partners. Indeed, the patient may undertake various roles in the value co-creation process, such as taking on tasks to contribute to better self-care (McColl-Kennedy *et al.,* 2012) or benefitting others by contributing ideas to improve or design services (Elg *et al.,* 2012; Witell *et al.,* 2011).

The interactional and relational aspects of value co-creation are well in line with the methodology of participatory action research (used in two of the three appended papers) that emphasizes equity and access to resources for research participants (McIntyre, 2008). This thesis and the appended papers highlight the concept that (preventive) cancer care in Sweden is not equitable, whether regarding foreign-born women not being reached by cancer preventive services (papers I and II) or men and women experiencing different and insufficient interpersonal services in cancer care (paper III). Adopting value co-creation theories clarifies that these healthcare customers and their knowledge and skills may very well play an important role in improving healthcare services to better meet the needs and expectations of different segments of the population, and may be an important step toward equity in healthcare.

1.2 Research purpose and interest

The driving force and the purpose for writing this thesis is to contribute to greater equity in healthcare by illuminating disparities and difficulties among disregarded groups of healthcare customers and by presenting ideas on how services may be carried out to better meet differential needs and expectations. More specifically, the barriers that healthcare customers face during the process of service delivery are investigated and the various activities that they may undertake in their effort to jointly create value are identified.

Various domains are applied to support the overriding purpose of equity in healthcare. Thus, this thesis explores the kinship among theories of quality management, value co-creation, social construction, and the methodology of action research.

1.3 Contexts of the studies and outline of the thesis

To evaluate the purpose, two research studies that comprise the backbone of this thesis are references. Both studies occurred in the Western Region of Sweden.[3]

The first study (papers I and II) was launched to increase awareness of cervical cancer prevention in the northeastern part of Gothenburg, the country's second largest city. In this particular area of the city, approximately half of the 100,000 residents were born outside the Swedish borders (Olsson and Panifilova, 2009). In the Western Region as a whole, more than 80 percent of the women between 23 and 60 years of age participated in the cervical screening program (Västra Götalandsregionen, 2010). However, before the study, in one parish in northeastern Gothenburg, participation rates were 57 percent, compared with a corresponding 88 percent in a wealthier parish on the other side of the city (Strander, Holtenman and Westlund, 2011). For the situation to change, the local *doulas* were invited to participate in the study. In the northeastern part of Gothenburg, the doulas were already well established and support parents by sharing their cultural background during pregnancy and childbirth. The doulas spoke approximately ten languages among them; just as importantly, they functioned as interpreters of culture. Focus groups with the doulas were conducted to identify barriers hindering women in the community from taking the test and to develop possible interventions to increase participation in the screening program. A one-year campaign was planned, designed, and launched, and the doulas participated in various outreach activities, often with the local midwives. Through collaboration between various organizations and professions and by focusing on information spread orally and through various media, the campaign increased its

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[3] The official English translation of *Västra Götalandsregionen* is *Region Västra Götaland*. However, this translation reveals nothing about the geographic location, which is why the translation *Western Region of Sweden* was favored.

local participation in the screening program by 42 percent. The campaign was given the national award *Guldskalpellen* with the motivation: "The award winners have considered new and innovative ideas, have crossed borders, and have shown that it is possible to give more women the possibility of making an active choice concerning their participation in cervical cancer screening" (Dagens Medicin, 2012, my translation).

The second study (paper III) comprises complaints lodged at any of the four local Patients' Advisory Committees in the region. According to the law (SFS 1998:1656), every county council and municipality must provide such a committee for its citizens and shall, based on the complaints, support and assist individual patients and contribute to quality improvement and patient safety in healthcare. Fifteen total officials primarily investigating the lodged complaints, approximately 13,000 during 2009–2011, the period of study. The cancer complaints and interpersonal matters were chosen based on previous research and official reports that highlight the lack of interaction and participation in cancer care (Schoen *et al.,* 2011; SOU 2009:11). The gender lens was applied because previous findings on patient complaints suggested that men and women express dissatisfaction over different service attributes (Murad *et al.,* 2009). Before the study, little was known about cancer patients' and their relatives' complaints lodged to the committees.

Thus far, I hope that I have provided the reader with sufficient background that accounts for the relevance of this inquiry. The remainder of the thesis is organized as follows. The next chapter presents *theories* inspiring the inquiry process. The third chapter presents *methodological* approaches, the tools used to collect and analyze the empirical findings, and a discussion of the quality of the research and ethical considerations. Next, a *summary* of the three papers appended to the thesis is provided, as is a reflection of the common themes derived from the interest of the research. This reflection is broadened in the following chapter into a *discussion* that elaborates on, in particular, the kinship of the presented theories and methodology. The *conclusion* presents the believed practical, theoretical, and methodological implications and contributions. Ideas for future research make up the remainder of this thesis.

2 THEORIES OF INSPIRATION

Theories from different fields are included to make sense of the empirical findings. By way of introduction, the development within quality management is briefly described. At the heart of these presentations lies quality from the customer's point of view. Next, the focus shifts from what quality may be to how quality may be achieved, for example how customers may contribute to improving quality for themselves and others. Theories are presented that give the customer an active and complex role as value co-creators. A section accounting for the concepts of quality and value in a healthcare context is next. Building on the notion that value and the value co-creation process must be understood in a social context, social construction theories follow to elaborate on how the collective level may be incorporated in value co-creation. A conceptual frame of theories ends the chapter that offers an explanation of similarities and differences among the presented theories.

2.1 What is quality?

The concept of quality evolved following the historical development of human activities related to producing and selling products. However, this evolution does not indicate that new definitions replaced old ones and that one universal definition of quality exists. Rather, all definitions are used today and different definitions are appropriate in different circumstances (Reeves and Bednar, 1994; Garvin, 1984).

Garvin (1984) identified five major approaches to the definition of product quality. In the first – the *transcendent approach* – quality cannot be defined precisely. This approach borrows from the Greek philosophers' definition of quality as excellence and "the highest idea of all" (Reeves and Bednar, 1994, p. 420). In the mid-1700s, quality was judged relative to price because of the belief that it was the primary determinant of consumer choice (Reeves and Bednar, 1994). This concept formed the foundation of the *value-based approach*, which defines quality in terms of costs and prices (Garvin, 1984). In the *product-based approach*, quality is regarded as a precise and measurable variable. Differences in quality are measured through the differences in the quantity of the attributes of a product (Garvin, 1984). Mass-production increased inspection costs. After the 1930s, reducing these costs was desired, and statistical tools were used to quantitatively measure quality (Reeves and Bednar, 1994). This focus on the supply side is distinct for the *manufacturing-based approach*, for which "excellence is equated with meeting specifications" (Garvin, 1984, p. 28). During the twentieth century, the service sector increased significantly and the definition "meeting specifications" was believed to not address the unique characteristics of services; hence, service scholars' used the definition of quality as "the extent to which a product or service meets and/or exceeds a customer's expectations" (Reeves and Bednar, 1994, p. 423). This definition has obvious similarities with the *user-based approach* of product quality in which quality "lies in the eyes of the beholder" (Garvin, 1984, p. 27).

2.1.1 Quality management and customer focus

Shewhart (1931) elaborated on the subjective side of quality, and suggested that "it is impossible to think of a thing as having goodness independent of some human want" (p. 53), and that these wants may be different for different individuals. Half a century later, Kano *et al.* (1984) suggested that an individual's various needs may influence customer satisfaction differently. Some basic needs are taken for granted and are not even expressed unless they are not fulfilled. Fulfilling these basic needs is necessary but not sufficient for customer satisfaction. Other needs are spoken of and expected and, therefore, create satisfaction when present and dissatisfaction when absent. Yet, other needs are not expected to be fulfilled by customers; hence, they are satisfying when present and not dissatisfying when absent.

In quality management, customer satisfaction and customer focus are most important in designing and delivering products and services that fulfill customer needs (Dean and Bowen, 1994). Common practices attributable to customer focus include the promotion of direct contact with customers, the collection of information about a customer's needs, and the spreading of this information within the organization; various techniques are used to accomplish these practices, such as surveys, complaint lines, and customer focus groups (Hackman and Wageman, 1995; Dean and Bowen, 1994). Given the different techniques that provide data on customer needs, quality improvement may focus on the aspects of work processes that have the greatest effect on customer satisfaction (Hackman and Wageman, 1995).

Within quality management, individuals may have different needs and different customer roles. Lengnick-Hall (1996) identified two such major roles. One role is upstream or at the input, in which the customer is seen as a resource and as a co-producer. The other main role is downstream or at the output side. In this situation, the customer is the buyer, the user, and the product. Lengnick-Hall (1996) called for "a redefinition of *customer orientation* from relying on customers to merely define their preferences and evaluate what firms provide to designing systems that involve and empower customers throughout the input-transformation-output system" (p. 816, italics non-original). A year earlier, Lengnick-Hall (1995) offered a similar distinction of patient roles in healthcare. These roles and similar constructions are further elaborated on in subsection *2.3.2*.

2.1.2 Service quality and customer perceptions

As previously noted, in the 1980s, service scholars redefined quality by accentuating that quality of services was different from quality of tangible products (Parasuraman, Zeithaml and Berry, 1985; Grönroos, 1984). Service quality was described as an abstract construct with unique characteristics: *intangibility* because services are performances rather than objects; *heterogeneity*, with performance varying from producer to producer, from customer to customer, and from day to day; *inseparability* of production and consumption because quality occurs during service delivery; and *perishability*, making them impossible to stock (Reeves and Bednar, 1994; Parasuraman, Zeithaml and Berry, 1985).

In the literature, a distinction is often made between the "American" model represented by Parasuraman, Zeithaml and Berry (1985) and the "Nordic" model represented by, in particular, Grönroos (1984). Note that neither of these models are healthcare specific but are generic to various service sectors. In both conceptualizations, quality is perceived through a comparison between expectations and perceptions/performances with respect to a number of quality attributes or dimensions.[4] Grönroos (1984) argued about the (mis)match between perceived service and expected service. Similarly, Parasuraman, Zeithaml and Berry (1985) viewed service quality as a gap between the expected level of services and customer perceptions of the level received. The emphasis on the expectations of the customers has been criticized. More recent scholars argued that measuring perceptions alone is sufficient or even better than difference measures (Brady and Cronin, 2001; Dabholkar, Shepherd and Thorpe, 2000; Babakus and Boller, 1992).

Of the "American" and "Nordic" models, the most widely used is the development of the former presented as the SERVQUAL model/instrument (Parasuraman, Zeithaml and Berry, 1988), even though suggestions were made regarding the increased interest in the "Nordic" model (Brady and Cronin, 2001). The SERVQUAL model is a questionnaire that examines the differences between customers' perceptions of a service and their preexisting expectations of the service on five separate service quality dimensions (tangibles, reliability, responsiveness, assurance, and empathy). A common criticism of the model is that it evaluates only service *process* characteristics and not the *outcome* dimension (Kang and James, 2004).[5]

To Grönroos (1984), customers of services evaluate the service received based on the two different dimensions of technical quality and functional quality (Figure 2.1). Technical quality addresses the outcome of the process. Because a service is produced through interaction with the customer, technical quality cannot account for the total quality that a customer perceives. Additionally, *how* the customer receives the technical outcome is important and represents functional quality or the process-related dimension. Grönroos added a filter to the model – the image – because customer expectations are influenced by their view of the organization. If an organization has a positive image, customers may find excuses for negative

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[4] The expectation–perception comparison is similar to the so-called *disconfirmation theory: positive* disconfirmation if the product is better than expected, *negative* disconfirmation when the product is worse than expected, and *simple* confirmation if the product is as expected (see, e.g., Oliver, Rust and Varki, 1997).

[5] In the original ten dimensions (Parasuraman, Zeithaml and Berry, 1985), the outcome dimension was represented. However, in the development resulting in the SERVQUAL model (Parasuraman, Zeithaml and Berry, 1988), only five dimensions remained, none of which cover the outcome dimension.

experiences. The perceived service quality is the result of technical and functional quality, and the image (Grönroos, 1984).

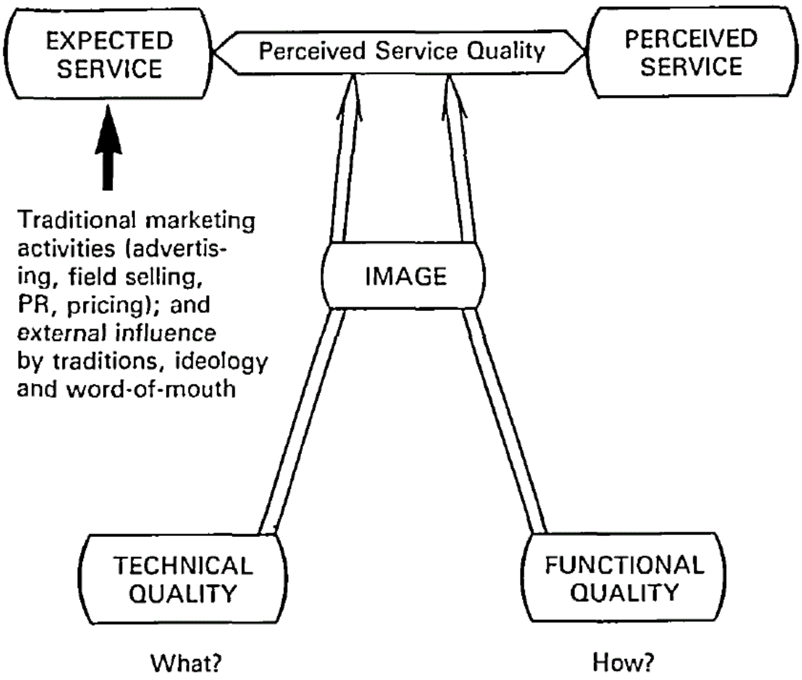

Figure 2.1 *Service quality model (Source: Grönroos, 1984)*

Researchers attempted to hybridize the SERVQUAL model with the service quality model of Grönroos (Kang and James, 2004; Brady and Cronin, 2001; Swartz and Brown, 1989). Research also added the two original dimensions of Grönroos (1984) and, in particular, suggested that a dimension concerning the environmental or physical aspects of service, such as equipment or a building, exists in addition to the functional and technical dimensions (Brady and Cronin, 2001; Zifko-Baliga and Krampf, 1997). However, the environmental aspect is arguably part of the service delivery process and, hence, functional quality because the service process depends on the context of the process (Kang and James, 2004). Other researchers specifically suggested that interpersonal interactions seem to have an important effect on the perceptions of service quality (Dagger, Sweeney and Johnson, 2007; Brady and Cronin, 2001). In addition, Lehtinen and Lehtinen (1991) highlighted the notion that interactions with other customers may be more important than interactions with the staff. Dagger, Sweeney and Johnson (2007) suggested the administrative dimension, which facilitates the production of a core service. In addition to the suggested additional dimensions of service quality, the level of these dimensions of service quality perceptions has been argued, for example, various sub-dimensions, in recognition that evaluation may be more complex than previously conceptualized (Kang and James, 2004; Brady and Cronin, 2001).

2.1.3 Perceived service quality and satisfaction: Is it the same thing?

The relationship between perceived service quality and satisfaction has been greatly debated. What comes first, service quality or satisfaction? Many of the constructions of perceived service quality previously presented also address satisfaction. Quality perceptions often precede the evaluation of satisfaction (Dagger, Sweeney and Johnson, 2007; Kang and James, 2004). Moreover, satisfaction is suggested as a mediating variable between service quality and behavioral intentions, such as complaints or loyalty (Fornell *et al.,* 1996). Golder, Mitra and Moorman (2012) defined customer satisfaction as "a postconsumption judgment that compares an offering's evaluated aggregate quality with its quality disconfirmation" (p. 4). Parasuraman and associates (1988) suggested the reverse, which is that service quality perceptions are treated as outcomes of satisfaction: "perceived service quality is a global judgment, or attitude, relating to the superiority of the service, whereas satisfaction is related to a specific transaction" (p. 16). Dabholkar (1995) suggested a framework based on a literature review and a qualitative study, and recommended that satisfaction include both cognitive and affective evaluations, whereas service quality is only a cognitive evaluation. Fornell *et al.* (1996) suggested that satisfaction – but not quality – takes into account price during an evaluation.

As previously noted, the evaluation of service quality may be constructed in a rather complex manner, such as by adding further dimensions (Dagger, Sweeney and Johnson, 2007) or different levels of dimensions (Brady and Cronin, 2001). Similar to Kano *et al.* (1984), whether each such (sub)dimension or attribute of an offering contributes equally to customer satisfaction and dissatisfaction has been questioned; hence, some are suggested as being *satisfiers* and others *dissatisfiers* (Vargo *et al.,* 2007; Oliver, 1997; Johnston, 1995). For bank customers, Johnston (1995) found that the main sources of satisfaction were attentiveness, responsiveness, care, and friendliness, whereas the main sources of dissatisfaction were integrity, reliability, responsiveness, availability, and functionality. Similarly, Friman and Edvardsson (2003) found that complaint and compliment in public transport contain different attributes of service quality and that reliability of service and simplicity of information (when and how information was given) resulted in more complaints than compliments. Bitner, Booms and Stanfield Tetreault (1990) found that incidents in their study of customers of airlines, hotels, and restaurants caused both satisfaction and dissatisfaction, but that the frequency of occurrence differed. In many studies, the manner in which customers were treated by employees seems more frequent in expressions of satisfaction than dissatisfaction (Friman and Edvardsson, 2003; Johnston, 1995; Bitner, Booms and Stanfield Tetreault, 1990).

Different attributes or dimensions of an offering may act as satisfiers or dissatisfiers, and different customer segments may place different importance and judgment on these attributes or dimensions. In the *American customer satisfaction index*, designed to measure the quality of offerings as experienced by American customers, Fornell *et al.* (1996) found customization to be more important than reliability, standardization, and an offering being free of deficiencies. One year later, Anderson, Fornell and Rust (1997) suggested that, in the service sector, customization quality – the degree to which the organization's offering is customized to meet heterogeneous customer needs – becomes particularly important.

Whether satisfaction precedes or follows perceived service quality, these and similar constructions such as complaining are predominantly described as a customer's post-consumption evaluation (Golder, Mitra and Moorman, 2012; Kang and James, 2004). Tronvoll (2007) offered the alternative explanation that complaining is not to be regarded as something isolated from service delivery; rather, complaining may be understood as an adjustment process that occurs *during* service interaction. This somewhat different view is further elaborated on in subsection *2.5*.

2.2 Achieving quality

In the previous text, the customer is regarded as a sheer receiver and evaluator of quality. However important, little is revealed about the different activities in which a customer may engage. Golder, Mitra and Moorman (2012) offered a three-part process view of quality: *quality production process*, *quality experience process*, and *quality evaluation process*. The organization and the customers may be involved in all three processes, but the production process is primarily the domain of the organization, the evaluation process belongs primarily to customers, and the experience process is where they interact. However, through interactions, the customer may be a co-producer in the quality production process (Golder Mitra and Moorman, 2012), which is similarly emphasized in the service logic discussion presented in the next section.

2.2.1 Service logic

As noted in previous sections, the concept of a service has often been described in terms of the opposite of goods, with unique characteristics such as *intangibility*, *heterogeneity*, *inseparability*, and *perishability* (Reeves and Bednar, 1994; Parasuraman, Zeithaml and Berry, 1985). This view of service has been criticized as building on the goods and manufacturing-based model and describes the negative characteristics of services (Vargo and Lusch, 2004b). This rather (reverse) goods-dominated view of service has recently been challenged and a shift in perspective has occurred. Scholars now argue that all providers are seen as service providers and that the role of the customer has changed to that of a co-creator of value (Vargo and Lusch, 2004a). The introduction to this subsection presents the foundation of this so-called *service logic*,[6] followed by an elaboration of the central aspect of the logic, *co-creation of value*.

In their highly influential article, *Evolving to a new dominant logic for marketing*, Vargo and Lusch (2004a) argued that a new dominant logic for marketing has been formed, one in which service provision, not goods, is fundamental to economic exchange. Whereas the traditional goods-dominant view in which tangible output and transactions were central, the service-dominant view focuses on intangibility, the co-creation of value, and relationships (Vargo and Lusch, 2004a). *Services* is defined as "the application of specialized competences (knowledge and skills) through deeds, processes, and performances for the benefit of another entity or the entity itself" (Vargo and Lusch, 2004a, p. 2). Thus, the definition includes all offerings, including those involving goods in the process of the provision of service (Vargo and Lusch, 2004a). Previous to Vargo and Lusch (2004a), Normann (2001) similarly recognized the need to use service logic, rather than production logic: "… the service logic clearly *frames* a manufacturing logic rather than replaces it" (p. 120, italics in original, my translation).

A key concept in service logic is the distinction between *operand* and *operant* resources (Vargo and Lusch, 2004a). The physical operand resource includes items such as raw materials or products, whereas operant resources include items such as skills, knowledge, competencies, information, and relationships (Edvardsson, Tronvoll and Gruber, 2011). In contrast to traditional marketing that focuses on operand resources as the unit of exchange, the service logic favors operant resources (Vargo and Lusch, 2004a).

In their original article, Vargo and Lusch (2004a) presented a number of foundational premises (FPs) of the service(-dominant) logic. Four years later, the authors (Vargo and Lusch, 2008) modified the original premises and added one more (Table 2.1).

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[6] The definition by Vargo and Lusch (2004a) is service-*dominant* logic. Normann (2001) and Grönroos (2006) suggested the term *service logic*, motivated by Grönroos (2011a) in the following: "If one agrees with this view that all types of resources transmit service and are used as service […] it is a logic of *service*, not a logic *dominated by service*. In this logic there are no goods-centric aspects" (p. 283–284, italics in original). I agree with this reasoning and, hence, adopt *service logic*.

***Table 2.1** Foundational premises of the service(-dominant) logic (Vargo and Lusch, 2008)*

FP 1. Service is the fundamental basis of exchange.
FP 2. Indirect exchange masks the fundamental basis of exchange.
FP 3. Goods are a distribution mechanism for service provision.
FP 4. Operant resources are the fundamental source of competitive advantage.
FP 5. All economies are service economies.
FP 6. The customer is always a co-creator of value.
FP 7. The enterprise cannot deliver value, but only offer value propositions.
FP 8. A service-centered view is inherently customer oriented and relational.
FP 9. All social and economic actors are resource integrators.
FP 10. Value is always uniquely and phenomenologically determined by the beneficiary.

The premises may be understood as criticism of the goods-dominated logic for which value is created by organizations and the customer is given a passive role solely as a payer or receiver.

The ten premises are interwoven, as shown in the following example inspired by Kristensson (2009). Most often a customer does not purchase *Blood on the tracks* by Bob Dylan for the attributes of the good itself; rather, the record makes the service possible, for example, pleasure (FP 3). To be able to listen to the record, the customer lends money to buy a new sound system and hires someone to install it. According to FP 2, the customer may believe that various goods and services have been purchased. Rather, the value realized by the customer (FP 6) is the actual service, pleasure. However, customers perceive propositions differently and may choose to realize the value of the service in different ways (FP 10) and may choose to integrate resources differently depending on how they combine propositions in their networks (FP 9).

The previous example shows that organizations clearly cannot produce value, only value propositions (FP 7). Rather, only the customer may realize this value (FP 6). Obviously, co-creation of value is a central notion in service logic. Indeed, Grönroos (2011a) pointed out that six of the ten premises (1, 3, 6, 7, 9, and 10) are related to value creation and co-creation. Hence, value co-creation needs to be further elaborated.

2.2.2 Value co-creation

Then, what are value and the creation of value? According to Vargo, Maglio and Akaka (2008), value creation increases a customer's well-being. Similarly, Grönroos (2008) argued that value creation is a process through which the customer becomes better off. Similarly, *when* value occurs is not straightforward because it is perceived in an individualistic manner (Grönroos, 2011a) and is "uniquely […] determined by the beneficiary" (Vargo and Lusch, 2008, p. 7). Returning to the example of the Bob Dylan record, pleasure from listening to the record may indicate value for some, whereas for others the value may be in meeting friends and socializing when listening to the record. For others, the sheer feeling of owning the record may indicate value.

That Vargo and Lusch (2004a) did not introduce many of the notions central to the service(-dominant) logic, including the co-creation of value, has been accurately argued (Gummesson and Grönroos, 2012)[7]. Indeed, in 1993, Normann and Ramírez claimed that value creation does not happen in sequential steps but through complex constellations and, thus, "the goal is not to create value for customers but to mobilize customers to create their *own* value from the company's various offerings" (p. 69, italics in original). This claim indicated a shift in focus of the offering (or *proposition*, to use vocabulary from Vargo and Lusch (2008)) from an output for which the customer is a receiver of value to a process of value creation organized by the organization, with the customer being a co-creator (Normann, 2001). Similarly, Grönroos (2006) stated that the *process* of using a specific good, such as knowledge and information about the good, is the service and that "suppliers only create the resources or means required to make it possible for customers to create value for themselves" (p. 324). Because an organization cannot create value for customers, the providers are to, first, serve as value organizers and facilitators of the customer's value creation process (Grönroos, 2008). This notion is in line with the statement of Vargo and Lusch (2008) that the provider cannot unilaterally create value but can only offer value propositions.

However, value creation goes beyond provider and customer. As previously indicated, value is created in complex constellations or combinations (Normann, 2001; Normann and Ramírez, 1993) and through the integration of resources (Vargo and Lusch, 2004a; 2008). Hence, in value creation, the customer may integrate resources from sources other than the main provider, such as other service providers; private sources including family, peers, friends, or other customers; or even the customer's self-generated activities (McColl-Kennedy *et al.,* 2012).

Thus, with respect to service logic, the role of the customer changed to that of a co-creator of services as a process of doing things through interactions (Vargo and Lusch, 2004a; 2008). Similarly, value is not produced or delivered by organizations, consumed by the customer, or determined by the price it yields in exchange (*value in exchange*). Rather, value is co-created by different actors that exchange a variety of operand and – more importantly – operant resources and emerges during use by the customer (*value in use*) (Vargo and Lusch, 2004a).

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[7] Vargo and associates (Michel, Vargo and Lusch, 2008) recognized the work of Normann and acknowledged the similarities between their respectively contributions.

2.3 Quality and value co-creation in healthcare

Sousa and Voss (2002) argued that quality management literature often advocates universal applicability and that a need exists to better understand the effect of contextual variables. Similarly, Vargo and Lusch (2008) included context in their updated set of premises, suggesting that value is contextual. This subsection presents how notions from quality management and value co-creation may be understood in a healthcare context.

2.3.1 Perceptions of quality and satisfaction in healthcare

In 1966, Donabedian first published a model for the evaluation of quality of care. According to the model, quality may be evaluated based on outcomes, process, and structure. *Outcome* refers to the effects of healthcare, such as recovery and survival, and to satisfaction; *process* describes whether medicine is properly practiced; and *structure* is constituted by the setting in which the process occurs and includes elements such as qualification of healthcare staff, facilities, and equipment. Later work stressed the importance of the relationship between healthcare provider and customer, not the least because this relationship motivates the patient to cooperate (Donabedian, 2003). For example, showing concern and empathy and taking the time to explain are highlighted as pleasing the patient, and to reassure her or him that these attributes are evidence that the more technical aspects – difficult for the patient to evaluate – are also good. The so-called *amenities* of care include properties such as cleanliness, convenience, and privacy that may contribute to making the care experience pleasant or unpleasant for the patient (Donabedian, 2003).

The construct of outcome, process, and structure suggested by Donabedian (1966) is similar to the functional and technical dimensions in the service quality literature (e.g., Grönroos, 1984). When applied to a healthcare context, these dimensions translate to the technical quality – or *what* the patient gets – being the clinical or disease-specific outcome of care. The functional quality is *how* the patient receives the technical outcome and includes non-clinical aspects of care. The latter includes interactions with the healthcare staff. However, Dagger, Sweeney and Johnson (2007) suggested that these interpersonal aspects are particularly important in healthcare and should constitute a dimension of their own. The functional or process quality of healthcare is the dimension that most scholars suggest is easier for patients to assess compared with technical quality (Fiala, 2012; Marley, Collier and Meyer Goldstein, 2004), not the least because technical quality may be difficult for patients in healthcare to evaluate given the healthcare provider's specialized knowledge (Berry and Bendapudi, 2007; Kang and James, 2004; Swartz and Brown, 1994). In contrast, physicians tend to focus on technical quality (Fiala, 2012). Lack of expertise and lack of opportunity and equipment may complicate the evaluation of technical quality and the fact that the outcome is not always immediately detectable (Kang and James, 2004; Marley, Collier and Meyer Goldstein, 2004). In their research in a hospital setting, Zifko-Baliga and Krampf (1997) argued that traditional outcome evaluation based on hard data is insufficient because outcome also involves perceptions: "If patients do not feel cured in their minds, then indeed they have not been cured" (p. 29). Hence, they identified two dimensions of outcome: the *physical cure* and the *emotional cure*, and that both need to be addressed when measuring outcomes (Zifko-Baliga and Krampf, 1997). However, functional quality (FQ) seems more important to patients than technical quality (TQ) or, to quote Fiala (2012, p. 753): "FQ trumps TQ, for many patients." Indeed, in what Dagger *et al.* (2013) called *selective halo effects*, the customer's perceptions of frontline staff's interpersonal skills have an effect on their perceptions of the attributes they find difficult to evaluate.

Whether satisfaction or dissatisfaction is always an appropriate measure in healthcare may be questioned. Research suggested that dissatisfaction in healthcare tends to be expressed only when extreme negative events occur (Williams, 1994). Berry and Bendapudi (2007) argued that healthcare services might be something that patients need but do not necessarily want, in contrast to many other services. Alternatively, some patients may want certain treatments that may not be necessary or may be bad for them (Donabedian, 2003), complicating the measurement of satisfaction and dissatisfaction in healthcare.

2.3.2 Value co-creation in healthcare

Naturally, healthcare providers are not excluded from the service logic's notion that all providers are service providers and that customers are viewed as active, rather than passive, in co-creating value with an organization and others (Vargo and Lusch, 2004a; 2008). Nordgren (2008) suggested that a similar transformation occurred in the linguistics in a healthcare context, "from a waiting patient […] to a customer creating value" (p. 510). However, in healthcare practice, the customer is still often viewed as a recipient (Tariman *et al.*, 2010; Holman and Lorig, 2000). That more participatory healthcare customers lead to better medical outcomes, lower costs, more effective and efficient healthcare delivery, and increased perceptions of satisfaction and quality has been suggested (Gallan *et al.*, 2013; Groene *et al.*, 2009; Holman and Lorig, 2000). Similarly, Lengnick-Hall (1995) argued that the patient ought to be regarded as a participant in the production and delivery of the service because service quality diminishes if a patient does not collaborate.

Referring to the patient as a customer is not done without opposition. Goodrich and Cornwell (2008) asked healthcare practitioners in the United Kingdom and found primarily hostile reactions to referring to patients as *customers*. In contrast, Tabrizi, Wilson and O'Rourke (2009) concluded that *patient* implies dependency on health providers and that *customer* was more inclusive, not the least because healthcare users are both patients and preventive care users, family members, or friends to a patient. Mayer and Cates (1999) summarized their findings concerning customers and patients as follows: "The more horizontal they are, the more they are a patient. The more vertical they are, the more they are a customer" (p. 1283). Hudak, McKeever and Wright (2003) argued that the customer metaphor might be inappropriate concerning treatment outcomes because he or she is an organic part of the treatment. Rather, *customer* is more appropriate for satisfaction with the *process* of care and services. However, Nordgren (2008) argued that difficulties exist related to using the concept of customer because the responsibilities and tasks of healthcare professionals is regulated by law and is institutionalized, and delegating tasks to patients may not be applicable to healthcare. Berry and Bendapudi (2007) studied a medical institution to compare healthcare with other services. They argued that healthcare is different from many other services because patients are sometimes reluctant; thus, healthcare is a service that patients need but may not always want. If customers are seen as co-creators, whether they should shoulder responsibilities for risks has been questioned (Prahalad and Ramaswamy, 2004) and is something particularly important to note in a healthcare context (Nordgren, 2008).

The notion that the customer is always a co-creator of value (Vargo and Lusch, 2008) highlights the importance of relationships between the customer and the provider through interaction and dialog (Payne, Storbacka and Frow, 2008). Indeed, Grönroos (2011b, p. 244) argued that, "No joint value creation exists and no co-creation of value can take place, unless interactions between the supplier and customer occur." Normann (2001) referred to these interactions, or service meetings, as the *moment of truth* because, in particular, the face-to-face interactions between the customers and the frontline staff are important as a value-creating process. Similarly, the interaction between the patient and the healthcare provider was highlighted as particularly important in healthcare services (Dagger, Sweeney and Johnson, 2007). Nordgren (2008) argued that, "the meeting can be seen as a relation in whom both parties learn from each other. The role casting is such that the customer imparts knowledge about him/herself while the doctor takes on the responsibility of the examination, the conclusion of a diagnosis and the proposition of possible treatments" (p. 519). Nevertheless, Schoen *et al.* (2011) suggested that the *moment of truth* between patient and healthcare staff might often be unsatisfying to patients.

However, interaction and integration of resources may occur with and from the main healthcare provider and with other healthcare providers, associations and other public sources, private sources such as friends and family, and through self-activities using personal sources such as reframing and psyching oneself up (McColl-Kennedy *et al.,* 2012). McColl-Kennedy *et al.* (2012) defined customer value co-creation as "benefit realized from integration of resources through activities and interactions with collaborators in the customer's service network" (p. 1). Through interviews and focus groups with cancer patients, McColl-Kennedy *et al.* (2012) identified different co-creation activities in healthcare (Table 2.2).

***Table 2.2** Co-creation activities in healthcare (McColl-Kennedy et al., 2012)*

Cooperating: accepting information from the service provider, compliance with basics.

Collating information: sorting and assorting information, managing basic every day activities.

Combining complementary therapies: use of supplementary medicine, exercise, yoga, and diet.

Co-learning: actively seeking and sharing information from other sources and providing feedback.

Changing ways of doing things: long-term adaptive changes such as changes in financial position and involvement in activities that deliberately take the mind off cancer (for example, through hobbies).

Connecting with family and friends, doctors and other health professionals, and support groups; build and maintain relationships.

Co-production: assisting with redesigning treatment programs and reconfiguring the composition of medical teams.

Cerebral activities: positive thinking, psyching oneself, emotional labor, and reframing and sense-making to accept one's situation.

Of the activities in Table 2.2, a particular need exists to clarify the distinction between co-production and co-creation. Indeed, in their revision of the foundational premises of service logic, Vargo and Lusch (2008) replaced the goods-dominant logic lexicon of *co-production* – making units of output – to service logic's value *co-creation.* However, the authors suggested that co-production is part of value co-creation and includes participation in the development of the core offering (Vargo and Lusch, 2008). McColl-Kennedy *et al.* (2012) argued that co-production includes assisting with administering drugs or other treatments with the staff (self-service), giving the provider new ideas such as how to reduce waiting time, assisting in the redesign of treatments, and reconfiguring the composition of the medical team. As previously pointed out by scholars (Elg *et al.,* 2012; Witell *et al.,* 2011), these activities may benefit patients and may enable them to be active contributors of knowledge and skills in healthcare service development – benefitting others as well. However, previous scholars suggested that customers' knowledge and skills are not sufficiently used in the development of healthcare services (Groene *et al.*, 2009; Lombarts *et al.*, 2009).[8]

Using groupings of activities and interactions, McColl-Kennedy *et al.* (2012) identified five value co-creation practice styles in healthcare (Figure 2.2).

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[8] Magnusson, Matthing and Kristensson (2003) suggested that involving users in service innovation makes ideas more original and gives them a higher perceived user value. However, the authors also argued that users' ideas are frequently less producible.

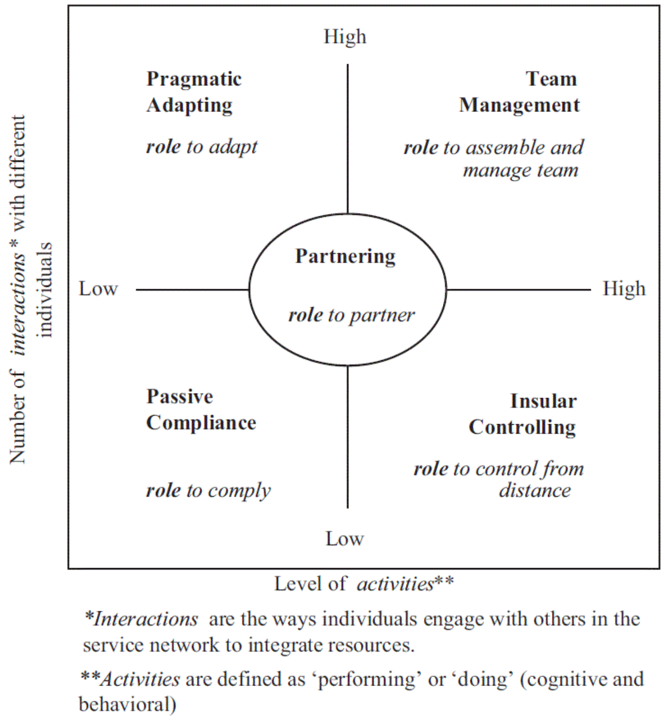

***Figure 2.2** Co-creation practices styles (Source: McColl-Kennedy et al., 2012)*

Healthcare customers adopting the *team management* practice style have a high level of activities and a large number of interactions with different individuals from the main healthcare provider and others. They manage their respective "team" (such as medical experts, friends, and support groups) with whom they have open communication. These customers demonstrate a high level of being in control. The contrast to the team management practice style is *passive compliance*, characterized by a low level of activities and a low number of interactions with different individuals from the main healthcare provider and others. Interactions are often only with the medical profession and follow the physician's orders. These patients do not question their physician and do not take initiative, such as searching for information elsewhere, exercising, and changing one's diet. Patients with the *insular controlling* practice style are rather self-focused and have few interactions with different individuals. However, their activity levels are high and they have strong emotional labor, preferring to be alone and to not share their feelings with others. The reverse goes for *pragmatic adapting*, which is characteristic of a relatively low level of activities but a large number of interactions with different individuals. These patients see their role as adapting to their changed circumstances. *Partnering* is characterized by a medium level of activities and interactions. These individuals see their role as a partner but collaborate only with their physician and a few other professionals.

Lengnick-Hall (1995) offered a different construction. Two major patient roles to achieving quality in healthcare are offered—one at the input and another at the output. For the former, patients provide input to the system as suppliers and participants. As *suppliers*, patients are a resource for healthcare activities – the "raw material" that needs to achieve greater wellness. By achieving quality through the patient as a *participant*, he or she is seen as an active member of the service delivery team. Within the team, the patient is the one with the most direct control over outcomes; therefore, her or his knowledge and skills, for example, are crucial to achieving outcome quality. For the output, patients may be seen as products or recipients. As *products*, the patient is the outcome of the healthcare system, such as by getting well. As *recipients*, the patient is the primary beneficiary; for example, the importance of feeling satisfied is highlighted by Lengnick-Hall (1995).

2.4 Social construction

As noted in the introductory section and the appended papers, previous studies illuminated the fact that disparities exist in the quality of healthcare services for various patient segments. The purpose of this thesis is to contribute to enhancing equity in healthcare. For this purpose, social construction offers a useful framework for understanding the most important factors in the appended papers: ethnicity (papers I and II) and gender (paper III).

This thesis frequently refers to "groups of people," "segments of healthcare customers," and similar constructions. Naturally, the categorization of people into groups is not unproblematic. McCall (2005) accounted for various categorization approaches for people. In one approach, social life is believed too complex to create fixed categories that simplify and create unequal conditions. Existing categories are deconstructed and the *process* that creates boundaries is investigated. In contrast, another approach uses existing categories strategically and temporarily by investigating the disparities among social groups. Yet a third approach is found in the middle of the two previous ones and investigates the process of creating boundaries and strategically uses social categories by focusing on complexity in relationships among multiple social categories and not within these groups. Subsection *2.4.3* further elaborates on this approach.

Frequently, *The social construction of reality* by Berger and Luckmann (1966) is regarded as the milestone of social construction theory. Their notions are in stark contrast to positivistic explanations; rather than knowledge being out there for us to find, knowledge is created by interactions among people within society and transferred and maintained in various social contexts and systems. Hence, "reality" and "knowledge" are relative because they relate to specific social contexts. With this concept comes the notion that "a 'sociology of knowledge' will have to deal not only with the empirical variety of 'knowledge' in human societies, but also with the processes by which *any* body of 'knowledge' comes to be socially established *as* 'reality'" (Berger and Luckmann, 1966, p. 15, italics in original).

Gergen and Gergen (2008) provided an account of three independent social construction movements, following Berger and Luckmann (1966): the *critical* movement, with its critique of authority including, for example, feminism, black, and gay movements; the *literacy/rhetorical* movement on how discursive conventions construct what we take to be the world; and the *social* movement, with its focus on the social processes giving rise to knowledge. The authors also outline the most widely shared agreements from these movements, such as that no transcendent truth exists. Rather, historically and culturally situated social processes shaped what we believe to be true/false, moral/immoral, and equitable/inequitable. Thus, knowledge is shaped and resides in relationships, not the individual mind, and meaning is derived from language use within relationships. With this concept comes the notion that "it is not individuals who come together to create relationships, but relationships that are responsible for the very conception of the individual" (Gergen and Gergen, 2008, p. 163).

The notion of social construction has been increasingly used, made obvious by Hacking's (2000) alphabetic list of things claimed to be socially constructed. Hacking (2000) argued that the foundation of social construction includes criticism of current conditions. The starting point is the notion that the existence of a certain socially constructed X, or its characteristics, is not determined by the nature of things. X is not inevitable and was created or shaped by social events, forces, or historical developments that could as well have been different. According to the author, inquires about social construction often proceed to the realization that something that currently seems inevitable is not inevitable and, therefore, it must be something bad. That said, Hacking (2000) focused on gender, one of the most influential Xs, or social constructions.

2.4.1 Gender

Gender[9] is a socially constructed unity that is different from *sex* in that is a biological fact (e.g., SOU 1990:44). In the late 1990s, biological research used to explain disparities between men and women increased, often without considering other models of explanation (Hammarström, Hovelius and Wijma, 2004). The situation is still the same, particularly in medicine, in which individuals become men and women based on factors such as their hormones, and in which these biological explanations have prevail to other explanations, such as social processes (Hamberg, 2004).

Research suggested that socialization of sexes shows in childhood; for example, boys are socialized not to express emotions such as sadness, whereas the opposite seems the case for girls. However, socialization accumulates over time and, therefore, gender emotion stereotypes apply more to the adult population (Kelly and Hutson-Comeaux, 1999). Gender stereotypes described in studies suggest that men are goal and outcome oriented, whereas women tend to focus more on

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[9] Gender is an umbrella concept that covers, for example, masculinity theories, feminist theory, sexuality, and transgender theory. However, for the purpose of this thesis, further elaboration within the concept of gender is not necessary.

process and, hence, value relationships, caring, nurturing, and cooperating more than men do (Nameda, 2013; Danielsson, 2010; Howell and Day, 2000; Iacobucci and Ostrom, 1993). In a healthcare context, traditional gender norms may explain why men are less willing to seek healthcare services than women (Addis and Mahalik, 2003), and that women's motivation for exercising is more often related to tone and weight than it is for men (McDonald and Thompson, 2006).

The two concepts of sex and gender may not necessarily be treated as too separate. Krieger (2003) argued that sometimes both gender and sex need to be studied, sometimes one of them needs to be studied, and sometimes neither needs to be studied. In the same manner, Hamberg (2004) suggested the need to get beyond the strict distinction of sex/gender and to apply a more pragmatic definition that indicates that gender is equal to "sex with a holistic view" (p. 26).

2.4.2 The others

In 2004, the Swedish government appointed a commission to inquire into power, integration, and discrimination based on ethnical and religious affiliation (SOU 2006:78). One of the reports of the commission put a special focus on healthcare, a sector that was argued as particularly neglected in this area. The report concluded that a strong connection exists between perceived discrimination (interpersonal as well as institutional) and illness among foreign-born residents in Swedish society (SOU 2006:78).

The concepts used in this thesis to neatly categorize the participants are "mother tongue" or "foreign-born" (see papers I and II). Indeed, previous research showed that a lack of skills in Swedish may explain, for example, whether basic needs are provided in the patient–provider interface (Björk Brämberg, Nyström and Dahlberg, 2010), self-reported health (Wiking, Johansson and Sundquist*,* 2004), and when treatment is given for patients with acute chest pain (Santos *et al.,* 2013). Nevertheless, the concept of race or ethnicity is more often used in the literature. However, according to the Swedish Personal Data Act (SFS 1998:204), registering data that reveals that, for example, race or ethnicity, is prohibited. Hence, other concepts were used to identify potential disparities. However, one risk related to solely investigating language skills – similar to only investigating socio-economic differences – is to neglect discriminating structures and mechanisms in society (SOU 2006:78). Nevertheless, similarities exist between these constructions, such as the emphasis on the notion of something different and grouping people together by cultural communalities.

The concepts of race and ethnicity are often used interchangeably. However, scholars argue over the distinctness of the concepts from one another. Cornell and Hartmann (1998) suggested that of the social constructions of race and ethnicity, race is constructed by others whereas ethnicity is most often constructed by the group itself. Despite the fact that race as a biological "truth" has been abandoned, conceptions about race are part of society and still organize material, social, and symbolic resources (SOU 2006:78). Through *racialization,* often based on historical heritage, groups of people are considered different based on their cultural background or ethnicity, creating the dichotomy of *Us* and *The others* (Neergaard, 2002; Tesfahuney 1998). However, scholars argued that race is not just constructed by others but is part of the social identity (Haney-López, 1994). Moreover, the notion that ethnicity is shaped solely by the ethnic group itself was criticized for neglecting structure and that, indeed, others may influence these categories (Nagel, 1994). Similarly, Chung and Fischer (1999) suggested that ethnicity might be shaped by the immigration experience, a negotiation process between the host society and the immigrant.

2.4.3 Intersecting social constructions

Various aspects of our lives are organized based on social constructions such as ethnicity (and similar constructions) and gender; family, education, employment, and economic prospects, to mention a few (Smedley and Smedley, 2005; Haney-López, 1994). Sometimes, two socially constructed categories intersect and the disparities that a single category could not achieve are illuminated. The so-called *intersectionality* assumes a dynamic between the socially constructed categories, and these categories may therefore interact or even change one another (Walby, 2007; Lykke, 2005). For example, Mair (2010) found that the relationship between social ties and depression varied among black men, black women, white men, and white women. Similarly, in a national survey, patients not having Swedish as their native language reported consistently lower perceptions of quality regarding encounter and information compared with patients having Swedish as their mother tongue (Diskrimineringsombudsmannen, 2012). By adding on the patients' sex to native language, the survey revealed that, in particular, *women* with a mother tongue other than Swedish reported the lowest perceptions of quality in healthcare (Västra Götalandsregionen, 2013).

2.5 Conceptual frame of theories

This theoretical chapter does not elaborate on equity as a separate theory. Rather, and in line with the purpose of the thesis, equity is the overarching concept that the presented theories are supposed to support. Thus far in this thesis, theories within quality management, value co-creation, and social construction have been presented. Figure 2.3 visualizes both the kinship connecting them and the potential to reinforce one another.

Figure 2.3 *Conceptual frame of theories*

Within quality management, process quality is emphasized as particularly important to healthcare customers (Fiala, 2012), not the least the interpersonal aspects (Dagger, Sweeney and Johnson, 2007). Value co-creation scholars further penetrated this emphasis (e.g., Vargo and Lusch, 2008) and paid particular attention to relations and the fact that the customer may involve others in an effort to realize value (McColl-Kennedy *et al.,* 2012).

Nevertheless, service logic scholars frequently overemphasized the individualistic aspect of value co-creation by paying little attention to the social context. By incorporating social construction (e.g., Berger and Luckmann, 1966), value co-creation may be understood as a socially constructed process – and value itself as something existing not in a vacuum but in a social context. After all, "truths" are created in relationships between humans (Gergen and Gergen, 2008). With this comes the notion that certain groups may very well have common experiences, needs, and expectations of which healthcare providers should be aware and that should be included when designing value propositions that are more appropriate and equitable for a given group of healthcare customers. Equity and joint creation are also key concepts of the participatory action research methodology, elaborated on in the next chapter.

Before presenting the methodology, clarifying my own construction of quality, value, and satisfaction is necessary. I adopt the definition of *quality* as something perceived by customers (e.g., Grönroos, 1984). In line with more recent developments of perceived service quality (Brady and Cronin, 2001; Dabholkar, Shepherd and Thorpe, 2000), I argue that collecting customers' expectations prior to service delivery is not always necessary (or even possible) to understand customers' perceptions of quality. Hence, emphasis is on perceptions, which is where the disparities between the customer's expected and experienced quality is embedded. *Value* is explained within service logic as the customer being better off (Grönroos, 2008) or having increased well-being (Vargo, Maglio and Akaka, 2008). Semantics aside, the two constructions of *perceived quality* and *value* show clear similarities and indicate that both may be explained as something that only the customer evaluates and determines. Hence, my working definition (see *Future research*) of the concepts is that value and quality may be used interchangeably within the frame of this thesis.

Satisfaction is more complicated; certain studies described it as preceding service quality perceptions (Parasuraman, Zeithaml and Berry, 1985), whereas others described it as an outcome of the same (Dagger, Sweeney and Johnson, 2007; Kang and James, 2004). Satisfaction was also described as a more emotional evaluation than the cognitive evaluation of service quality (Dabholkar, 1995). However, whether human emotions may at all be put aside when the customer evaluates service quality is questionable. The view of Fornell and associates (1996) is that as perceived quality and perceived value increase, satisfaction should increase as well. Whether or not they precede quality, satisfaction and behavioral intentions such as complaints are often described as post-consumption judgments (Golder, Mitra and Moorman, 2012; Dagger, Sweeney and Johnson, 2007). Returning to the focus on process and interpersonal aspects, I adopt Tronvoll's (2007) somewhat deviant view that complaint behavior is not only a post-consumption evaluation but may also be understood as a "dynamic adjustment *process* that occurs during the service interaction […] between the parties in their effort to co-create value" (p. 614, italics non-original). Because the service interaction and the *value in use* assessments often occur simultaneously in healthcare, complaining is more likely to occur during the co-creation process and not as a post-consumption assessment (Tronvoll, 2007). This thesis also adopts this construction of complaining.

3 METHODOLOGY

This section presents the two research approaches used in the appended papers. It continues with a joint description for all three papers on how data was collected and analyzed, and ends with quality and ethical considerations related to the inquiry.

3.1 Self in research

Similar to many of my fellow students studying political science, I wanted to work in foreign politics. After six rather disappointing months at the Department of Foreign Ministry, I returned to university with a blank mind and no clear idea of what to do. Luckily, this situation changed rather quickly. The course I attended when returning to studies was about diversity in public administration, and I spent my last year at university with my nose deep in books written by gender equality and postcolonial scholars. I ended up writing my master's thesis about the (under)representation of foreign-born inhabitants in the public labor market.

Ten years have passed, and I have been working primarily on healthcare-related issues and, lastly, at the councils in Stockholm and the Western Region. At my last employment, I worked with quality improvement in healthcare and focused on equity issues from the patient's perspective. A typical project started with disparities, whether shown as numbers in statistics or retrieved from the experiences of the healthcare staff. Usually, a literature review followed to identify both the problem and the interventions to solve the problem. After that, data was collected, often through focus groups with patients or healthcare personnel, and then analyzed together with the practitioners. Interventions were then launched.

As I see it, I started working with healthcare issues by chance. However, I stayed in the field because I see a great opportunity to contribute to improvement concerning issues of significant importance to many people. Over the years, my interest has moved from politics to quality (however, that quality *is* politics may be rightfully argued, but I omit that discussion). Now, my interest is primarily to improve the quality of healthcare services. More specifically, my focus is on different needs, expectations, and experiences of different – and often aggrieved – segments of the population that might require specific or tailor-made services. Using segments of patients, I address characteristics such as, for example, gender, ethnicity, and socio-economic background. To me, simply understanding a problem is not enough. A driving force is to improve services to ensure that everybody has equal access to them, is treated appropriately, and is met with respect. I believe that one problem in healthcare is to treat patients as either *one* group or *too* individualistically – either everybody is alike or has nothing in common. My strong belief is that better and actionable knowledge of certain groups must be brought to light to improve and adapt healthcare services.

A personal reflection is that literature within political science is rather problem focused. There is nothing wrong with illuminating problems (be it low voting rates or why a car does not function as desired). However, because I started my PhD at a university of technology, I somehow had to learn to be more solution-oriented. This focus may seem trivial, but it taught me to see problems differently or, to paraphrase Kurt Lewin, "If social scientists truly wish to understand certain phenomena, they should try to change them" (Kurt Lewin, cited in Argyris, 1997, p. 817).

Why have I wasted precious space in this thesis rambling on about myself? What good does it do? The simple reason is because I believe that nobody gets into a project as a *tabula rasa*. We bring experience, values, and needs to a project, or what is simply called our *pre-understanding*, as explained by Gummesson (2000, p. 57): "people's knowledge, insights, and experience before they engage in a research program." This pre-understanding includes both explicit and tacit knowledge (Coghlan and Brannick, 2010). McNiff and Whitehead (2009) argued that the *personal context* must be explained to the reader because information is central to the research. Naturally, this reasoning needs to be highlighted when writing up the research because it has an effect on choices made, which is particularly relevant and common regarding action researchers who tend to be more autobiographical than traditional researchers (Bradbury Huang, 2010). Thus, what is action research?

3.2 Research approach: papers I and II

This section starts with an introduction of the concept of action research, followed by a presentation of one of its branches – the participatory action research approach used in papers I and II. An elaboration of the different roles in action research and a reflection of the screening study conclude the section.

Kurt Lewin is frequently said to have coined the term *action research* in his article, *Action research and minority problems* (1946), and two subsequent articles a year later (1947a; 1947b). Still today, the foundation of action research is to change a certain situation for the better (McNiff and Whitehead, 2009; McIntyre, 2008). In the introduction to the *Handbook of action research,* Reason and Bradbury (2008, p. 4) summarized the main characteristics of action research:

> *Action research is a participatory process concerned with developing practical knowing in the pursuit of worthwhile human purposes. It seeks to bring together action and reflection, theory and practice, in participation with others, in the pursuit of practical solutions to issues of pressing concern to people, and more generally the flourishing of individual persons and their communities.*

Action becomes *research* when the focus shifts from describing the action to explaining the action (McNiff and Whitehead, 2009), and when contributing to scientific knowledge (Coghlan and Brannick, 2010). Thus, the action researcher needs to investigate what he or she is doing in the project and explain how and why the problem under study improved (or why it did not), which is neither done by the action researcher herself/himself nor *for* the practitioners. Rather, to make action more effective, the research is carried out in a collaborative manner – action research is research *with* practitioners and others (Bradbury Huang, 2010; Coghlan and Brannick, 2010; McIntyre, 2008).

Lewin (1946) proposed an action research cycle with the three main steps of *planning*, *action*, and *fact-finding* regarding the result of the action. Coghlan and Brannick (2010) offered a similar cycle, as shown in Figure 3.1.

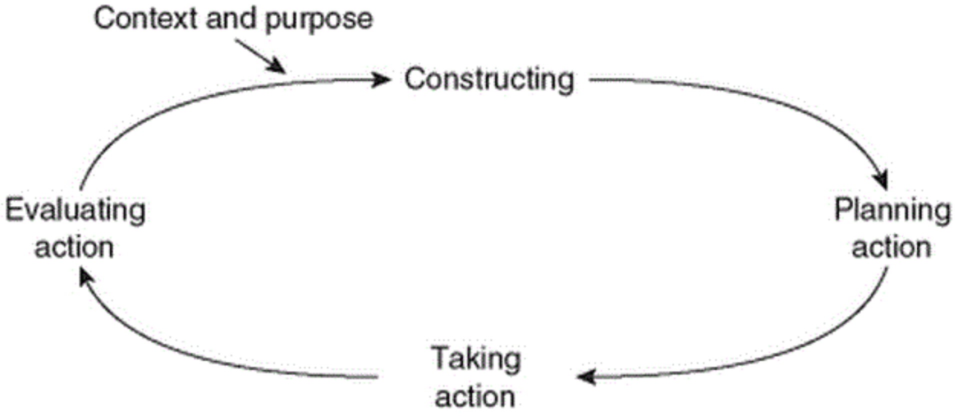

Figure 3.1 *Action research cycle (Source: Coghlan and Brannick, 2010)*

The *pre-step* deals with context and purpose. In this step, an understanding of the context (internal such as cultural and structural, and external such as political and social) is sought, as is a definition of a desired future state and the establishment of collaborative relationships. In the *constructing* step, stakeholders of the project engage in constructing the issues and in the basis from which action will be taken in the following steps of *planning action* and *taking action*. In the concluding step of *evaluating action*, intended and unintended outcomes of actions are examined to determine whether the original constructing fit, whether the actions taken matched the construction, and whether these actions were taken appropriately. The learning is then fed back into the next action research cycle (Coghlan and Brannick, 2010).

The cervical cancer screening study (papers I and II) may be understood on the basis of an action research cycle. Together with the healthcare staff, we discussed the local context, the diversity of the inhabitants, and the failed integration policies, among other topics. This discussion resulted in the aim to increase awareness of cervical cancer prevention in the local context and, hopefully, in the extension to increase participation in the screening program by at least 25 percent compared with the previous year. The local doulas participated as follows. Together with the healthcare staff, they identified barriers and proposed a number of interventions (or *actions*) that were jointly launched during one year. Some interventions were evaluated rather quickly and were changed. Other interventions were evaluated first after the year-long campaign, but were still fed back to improve cervical cancer preventive services.

Participation in the screening program increased by 42 percent compared with the previous year and the participating local doulas saw that the locals seemed to talk about and understand the reason for cervical cancer prevention. However, importantly, the desired outcomes from using action research should be stressed as being not merely "practical solutions to issues of pressing concern to people" (Reason and Bradbury, 2008, p. 4) but as reflecting learning that influenced improvement processes (McNiff and Whitehead, 2009), not the least one's own learning as an action researcher about self and the collective (McIntyre, 2008). Hence, action research also includes a meta-cycle, which is to be understood as a reflection cycle. This cycle focuses on the action research project itself and what the participators are learning, which is what makes action research more than just problem solving: "it is learning about learning" (Coghlan and Brannick, 2010, p. 12). This concept is further elaborated on in the subsection *Roles in action research, 3.2.2*.

3.2.1 Participatory action research

Since Lewin's (1946) introduction of the term *action research*, many varieties of the approach have been developed (Bradbury Huang, 2010) that cover various techniques, methods, and practices used in different contexts and that have their origin in various traditions and ideologies (McIntyre, 2008). As previously mentioned, one common cornerstone of action research as an umbrella concept is to achieve change together with practitioners. This cornerstone is particularly relevant for the branch of *participatory action research*. Indeed, one criticism of Lewin's work is that participants were not involved in either setting the agenda or making decisions (Koch and Kralik, 2006).

In particular, the liberation work of Paulo Freire drew considerable inspiration to participatory action research. In *Pedagogy of the oppressed* (1970), Freire criticized the traditional teacher–pupil model as being authoritarian and advocated that the poor should be actively involved in education to critically analyze their situation and enable them to transform their environment. In a Freirean way, participatory action research deals with how the powerless are excluded from, for example, decision making and access to resources, and focuses on empowering people for them to use their own knowledge (Coghlan and Brannick, 2010). Hence, action researchers often emphasize individual and interpersonal levels of action and analysis, whereas practitioners of *participatory* action research typically focus on social structures and emphasize equity, oppression, and access to resources (McIntyre, 2008). Thus, the participatory action research project focuses on the community level rather than on organizational context and aims to provide opportunities for local people to develop strategies and gather resources to improve certain aspects of their environment (Coghlan and Brannick, 2010; McIntyre, 2008).

Naturally, research on foreign-born women's exclusion from the standard-practice of cervical cancer screening programs has a political dimension characterized by unequal access to, and information on, health promoting services. Hence, I decided to explicitly position the project as *participatory* action research. This project included both service providers and local community participants for the purpose of empowering locals to make informed decisions and to improve the situation in the local context. The involvement of so-called *paraprofessionals* and *volunteers*[10] in sharing background with community members receiving services may help bridge the cultural gap (Allen *et al.,* 2006; Reeb, 2006). Indeed, the benefit may not only be for community members but also for involved paraprofessional and volunteers themselves, for example, to experience a sense of self-efficacy toward making a difference in their community (Ferrari *et al.,* 2006). In particular, a similar conclusion may be drawn in papers I and II: by participating in the project, the local doulas reported that they learned a lot by working side by side with the midwives and experienced increased confidence and a sense that they did something important as the project proceeded. However, the benefits were not only for community members or doulas but also for the healthcare service providers who gained a better understanding of the needs and expectations of the local inhabitants.

3.2.2 Roles in action research

Naturally, my own personal background and values previously highlighted were brought into the project and might very well explain the certain choices made; certainly, my background and role on the project had an effect on the process and its results.

Elden and Levin (1991) elaborated on the roles of the action researcher coming from the outside and the local participants inside the organization or community. They argued that the researchers and the local participants bring different types of knowledge, expertise, and ways to understand the project – their frameworks. The local participants want to solve practical problems and achieve organizational and personal goals. They are experts in the specifics of the situation or setting and, from personal experience, know about values, attitudes, and how things work. However, this type of knowledge is often tacit, nonsystematic, unreflected on, and highly individual. The action researcher from the outside is interested in solving particular types of problems or in methods, general knowledge, or values. The researcher recognizes patterns and has training in systematic inquiry and analysis and in creating new knowledge. Ideally, through dialogue, the insider's and outsider's respective frameworks intermingle to create a third framework of *local*

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[10] A *paraprofessional* is a worker with no advanced degree but who receives training and supervision by a professional to enable her or him to perform certain tasks. In contrast to *volunteers*, they are typically paid (Reeb, 2006). In the case of this project, the doulas were given training and were paid; therefore, they are considered *paraprofessionals*.

theory. This theory is tested and the results are fed back to improve the local theory. Hence, the goal of the inquiry is to both solve practical problems and generate general theory that is neither local nor context bound (Elden and Levin, 1991).

However, the action researcher may very well be considered on the inside. In *Doing action research in your own organization,* Coghlan and Brannick (2010) distinguished between the roles of the action researcher as an insider or an outsider. As soon as I had the book in my hands, I wondered whether or not I was actually conducting research in my own organization. Because I position myself within *participatory* action research, the insider/outsider perspective may be understood as being part of both the *organization* and the local *community* under study.

My employer is the organization of the Western Region of Sweden, the second largest council in the country. Providing healthcare to the citizens is the main task of the council, which is also concerned with public transportation and culture. If I limit *my* organization to be part of the organization working only with healthcare, I still work in a very large organization. Furthermore, my home unit is at a central level, working with quality improvement over the entire region, whereas the local hospital and the three antenatal clinics involved in the screening study have a local concern. More importantly, most of the participating healthcare staff were clinicians (midwives, nurses, gynecologists) whereas I am not; they face similar daily obstacles and share an organizational cultural of which I am not a part. The same applies to the local community under study; I have never lived in the area and have not experienced what many of the inhabitants experience on a daily basis. Getting back to the distinction between insider and outsider, simply put, the insider is a *full* member of the organization (or local community, I add) under study, whereas the outsider is not (Coghlan and Brannick, 2010). With this in mind, I do not consider myself an insider action researcher because I am not a full member of the organization or the local community under study. More importantly, I do not believe that either the involved healthcare staff or the community participants would consider me to be a full member of their organization or the local community.

Whether an insider or an outsider, previous research highlights that the action researcher must not serve as an expert telling people what to do (Coghlan and Brannick, 2010; McNiff and Whitehead, 2009). Rather than acting as an expert, the action researcher must mobilize the organization's own expertize (Whyte, Greenwood and Lazes, 1991). Because I have no experience working in clinical healthcare or as an inhabitant in the community under study, the project depended on the professional knowledge and skills of the involved gynecologists, nurses, and midwives, and the local and cultural competence provided by the doulas. Hence, the expertise of those working and living in "the field" was brought into the cervical cancer screening project.

Previous action researchers used first-, second-, and third-person perspectives (Coghlan and Shani, 2008; Reason and Bradbury, 2008). The *first-person* perspective includes reflection on our own assumptions and values, and on how we behave. On a *second-person* basis, we engage in face-to-face interactions with others concerning issues of mutual interest. In the *third-person* perspective, the wider community is addressed and we make a contribution to the body of knowledge (Coghlan and Shani, 2008; Reason and Bradbury, 2008). Although the first-, second-, and third-person perspectives are not explicitly addressed in papers I and II, many of the reflections included in such a distinction is presented in the papers. Hence, I only briefly elaborate on the application of the terms to this study. On a *first-person* basis, my own taken-for-granted assumptions were questioned. For instance, disseminating information only to women proved too limiting because many men showed interest in what I first believed to be a typical women's issue. On a *second-person* basis, collaboration with the healthcare staff and the doulas proved not only to generate new knowledge for the involved stakeholders but also strengthened relationships and empowered participants. Indeed, surprisingly little resistance and obstacles occurred in this rather intense study. When planning the project, principles believed to be success factors were developed. These principles were evaluated and reinforced not only as success factors but also knowledge transferable to other contexts, whether other geographical locations or other health promoting activities, hence addressing the *third-person* perspective of contribution to a wider body of knowledge.

3.3 Research approach: paper III

In the inquiry for paper III, a more conventional research approach was applied. Still, commonalities exist with the approach used in papers I and II. To start, the reason for conducting the research was to illuminate the situation for segments of patients. Yet, unlike papers I and II, the immediate objective to improve a certain situation is absent. Paper III has not yet rendered any actions in the sense of the action research lexicon. Nevertheless, the third paper may be regarded as a pre-step in an action research cycle (Coghlan and Brannick, 2010), and the problem identified (in short, gender disparities and lack of involvement of relatives) could be understood as the starting point for an improvement study.

The inquiry in paper III was not carried out as collaboratively as the screening study. Still, the staff of the committees was involved in identifying keywords (see *3.4.1*) and meetings were held with a few of the officials and the head of the committee to engage in a dialogue on theories and the study's practical relevance to them. The research findings and constructed categories were discussed with the involved practitioners. The approach was similar to a *utilization-based evaluation* of Greenwood and Levin (2007), in which whether the results of the research matter to the involved stakeholders is vital.

The feedback and ongoing dialogue from the practitioners in the committees and the empirical findings required me to go back to the theory, and then back to the committees and the data again. In line with Dubois and Gadde (2002), the framework was successively modified given the findings and insights gained during the research process. Initially, a quantitative inquiry was planned. However, I felt too remote from the complainants by investigating them as aggregated numbers. I was also curious to understand how the complainants expressed dissatisfaction in *their* words. Hence, I decided to proceed with a qualitative study. Because I was already working with cancer prevention in papers I and II and was familiar with the massive challenges of cancer care and the unmotivated disparities between men and women in healthcare (see the introductory section), I decided to investigate interpersonal cancer complaints between men and women in greater detail.

3.4 Collection and analysis of empirical findings

This section provides an account of how the data was collected and how the sometimes large amounts of text were dealt with to make sense through an analysis of data.

3.4.1 Collection of empirical findings

In the first and second papers, data was collected from diaries, official documents, informal and formal meetings, ongoing communication, and statistics. However, the main source was focus group discussions. Because the doulas were already an established group, the focus group proved to be an appropriate method because it allowed group dynamics and interactions to be observed (Morgan, 1996). In their study of minority women and health services in the United States, Saint-Germain, Bassford and Montano (1993) found focus groups to be an appropriate method when participants draw on oral traditions and argued that such things like community attitudes and behavior may be reproduced within the focus group. Hence, as in previous studies (Lasch *et al.,* 2000), the method was believed to serve the purpose of effectively developing tailored information to local women.

The focus groups were carried out using a similar approach to the *informal interviews* in Gummesson (2000), in which the situation and the conversation guided the questions asked. In the cervical cancer screening project, one focus group was conducted prior to the project with the aim of identifying barriers that prevent local women from participating in the screening program and interventions to increase participation. A second focus group was conducted after the project to evaluate the doulas' experience of participating and collaborating with the healthcare staff and their own learning process. My colleague and I were facilitators in both focus group discussions. Although the fluency level of the participants varied, the focus groups were conducted in Swedish and took place at the local hospital, a place the participants knew well and in which they were believed to be comfortable.

In paper III, the complaints were retrieved from a database. A total of approximately 13,000 complaints were lodged to the four committees in the Western Region of Sweden during 2009–2011. The period was selected given the launching of a new and shared database for all four committees in the middle of

2008. Because searching the database for a specific diagnosis was not possible, the officials at the committees identified several keywords commonly used to describe complaints by cancer patients and their relatives. A search of the database based on the keywords identified by the officials resulted in 752 complaints lodged by cancer patients or their relatives. The complaints were lodged through letters, e-mails, phone calls, and visits to the committees and varied significantly in length, from a few sentences to several pages. For example, complaints concerning waiting times and the results of surgery and treatment were excluded from the study and only 116 complaints concerning interpersonal matters were included. Hence, all complaints regarding face-to-face interaction, such as communication, information, encounter, and empathy, were anonymized and included in the subsequent text analysis. Complaints for which such interactions were explicitly asked for, but not provided, were also included.

3.4.2 Analysis of empirical findings

In all three papers, the rather large and unstructured amounts of texts from the transcribed focus groups and written complaints were dealt with in a similar manner. The analytical approach in both studies was based on the procedure explained by Graneheim and Lundman (2004), in which the complaints and the transcriptions of the focus groups were read (and, as for the recorded focus groups, listened to) several times and put into various categories based on similarities with often reoccurring topics.

Quality management tools were used in the cervical cancer screening study. The Ishikawa diagram (Bergman and Klefsjö, 2010) helped identify the root causes of the low participation rate problem identified in the first focus group. The root causes were used to guide the interventions to prioritize and launch. As the study proceeded, the root causes in the Ishikawa diagram were rejected or confirmed depending on the doulas' and midwives' stories of meeting the local women. Because the project was about to achieve an improvement, a control chart (Bergman and Klefsjö, 2010) monitoring the number of tests on a monthly basis was constructed. As previous scholars mentioned (Flyvbjerg, 2006; Jick, 1979), the combination of qualitative and quantitative data proved to be complementary; for example, the qualitative data from the focus groups provided more in-depth information on the reasons not to take the tests, whereas the quantitative control chart visualized that improvement indeed occurred. Table 3.1 summarizes the research approaches used in the three papers and the data collection methods and analysis.

Table 3.1 *Methodological summarization*

Paper	Approach	Data collection	Data analysis
Paper I	Participatory action research	Focus groups, diaries, documents, statistics	Qualitative content analysis
Paper II	Participatory action research	Focus groups, diaries, documents, statistics	Qualitative content analysis, Ishikawa diagram, control chart
Paper III	Utilization-based evaluation	Written complaints	Qualitative content analysis

3.5 Research quality and ethical considerations

As described, certain methods were selected over others and certain approaches to conducting the research were favored more than others. Of course, threats and difficulties with my choices of methods and approaches exist. This section illuminates these risks and describes how the inquiries were conducted to ensure high quality and ethically appropriate research.

3.5.1 Research quality

How good is my research? Similar to Lindhult (2008), my own construction of the notion of quality in research is twofold and based on *trustworthiness* and *value/relevance*. Trustworthiness deals with the credibility of the research, whereas its value/relevance is judged based on its effect. Value/relevance is elaborated on based on the various quality criteria as described in the action research literature. First, I account for the notion of trustworthiness.

The naturalistic approach to trustworthiness is suggested as being more appropriate to social sciences than traditional and positivistic quality criteria (Lincoln and Guba, 1985). Research must be conducted in a manner that enhances the probability that the findings are believable (the criterion of *credibility*, corresponding to *internal validity* of positivistic research). The researcher must also provide sufficient information about the context and setting for the receiver to decide applicability in the receiving context. Hence, because the researcher cannot know all possible contexts, the burden of this *transferability* criterion (as an alternative to the traditional criterion of *generalizability*) lies more with the receiver. *Dependability* indicates that account is taken of both factors of instability and change in a broader sense than in the *reliability* of positivistic research. Lincoln and Guba (1985) suggested that complete records are to be kept of all phases of the research processes. As a corresponding criterion for traditional *objectivity*, *confirmability* is concerned with the researcher not overtly allowing such things as her or his own personal values to affect the research or its findings.

Lincoln and Guba (1985) offered techniques to meet these criteria. I briefly discuss some of the techniques that I believe helped me ensure the quality of my research. As a researcher, that I am transparent and open is important. I believe that my work in the Western Region of Sweden is an advantage. I have knowledge about the local healthcare context. Yet, I need to learn the culture of the involved organizational units and earn their trust. Of course, the risk is that I will become too involved and that my professional judgment may be influenced, not the least in papers I and II, which apply an action research approach. Lincoln and Guba (1985) suggested a *debriefer*, and my research was indeed processed with other researchers. *Member checking* is a technique similar to *utilization-based evaluation* (Greenwood and Levin, 2007) and was used in the presentation of the data, categories, interpretations, and conclusions with the involved actors at meetings. To retell encounters and provide detailed descriptions of the context, I kept diaries on the studies. *Thick description* is suggested to meet the transferability criterion, which is in line with other researchers and emphasizes the importance of bringing the context into the research (Eisenhardt and Graebner, 2007; Flyvbjerg, 2006). In all three appended papers, I attempted to describe the contexts as detailed as possible to enable others to make judgments on the *transferability* to other contexts.

The naturalistic approach of trustworthiness is relevant in all three papers of this thesis. However, action researchers are interested in not only knowledge generation outcomes but also the action-oriented outcomes and the effect of the research. Therefore, I believe that applying other criteria to judge the action research approach of the first two papers is necessary.

Herr and Anderson (2005) proposed various criteria for action research. *Outcome validity* refers to whether the problems addressed in the study were solved by the actions taken. *Process validity* focuses on the extent that problems are framed and solved in a manner that permits ongoing learning of the individual and the system. *Democratic validity* deals with whether research is done in collaboration with the stakeholders concerned and the problem under investigation. *Catalytic validity* refers to the ability of the research process to change the researchers' and participants' understanding and motivate them to engage in further social action. *Dialogic validity* refers to researchers' participating in critical and reflective dialogue with other researchers (Herr and Anderson, 2005).

Similarly, the *Action research journal* (2013) clarified that good action research:

- is aimed at and grounded in the world of practice;
- is explicitly and actively participative: research *with*, *for*, and *by* people rather than *on* people;
- draws on a wide range of ways of knowing – including intuitive, experiential, presentational, and conceptual – and link these appropriately to form theory;
- addresses questions that are of significance to the flourishing of the human community and the more than human world;
- aims to leave a lasting capacity among those involved, encompassing first-, second-, and third-person perspectives; and,

- critically communicates the inquiry process instead of just presenting its results and some reflections on it.

In particular, the second last bullet point parallels with *outcome validity* from Herr and Anderson (2005). I believe that the first study (papers I and II) met this outcome-related criterion. Using triangulation, the positive effect of the study is presented verbally by the doulas' own stories and by presenting a positive quantitative development of the number of tests in the area under study. The project was awarded by an external jury, a fact highlighting that the project *did* make a difference. The *process validity* of Herr and Anderson (2005) is similar to the last two bullet points of the *Action research journal* (2013) and was met by the effort to describe the research process in as much detail as possible. The *democratic validity* (Herr and Anderson, 2005) was met by conducting research with, for, and by people (Action research journal, 2013) for which all were equal partners (Bargal, 2008; Bradbury and Reason, 2003). The *catalytic validity* (Herr and Anderson, 2005) and the bullet point "… leave a lasting capacity…" (Action research journal, 2013) that addressed the participants' transformation is described in the first two papers and further elaborated on in subsection *3.2.2*. In line with the *dialogic validity* (Herr and Anderson, 2005), the research described in papers I and II were discussed with other researchers both during and after the research process.

3.5.2 Ethical considerations

Bryman and Bell (2011) discussed certain ethical principles to consider when conducting research. The risk of causing *harm to participants* deals with the issue of whether my research will cause harm to the individuals included in the studies. All focus group participants and complainants were anonymously presented. However, the doulas in the focus groups are part of a rather small association, in total approximately 20 women. Ensuring that their identity cannot be derived from the presented information is important. Naturally, this concept applies to the complainants in paper III as well. To prevent *lack of informed consent*, I informed the involved actors of the purpose of the studies. However, informing the complainants of paper III was not possible, primarily because the complaints could have been anonymously lodged. In the case of the focus groups, all participants were informed about the reason for the focus groups and that the discussions would be taped, transcribed, and anonymized. They were also given the opportunity to withdraw. In particular, paper III recorded some personal and sensitive information about the patients. Therefore, the manner in which I handled the data is important to preventing an *invasion of privacy*. *Reciprocity* means that the research should be of mutual benefit to the researcher and the participants, and that some form of collaboration or active participation should be built into the research project from the beginning. This research accomplished such collaboration by sharing the results with the involved organizational units and others and not the least through the explicit participatory stance of papers I and II.

Because action research is about solving problems together with practitioners, the approach has many similarities with the so-called *mode 2* research (Ziman, 1998; Gibbons, 1997); for example, knowledge is generated in the context of an application and research is conducted on problem solving teams consisting of various professions rather than being an individualistic one-man project. The participatory research approach and the explicit purpose to enhance equity in healthcare place special attention on ethical considerations. First, conducting research *together* with participants creates a greater responsibility to fulfill the ethical principles previously described (Bryman and Bell, 2011). Second, grouping people together simply because they share gender or language requires cautiousness because the research risks perpetuating stereotypes and generalizations. Nevertheless, I believe that categorization of people sometimes is inevitable to illuminate disparities and, based on these, to take action to improve services. I hope that my research manages to problematize the studied problems through the selected theories and, hopefully, to contribute to increased knowledge.

4 SUMMARY OF APPENDED PAPERS

Three papers are appended to this thesis. This chapter offers a summary of the papers to give the reader an understanding of the foundations of the thesis. Table 4.1 provides an overview of the papers' main findings in relation to the research interest explained in the introductory section 1.2.

4.1 Paper I

When one size doesn't fit all: Using participatory action research to co-create preventive healthcare services

This paper elaborates on the contribution of a participatory action research approach to creating more equitable healthcare services by (re)designing a cervical cancer screening program to better meet the needs and expectations of local healthcare customers.

The introduction of cervical cancer screening programs in Sweden is often – and rightfully – described in terms of success, such as cancer prevention and reduced mortality rates. Nevertheless, participation rates in the screening program vary. The local area of this paper, a section of a city in which 50 percent of its inhabitants were born outside of the Swedish borders, experienced particularly low participation rates among the local women.

The predominant part of the paper is structured around the logic of the steps in the action research cycle of pre-step, constructing, planning, taking, and evaluating action. This structure also parallels the development of this quality improvement project with the explicit goal to improve a bad situation. In participatory action research fashion, the current state of the screening program was regarded as unequitable because it failed to reach the local women, many of whom spoke mother tongues other than Swedish. These women were regarded as a resource for jointly co-creating a preventive healthcare service that actually reached local residents. Through collaboration among the healthcare staff, locals, and civil society, and that included various skills and knowledge, more appropriate interventions were planned and eventually launched to the public during the year-long campaign. Using orally spread information, social media and tailored information proved appropriate and increased participation rates by 42 percent compared with the previous year.

The paper concludes by highlighting the advantage of bringing local community members into the participatory action research approach to jointly create more equitable healthcare services. However, the paper also communicates the difficulties of simultaneously carrying out a number of interventions during an entire year and reflects on what was learned during the project.

4.2 Paper II

Community collaboration to increase foreign-born women's participation in a cervical cancer screening program in Sweden: A focus group study

The second paper is a parallel paper to the first and describes the same research study. However, paper II covers neither the entire process nor the methodological considerations of participatory action research. Rather, it offers an in-depth investigation into the role of the involved community participants, *the doulas*, and primarily builds on findings from focus group discussions. The purpose of this paper is to explore how community members in an area with a large number of foreign-born residents may contribute to increasing participation in cervical cancer screening programs.

The involved local women were all well known in the local context, not the least because of their roles as doulas. In the particular area, the doulas support new parents during pregnancy and childbirth. Given that they have the same cultural background as the parents, the doulas also function as interpreters of both language and culture.

The result shows that bringing in the local women's cultural-specific knowledge and skills helps identify the barriers that hinder women from participating in the screening program, such as being unaccustomed to preventive healthcare, practical reasons, and fear of cancer. Moreover, the women were able to identify solutions such as oral communication and information on public squares and associations. The findings of the first focus group were analyzed using an Ishikawa diagram, a tool from quality management. The co-creation of the preventive healthcare service did not stop with the input of barriers and solutions. The doulas also participated in actual outreach activities, informed local residents, and worked with local midwives. A control chart, another quality management tool, was used to monitor the effects of the outreach activities launched during the campaign.

The paper concludes by discussing the benefits of involving the local inhabitants in outreach activities and identifying the risks they experienced. The role of the local doulas and their own learning during the project is also discussed, such as gaining increased confidence, having a sense of playing an important role, and acting as a bridge between healthcare providers and customers.

4.3 Paper III

Interpersonal complaints regarding cancer care through a gender lens

The third paper investigates cancer patients' and their relatives' complaints concerning interpersonal matters in cancer care, or lack thereof. The paper also incorporates gender theory to specifically illuminate the differences between female and male complainants.

The empirical setting of this study was the four local Patients' Advisory Committees to which the residents in Western Region of Sweden could lodge complaints. Using qualitative content analysis, 116 complaints dealing with the interpersonal matters of cancer patients and their relatives were registered between 2009 and 2011, and were sampled and analyzed.

The theoretical frame of this study, co-creation of value, offers an alternative approach to the traditional post-consumption view on compliant behavior, suggesting that complaining may also be regarded a dynamic adjustment process.

Many of the complaints included in the paper concern lack of information from healthcare providers and patients experiencing not being listened to. Additionally, lack of empathy and civility causes dissatisfaction, the latter particularly among female patients. Relatives complained that they did not feel included in the care process and did not feel that they were offered proper support. The incorporation of gender theory helped illuminate the disparities between men and women, and most of the complaints by relatives were lodged by a female relative and concerned a male patient. One reason for this finding may be the socialization of women to be more caring and fostering.

The paper concludes that complaint behavior runs parallel to the co-creation process. Therefore healthcare providers should enhance interpersonal skills that enable patients and relatives to provide feedback during service interaction. By doing so, dissatisfaction could be corrected through dialogue with the customer rather than through a formal complaint being lodged.

4.4 Common themes of the appended papers

Table 4.1 presents examples of the barriers that the healthcare customers in the papers faced during the service delivery process and the identified activities that they undertook in their effort to jointly create value. This information is further detailed in subsequent subsections.

Table 4.1 *Papers and findings*

Paper(s)	Empirical findings
Papers I and II	Examples of barriers during the service delivery process: o Practical hindrances, such as unavailable childcare o Information barriers, such as language o Not accustomed to preventive healthcare services Co-creation activities undertaken: o *Co-learning*, providing feedback to healthcare providers o *Connecting with others*, such as associations and building and maintaining relationships o *Co-production*, to redesign services
Paper III	Examples of barriers during the service delivery process: o Lack of information and lack of consideration o Lack of civility, particularly experienced by female patients o Not allowed to be involved in the care process, experienced by relatives of patients Co-creation activities undertaken: o *Co-learning*, providing feedback for things to change o *Connecting with others*, particularly family and friends, and other healthcare professionals

4.4.1 Barriers faced by healthcare customers during the service delivery process

Vargo and Lusch (2004a) emphasized a process in which the personnel of an organization and the customer interact. This process indicates a view of customers as participants and suggests that customers integrate resources, particularly non-material resources such as skills and knowledge, made available to them by the service provider, others, and themselves to increase their well-being (Vargo and Lusch, 2008). Hence, for healthcare providers that want to enhance the customer's perceived value, understanding the customer's value-creating process is critical (Engström, 2012).

In a way, all three papers deal with unsatisfied needs – whether consciously or not. The first and second papers show that the healthcare provider failed to provide appropriate information for certain groups of residents to make informed decisions, regardless of whether taking the test. In addition, experiences from their home countries proved one reason for not understanding information, such as being unaccustomed to preventive healthcare services. Indeed, not only the information itself but also how it was delivered proved to be a barrier. The lack of a relationship with the one providing the information was a hindrance. Other than information, practical issues such as unavailable childcare and a complicated summons system prevented women from participating. Hence, the service design of the screening program in this particular part of the city proved faulty because it did not match the needs, experiences, and expectations of the women in the community.

Similarly, the third paper shows that information hindered patients and relatives from participating in the healthcare process to such an extent that a complaint was lodged. Dissatisfaction was expressed through both the lack of information provided and the manner in which the information was shared, such as lack of empathy. Additionally, complainants believed they were not listened to by healthcare staff, thus ignoring their input. Women more than men complained about experiencing sheer rudeness from providers. In particular, female relatives were dissatisfied that they were not allowed to participate in their relatives' care process. The findings in this paper enhance Tronvoll's (2007) suggested notion that complaint behavior may run in parallel with the co-creation process rather than be regarded as a post-consumption evaluation.

The findings of the three papers show that customers of healthcare services experience barriers that hinder them from participating in the healthcare delivery process, whether foreign-born women not receive information that would enable them to make an informed decision about their own well-being or complainants in cancer care experiencing unsatisfying interpersonal healthcare encounters. Insufficient value propositions from healthcare providers come in various forms in these studies, such as lack of information, complicated procedures, indelicate delivery of services, and non-tailored information. Naturally, these issues make it more complicated for customers to be value co-creators in healthcare. However, the studies proved that, despite the barriers, healthcare customers undertook various co-creation activities.

4.4.2 Co-creation activities undertaken by healthcare customers

Value co-creation theories stipulate that customers may engage in various activities in their effort to co-create value (McColl-Kennedy *et al.*, 2012): cooperating; collating information; combining complementary therapies; co-learning; changing ways of doing things; connecting with others; co-production; and cerebral activities. Some of these activities were reveled in the papers to various degrees.

All three papers included the *co-learning* activity. In the first and second papers, the doulas played an important role in providing the healthcare organization with feedback on barriers that the local women faced regarding participation in the cervical cancer screening program and in offering suggestions on how to change services to increase awareness and participation. Feedback was provided not only during the planning phase of the project. Important feedback was provided during the project, as the doulas continuously provided the healthcare organization with the experiences of the local residents they met. Feedback was also provided after the campaign through the evaluation and refinement or rejection of interventions as part of the design. In the third paper, complainants undertook the co-creation activity of *co-learning* as manifested by complaints that should be understood as customers' feedback to healthcare providers about unsatisfying aspects of the service delivery. The reasons for lodging complaints may be numerous; however, previous research suggested that patients often lodge a complaint to prevent the incident from happening again through the complaint leading to changes in the performance of healthcare professionals (Jangland, Gunningberg and Carlsson, 2009; Friele and Sluijs, 2006). Indeed, some complainants in paper III said the reason they lodged a complaint was primarily to get things to change.

In all papers, customers to various degrees *connected with others* and expanded the traditional customer–provider relationship to include other actors in their network (McColl-Kennedy *et al.,* 2012; Normann, 2001). In papers I and II, local associations, housing, and shop owners were included and relationship and trust were considered important for the work of the local doulas. In paper III, this activity was primarily manifested by the fact that relatives – usually female family members – were involved with the patient, and that other healthcare professionals were contacted by patients or their relatives.

In the first and second papers, *co-production* was also an activity undertaken by the local doulas. They participated in coming up with ideas on how to improve or redesign services and executed them. Indeed, the doulas' participation was primarily to improve services for the benefit of other local women, or so-called *co-creation for others* (Elg *et al.,* 2012; Witell *et al.,* 2011).

Together, the three papers provide examples of how customers in healthcare undertake various activities in an effort to co-create value. Three distinct co-creation activities are identified (*co-learning*, *connecting with others*, and *co-production*), suggesting that customers in healthcare are not regarded as passive but are viewed as participants in the healthcare process. In papers I and II, healthcare customers contributed by providing and conducting solutions for services (*co-production*). In all three papers, healthcare customers also undertook activities to feed information back to providers about processes that did not work as expected (*co-learning*), and involved others outside the traditional healthcare staff–patient sphere in the healthcare delivery process (*connecting with others*).

However, the healthcare customers in these papers may have undertaken other co-creation activities. Whether the participants were *combining complementary therapies*, *changing ways of doing things*, *collating information*, or using *cerebral activities* cannot be excluded. In particular, complainants may have, and likely did, *cooperate* with the healthcare professionals to some extent. However, none of these activities was evident in the empirical data.

5 DISCUSSION

In light of the future challenges in cancer care (SOU 2009:11), including the voices of the customers is important to improving healthcare services. Yet, Swedish cancer care frequently lacks patient focus, such as appropriate interaction and communication (SOU 2009:11). Similarly, previous research noted that the healthcare *process* is most important to healthcare customers when they evaluate healthcare services (Fiala, 2012; Marley, Collier and Meyer Goldstein, 2004), and not the least the interpersonal aspects of care (Dagger, Sweeney and Johnson, 2007). The notion of value co-creation emphasizes the process of services, particularly the interactional and relational aspects (Vargo and Lusch, 2008).

The empirical findings in all three papers of this thesis suggest that process quality is not only important to patients but also that its absence constitutes barriers for customers to participate in their care and treatment and hinders them from making informed choices regarding their health and well-being. Groups of people were found to possibly have similar needs, expectations, and experiences, yet the healthcare provider failed to deliver appropriately designed propositions for these groups.

Equity is about justness for groups of people (Braveman and Gruskin, 2003; Carter-Pokras and Baquet, 2002) and addresses the needs of these people (Payne and Doyal, 2010; Whitehead, 1990). Moreover, the United Nation's (1987) report, *Our common future*, states that equity is encouraged through effective citizen participation, indicating that healthcare customers who share commonalities may be regarded as a resource and that their unique knowledge and skills should be included when designing healthcare services.

Throughout this thesis, the notion of the customer as a value co-creator was elaborated on. Naturally, this active role should be treated with caution, not the least in healthcare (see *2.3.2*). I continuously reflected on the adoption of the service logic lexicon when writing this thesis. Indeed, my own understanding of the value-creating customer must be considered to be in flux. Whether all patients at all times wish to be active co-creators may be questioned. Arguably, co-creating customers face the risk of becoming working consumers (Cova and Dalli, 2009) who continually create for the provider (Bonsu and Darmody, 2008). Further, value co-creation during interactions between the customer and the provider (Prahalad and Ramaswamy, 2004; Vargo and Lusch, 2004a) may be a destructive process; value may be both co-created and co-destroyed at the provider–customer interface (Echeverri and Skålén, 2011). Returning to the co-creation activities as suggested by McColl-Kennedy and associates (2012), perhaps the accurate question to ask is: What activities are *not* considered co-creation activities? The range of very active activities to not very active activities (for example, accepting information from the provider and complying with the basics) covers virtually all possible activities that a customer may undertake. Moreover, an active customer may suggest unnecessary treatment options. However, such options may be bad for the patient or may not be possible to offer given the limited resources in healthcare (Donabedian, 2003). This argumentation is relevant not the least from an equity perspective that states that those with the greatest needs should be prioritized (SFS 1982:763).

Nevertheless, the stark contrast of *patients* as passive (Gallan *et al.,* 2013; Holman and Lorig, 2000) offered by co-creating *customers* may be necessary to adopt with respect to disregarded groups, particularly those excluded from receiving healthcare. Hence, value co-creation offers an opportunity to treat these groups of healthcare customers as active partners with unique knowledge and skills (Vargo and Lusch, 2004a). Further, the role of customers as co-creators also emphasizes the interactions among provider, patient, and others, and the importance of the relationships among them (Vargo and Lusch, 2004a; 2008). Hence, for providers to create dialogue with their customers is important (Normann and Ramírez, 1993), which – again – may be particularly relevant for groups of patients of which the healthcare provider knows little.

The relational aspect of value co-creation – or the lack of the same – is highlighted in all three papers of this thesis. Hence, adopting the service logic semantics emphasizes the active role of the *customer* and the importance of the interpersonal and relational aspects of healthcare services. However, the choice of vocabulary is also pragmatic. Because the cervical cancer screening study was about the prevention of disease, it included no patients in the traditional sense. Similarly, lodging complaints to the Patients' Advisory Committees is not exclusive for the patient herself/himself. Indeed, the majority of the complaints lodged in the third paper were from a relative of the patients. In this thesis, indeed, traditional healthcare *patients* are the minority.

In this thesis, customers in (preventive) cancer care engaged in various activities in an effort to co-create value with healthcare providers and others. This collaborative and relational aspect bears similarities with the other theories and the methodology of action research. Next, the previously presented *Conceptual frame of theories* (Figure 2.3) is expanded with the methodology of action research used in papers I and II to offer the *Conceptual frame of theories and methodology* (Figure 5.1). The following subsections penetrate two of the nexus' that are of central importance to this thesis and elaborate on the domains' kinships and potential to reinforce one another.

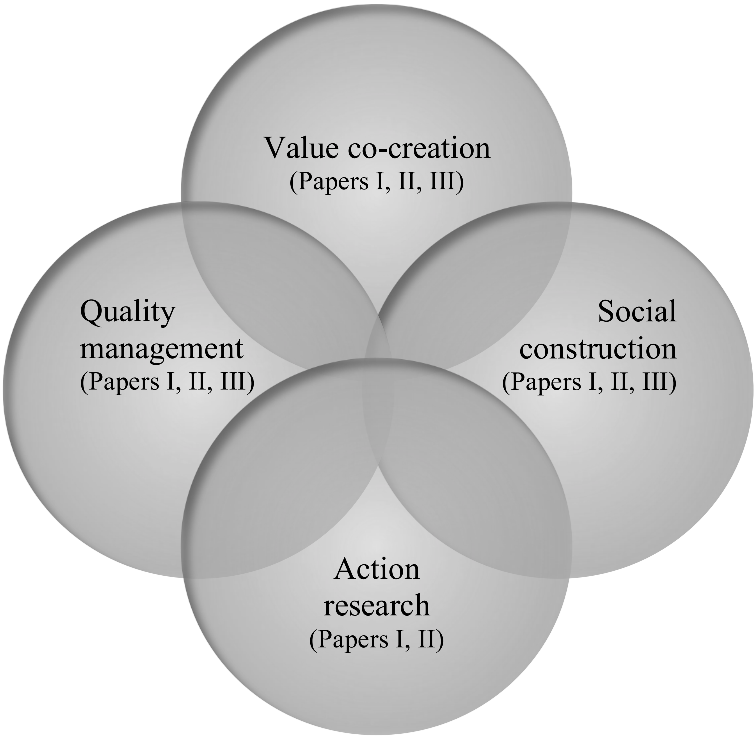

***Figure 5.1** Conceptual frame of theories and methodology*

5.1 The nexus between value co-creation and social construction

According to the tenth foundational premise of the service(-dominant) logic, "Value is always uniquely […] determined by the beneficiary" (Vargo and Lusch, 2008, p. 7). Other service management scholars offer similar explanations, such as value is "… perceived in an individualistic way" (Grönroos, 2011a, p. 282). Through an update of the premises, Vargo and Lusch (2008) included the context to reflect the fact that value is context dependent.

Despite the addition of context, these quotations are examples of the often over-individualized notion of value co-creation and the neglect of the *social* context in which the value co-creation process occurs – as noted by previous researchers. Peñaloza and Venkatesh (2006) argued that markets must be understood as social constructions. Similarly, Edvardsson, Tronvoll and Gruber (2011) emphasized that not only *value creation* but also – and similarly – *value* must be understood as socially constructed and have a collective and intersubjective dimension. This emphasis suggests that social forces have a major effect on value co-creation and on how value is defined and perceived (Edvardsson, Tronvoll and Gruber, 2011).

This reasoning may be understood in light of the argumentation by Berger and Luckmann (1966) that knowledge is relative because it is created by interactions among people within society and transferred and maintained in various social contexts and systems. In other words, what we believe to be *value* does not reside in the individual mind; rather, it is shaped by historically and culturally situated social processes and resides in relationships (Gergen and Gergen, 2008).

Adopting the socially constructed notion makes it clear that no single transcendent notion of *value* or way to *co-create* this value exists; moreover, these concepts may not be explained as solely “perceived in an individualistic way” (Grönroos, 2011a, p. 282). Naturally, the same reasoning also applies to similar constructions central to this thesis, such as service quality.

Integrating the group level into the co-creation framework implies that customers could co-create value for themselves and for other group members in the particular social context. In papers I and II, the involved doulas brought their unique (local and cultural) knowledge and skills to the study, co-creating propositions that were more appropriate to the women in the local social context. Additionally, the co-creation activities they undertook may be explained as socially constructed. If the project had been taken place somewhere else, in another social context, it is likely that other activities would have been carried out.

Grouping people together because of their sex (paper III) may reveal socially constructed disparities. In the particular case of this thesis, that more women than men complained for a relative’s sake could be explained by the fact that women are socialized to be more caring, nurturing, and cooperating than men (Nameda, 2013; Danielsson, 2010; Howell and Day, 2000; Iacobucci and Ostrom, 1993). Knowledge about how men and women are socialized into acting like men and women could also be used productively to assist healthcare providers in being more cautious about stereotypical encounters; husbands may wish to participate in their wives’ care process as well. However, traditional gender norms hinder them from expressing this wish and, more so, complaining when not fulfilled.

Accepting that value and the value co-creation process do not occur in a social vacuum but rather in a social context enables us to understand that improvement of services may be conducted at the group level. By integrating knowledge and skills from the particular group, the likelihood exists that propositions are created that better meet the needs and expectations of the people in a particular social context. Hence, value co-creation that adopts a social construction approach provides a good basis for creating more equitable healthcare services.

5.2 The nexus between theories and action research

How social construction theory may shed collective light on value co-creation theory has been previously elaborated on. The potential exists for reinforcement among the theories used in this thesis and with the methodology of action research used in papers I and II because of the significant kinships among the domains.

Surprisingly, few studies using an action research approach measure change quantitatively. After all, a cornerstone of action research is the action-oriented outcomes (Herr and Anderson, 2005). In particular, in a healthcare context shaped by positivism and in which people are frequently used to talking in terms of numbers, I believe that measuring change quantitatively has its benefits. The experiences from appended papers I and II show that presenting change quantitatively may give a mandate in a physician-led context and, not the least, fuel positive energy to the group jointly struggling to improve a situation. As in paper II (see also Lifvergren, 2013), incorporating tools from the toolbox of quality management should strengthen the work of many action research projects.

Another nexus in Figure 5.1 is the one among value co-creation, social construction, and action research. This kinship may be explained using terms such as *relation*, *collaboration*, or *togetherness*. As previously explained, I believe that value co-creation theories benefit from moving away from individual and to a socially constructed collective sphere, not the least to create more equitable healthcare services that are more contextually sensitive. Naturally, the collaborative nature of action research has strong kinship with value co-creation. Thus, applying an action research approach may enable customers to co-create value with an organization and others (McColl-Kennedy *et al.,* 2012; Vargo and Lusch, 2008). All three papers illuminate disregarded groups – whether groups dissatisfied with healthcare services (paper III) or groups not being reached by healthcare services (papers I and II) – whose voices are not being paid appropriately or are not receiving satisfactory attention. From an equity perspective of emphasizing the ethical dimensions of justness and fairness (Braveman and Gruskin, 2003; Carter-Pokras and Baquet, 2002; Whitehead, 1990), *participatory* action research is an appropriate methodology for shedding light on oppression and improving access to resources for research participants (McIntyre, 2008).

The extended sphere, or networked nature, of value co-creation (McColl-Kennedy *et al.,* 2012; Vargo and Lusch, 2008; Normann, 2001; Normann and Ramírez, 1993) may be particularly relevant for patients with complex needs, such as cancer patients, because it involves many actors and the integration of various resources. In the described studies in this thesis, the integration of resources from relatives and associations proved important. Adopting the linguistics of Normann and Ramírez (1993) indicates a need for healthcare providers to *reconfigure* their relationships and systems to enable them to create the most affective proposition possible because one provider typically cannot provide everything. In this out-zoomed system, other actors may be revealed (Normann, 2001); in a healthcare context, actors other than those traditionally associated with healthcare could be included. This networked nature was evident in both studies in this thesis through the associations, shops, relatives, and others that added value in various ways. Similarly, the *participatory* action research approach of papers I and II zoom outside the organizational level and focus on the community level (Coghlan and Brannick, 2010; McIntyre, 2008).

6 CONCLUSION AND CONTRIBUTION

This thesis was written to make a contribution to more equity in healthcare. To do so, knowledge about the barriers that hinder segments of healthcare customers from participating in the healthcare delivery process were illuminated, as were various co-creation activities that customers may undertake in their effort to co-create value.

Incorporating the social context into value co-creation theories may help increase the understanding and enable improvements on a collective scale, which may contribute to increasing equity in healthcare. Because of groups' different needs and prerequisites, offering but one proposition for everyone maintains the prevailing inequities. Giving groups of healthcare customers a genuine opportunity to participate in the co-creation process through proper interaction and by including their unique knowledge and skills provides value co-creation the potential to (re)design and tailor healthcare services that better meet the needs and expectations of groups of customers.

Methodologically, the main contribution of this inquiry is from exemplifying that participatory action research projects may benefit from their quantitative accounts of changes and improvements, and to measure using numbers. This contribution may be accomplished by incorporating quality management tools.

In a healthcare context, in which outcome measures are often predominant, the contribution to practitioners and policy makers is to highlight the importance of the process quality of healthcare services, particularly the collaborative, interactional, and relational aspects enabling customers' value co-creation processes. Therefore, healthcare customers must be considered participants possessing unique knowledge and skills that should be used to improve services. A need also exists to put the organizational map in the drawer, thus zooming outside the hospital walls and moving beyond the two-party sphere of provider–patient by including other actors of the customer's network, such as family members and civil society.

To conclude, this thesis emphasizes the importance to healthcare customers of the service process, implying that factors such as interpersonal matters must be improved to meet individuals' and groups' (different) needs and expectations of healthcare services. Doing so offers customers possibilities to co-create value to a greater extent than is the case today. Given this scenario, the customer may benefit from better healthcare services for her/his own sake and contribute to better designed propositions for other healthcare customers as well.

7 FUTURE RESEARCH

Writing this thesis took more than two years. I am fortunate to be part of a multidisciplinary environment and received inspiration from scholars and practitioners with various backgrounds. A lot was learned and relearned, and the journey was not a straight road. Still a work in progress, this thesis has opened up numerous future research initiatives.

- This thesis only superficially discussed the relationship between the concepts of *value* and *quality*. The potential differences should be further elaborated on.
- In contrast to many theories presented in this thesis, Bergman and Klefsjö (2010) included not only customers' expectations in their definition of quality but also their *needs*. Of course, these needs may not always be something of which a customer is aware, an aspect that may be further explored in future research.
- The study in papers I and II is to be regarded as a pilot project that is about to be institutionalized. Applying a participatory action research approach would enable an interesting investigation into the experiences of moving from a rather successful local project to institutionalization.
- Because different attributes are suggested to influence customer satisfaction and dissatisfaction differently, future research could investigate how customer feedback on various attributes sort in a given model, such as in Kano *et al.* (1984).
- Naturally, only the formal complaints lodged to the committees and not all expressions of dissatisfaction are included in paper III. As constructed by Winblad (2011), dissatisfaction may be voiced to other complaint handling systems or channeled in a more direct manner, such as yelling at the staff. Dissatisfaction may also be manifested through exiting, such as changing the general practitioner. A comparison of the complaints included in paper III with other expressions of dissatisfaction could offer interesting insights.
- The empirical findings of this thesis draw from two studies that build on the voices of preventive healthcare customers, patients, and relatives of patients. Future research could penetrate the potential different activities engaged in by patients, relatives, and preventive healthcare customers.
- Similar to previous research (Gustavsson, 2013), *roles* or *styles* that healthcare customers may undertake could be favored over *activities*, which is the case in this particular thesis.
- Many constructions illuminate a more active customer role, such as, to name a few, *empowerment*, *patient-centered care*, *health literacy*, and *experienced-based co-design*. Future research could investigate these and similar constructions from an equity perspective.

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