THESIS FOR THE DEGREE OF DOCTOR OF PHILOSOPHY

A Service Management Perspective on Healthcare Improvement

Integrating Social Context

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ABSTRACT

The current dissertation argues that ideas from service research should be given a more prominent position in improving healthcare that is capable of managing current and future challenges. The integration and combination of intangible resources, such as knowledge and skills, constitute the *service* in this thesis; thus, service is conceived as a verb. A central notion in such conceptualization is *value co-creation,* implying that healthcare providers may only offer *potential* value, which is realized as *real* value by people in their broader lifeworlds. Consequently, the healthcare provider is often only one of many actors in the individual's value-creation process – in which resources from a multiplicity of actors are integrated and combined.

One challenge that is particularly addressed in this thesis is unsatisfying inhabitant/patient perceptions concerning *how* healthcare is executed. More specifically, this refers to interpersonal aspects, including interaction between inhabitant/patient and provider, access to adequate information, and prerequisites to actively participate in one's own care. Another challenge addressed herein is disparities between groups in society. A mainstream service management perspective is deemed relevant in targeting the first challenge, with foci on the inhabitant's/patient's active role rather than the internal affairs of the organization; interaction rather than results; and providing a holistic view rather than treating healthcare in isolation. In order to face the second challenge of disparities between groups, I argue that it is necessary to explicitly integrate the social context, which is claimed to have been neglected in traditional service research. Such context includes not only a diversity of actors, but also societal structures that influence – and are influenced by – the healthcare meeting and thus the individual's prerequisites to actively participate in her or his care.

By adopting a moderate social constructionist position – which contrasts to the individualism characterized by mainstream service research – the focus of the thesis moves from singular to plural, from individual to groups in society. On one hand, in such a position, categorization of individuals into groups is not uncomplicated. On the other hand, healthcare improvements are enabled on a collective level. The constructionist position also permeates conceptions of knowledge: rather than an absolute "truth," knowledge is about different perspectives. An extension of this reasoning is that healthcare needs to manage multiple perspectives to achieve improvement. Consequently, the purpose of this thesis is not to proclaim a service management perspective as a universal solution, but rather to enhance its position among a diversity of mutually complementing perspectives.

The empirical material draws from three studies, discussed in five papers. The first study sought to increase knowledge of three groups' perceptions on parenthood in a child health service context. The second study mainly addressed the reasons why men and women reported complaints in healthcare. The third study addressed how healthcare providers and community representatives could contribute to increased participation in a screening program in an area with a large number of foreign-born inhabitants.

Cumulatively, the studies illuminate the potential of a service management perspective to improve healthcare, not least being the focus on the inhabitant's/patient's perceptions, but also their active role and the inclusion of actors in the individual's broader lifeworld such as family members and the local community. In line with a service management perspective, the interactional aspects are argued to be important *enablers* for individuals to participate in healthcare. However, by integrating the social context, it is also revealed that interaction may also constitute a *constrainer* of possibilities for individuals or groups to be participative.

A service perspective integrating social context also offers possibilities, not least by enriching the emerging field of *improvement science*. Through *lifeworld-situated perceptions*, in which groups' perceptions beyond healthcare are identified, healthcare may be improved to better address group members' needs given their broader life situations. *Representative co-creation* implies that a collective's unique knowledge and skills are used productively in order to improve healthcare that manages diversified needs and expectations.

Keywords: Service management, quality management, improvement science, social constructionism, healthcare

SVENSK SAMMANFATTNING/ABSTRACT IN SWEDISH

I föreliggande avhandling anförs att idéer från tjänsteforskning bör ges större utrymme vid utveckling av hälso- och sjukvård som står rustad att möta såväl nuvarande som framtida utmaningar. Att, som enligt tidig tjänsteforskning, reducera ett tjänsteperspektiv till tillverkningsindustrins motsats låter sig inte göras. Snarare innebär ett sådant perspektiv en abstrakt konstruktion där integreringen av immateriella resurser, såsom kunskap och färdigheter, utgör *tjänsten*. Tjänst är således här att betrakta som ett verb. En återkommande tankefigur inom denna syn på tjänst är *medskapandet av värde*. Häri kan hälso- och sjukvården endast erbjuda *potentiellt* värde, vilket realiseras till *reellt* värde av invånaren i hens livsvärld. Med detta fokus följer att hälso- och sjukvården oftast utgör en aktör av många i individens värdeskapande – i vilken resurser från en mångfald aktörer integreras och kombineras.

En utmaning som särskilt adresseras inom ramen för detta avhandlingsarbete är otillfredsställande upplevelser för invånaren/patienten avseende *hur* sjukvården utförs. Mer specifikt avses interaktionen mellan invånare/patient och personal, tillgång till adekvat information och förutsättningar att aktivt delta i sin vård. Ytterligare en utmaning som adresseras i avhandlingen är omotiverade skillnader avseende hälso- och sjukvård mellan samhällsgrupper. Med fokus på invånarens/patientens upplevelser snarare än sjukvårdens interna angelägenheter; interaktion före resultat; och helhet snarare än sjukvården som isolerad företeelse, bedöms tjänsteperspektivet lämpligt för att möta den tidigare utmaningen. För att möta den förra utmaningen, skillnader mellan grupper, bedöms nödvändigt att tjänsteperspektivet explicit integrerar den sociala kontexten, något som tjänsteforskningen traditionellt sett inte har gjort i tillräckligt stor grad. En sådan kontext inkluderar inte bara en mångfald aktörer, men också samhälleliga strukturer som påverkar – och påverkas av – mötet i sjukvården och därmed individens förutsättningar att aktivt delta i sin vård.

Genom en moderat socialkonstruktionistisk hållning – som kontrasterar till tjänsteforskningens huvudfåra präglad av individualism – flyttas avhandlingens fokus från singular till plural, från fokus på den enskilda individen till grupper i samhället. En sådan hållning innebär å ena sidan ett icke okomplicerat kategoriserande av individer, å andra sidan ett möjliggörande av förbättringar på gruppnivå. Också synen på kunskap genomsyras av den konstruktionistiska hållningen: kunskap handlar om olika perspektiv, snarare än en absolut ”sanning”. En förlängning av detta resonemang är att sjukvården måste hantera flera parallella perspektiv för att åstadkomma förbättring. Följaktligen gör avhandlingen inte anspråk på tjänsteperspektivet som universell lösning, utan avser snarare att stärka dess position bland en mångfald sinsemellan kompletterande perspektiv. Av dessa bedöms emellertid tjänsteperspektivets potential ännu inte har beaktats tillräckligt.

Avhandlingen baseras på tre studier, fördelade på fem artiklar. Den första studien söker att öka kunskapen om tre gruppers föreställningar om föräldraskap i en barnhälsovårdskontext. Den andra studien undersöker i huvudsak vad kvinnor och män anför för klagomål på hälso- och sjukvården. Den tredje studien undersöker hur hälso- och sjukvården tillsammans med bland andra lokala företrädare kan bidra till ökad kunskap om, och deltagande i, cellprovtagning i ett område med en betydande andel utrikes födda invånare.

Sammantaget understryker studierna nödvändigheten av att bättre beakta invånares och patienters upplevelser vid utveckling av hälso- och sjukvård, men också deras potentiellt mer aktiva roll och sociala nätverk, såsom närstående och det lokala samhället. I linje med ett tjänsteperspektiv argumenteras i avhandlingen för vikten av god interaktion mellan invånare/patient och personal för att *möjliggöra* för individer att aktivt delta i sjukvården och nyttja resurser från olika aktörer. Genom att integrera den sociala kontexten avslöjas emellertid att denna – ofta onyanserade – syn på interaktion också kan verka *begränsande* för individens eller grupper av individers möjlighet att vara just aktiva.

Ett tjänsteperspektiv integrerat av social kontext erbjuder också möjligheter, inte minst bidrar den till ökad kunskap till det framväxande forskningsområdet *improvement science*. Genom fokus på *livsvärldssituerade upplevelser*, i vilka gruppers upplevelser och föreställningar bortom sjukvården identifieras, kan hälso- och sjukvård erbjudas som är mer relevant givet människors livsvärld eller livssituation. *Representativt medskapande* innebär att ett kollektivs unika kunskap och färdigheter används produktivt i syfte att förbättra hälso- och sjukvården så att diversifierade behov och förväntningar tillgodoses.

To Vinga & Vega

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I was sitting in a room with a view over the rooftops of Gothenburg on a winter's day in 2011, talking with Sylvia Määttä and Andreas Hellström about an opportunity to do a PhD. I remember that I hesitated, doubting my own abilities. More than five years have now passed since we had that meeting. Sylvia, I am so thankful for the opportunity you offered me and for supporting me in so many ways. Andreas, you have been close during my whole PhD journey and your curiosity and encouragement, and the confidence you showed in me has been greatly appreciated. After our meeting on that wintery day, I met with Bo Bergman. Bo, your comfort and enthusiasm removed any hesitation I had left and made the decision to start my PhD later that year an easy one. Thank you for your engagement and valuable support! I ran into Svante Lifvergren just before starting my PhD. You have vividly and enthusiastically guided me through theoretical terrains that were inspirational but not always easy to pass. Thank you for that (yes, really!) and for all the efforts you have made to enlighten me. Andreas, Bo, Svante, and Sylvia have, sometimes alternately, composed my supervising committee and I am so grateful for having had your different perspectives enriching this journey and forcing me to move out of my comfort zone.

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Thank you to my father for inspiring me in writing and reading – starting over 30 years ago with *The Adventures of Huckleberry Finn*. Dad and mum, thank you for all support and love you have given me over the years. I would also like to send a *merci* to my sister and her family in France – I could not have had a better older sister, who has encouraged me since childhood and told me that anything is possible.

Writing this, it is close to midnight. My wife and children are upstairs sound asleep. The silence contrasts with the intensity in our house during daytime. However, the latter never fails – sometimes brutally, I admit – to remind me of what is truly important in my life. Anna, my wife, despite all my practice in writing and re-writing over the last few years, I am unable to express my gratitude for having you in my life. I am so grateful for all love and joy you bring to our family and for always having "a little faith in me." I love you and our children endlessly. Vinga and Vega, my beloved children, you bring such happiness, pride, and love into my life. This one is for you (yes, you have to share).

Hönö, August 22nd, 2016

Erik Masao Eriksson

LIST OF APPENDED PAPERS

Paper A When they talk about *motherhood:* A qualitative study of three groups' perceptions in a Swedish child health service context

Eriksson, E. M., Eliasson, K., Hellström, A., Määttä, S., and Vaughn, L. (2016)

Published in *International Journal for Equity in Health,* 15(99).
DOI: 10.1186/s12939-016-0387-8.

Paper B Interpersonal complaints regarding cancer care through a gender lens

Olsson, E. M. (2016)

Published in *International Journal of Health Care Quality Assurance,* 29(6): 687–702.
DOI: 10.1108/IJHCQA-03-2014-0032.

Paper C When one size does not fit all: Using participatory action research to co-create preventive healthcare services

Olsson, E. and Lau, M. (2015)

Published in *Action Research Journal,* 13(1): 9–29.
DOI: 10.1177/1476750314566216.

Paper D Community collaboration to increase foreign-born women's participation in a cervical cancer screening program in Sweden: A quality improvement project

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

Published in *International Journal for Equity in Health,* 13(1).
DOI: 10.1186/s12 939-014-0062-x.

Paper E Questioning the quest for evidence: The application of multiple interpretations in a healthcare context

Eriksson, E. M., Lifvergren, S., and Määttä, S. (2016)

Working paper.

CONTRIBUTIONS IN THE APPENDED PAPERS

Paper A	Vaughn proposed methods for collecting the empirical material, which was mainly collected by Eliasson and a Somali-speaking doula. Analyses were made jointly by Eliasson and myself, and interpretation was made by all authors. I drafted and revised the manuscript with support from the other authors.
Paper B	Collection of empirical material, analysis, and interpretation was made by myself. I single-authored this paper.
Paper C	I shared project management with Lau in this study; together we collected most of the qualitative and quantitative empirical material that was analyzed mainly by me. Lau and I interpreted the empirical material jointly. Drafting and revising the manuscript was mainly done by me, with support from Lau.
Paper D	Together with Lau, qualitative and quantitative empirical material were collected. Lifvergren introduced the quality management tools. I analyzed the qualitative empirical material, and Chakhunashvili analyzed the quantitative empirical material constructing the control chart. Interpretations of empirical material were done by all authors. Chakhunashvili authored the section about the control chart. The rest of the text was drafted and revised by me, with support from the other authors.
Paper E	I selected the empirical case, formulated the idea of using multiple interpretations, and suggested the three theories to use. Analyses were done by me, with Lifvergren and Määttä co-writing and co-analyzing, mainly one theory each. Drafting the manuscript was mainly done by me, with support from the other authors.

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1 INTRODUCTION

As way of introduction, the current state of Swedish healthcare is presented with emphasis on two of its challenges: the lack of inhabitant/patient perspective and involvement, particularly interpersonal aspects; and disparities between groups in society. Next, a section of the service management perspective and the integration of social context follow. Given the areas of concern addressed in this chapter, the purpose and questions guiding the research are then articulated. A brief description of the contexts of the appended papers comes next, with a note about my view on definitions to follow. A summary of the chapter and an outline of the remainder of the thesis ends this chapter.

1.1 Background

The current state of many healthcare systems is often painted in discouraging pictures, as costly, inefficient, outdated, or suffering from quality problems (Christensen *et al.,* 2009; Herzlinger, 2006; Porter and Teisberg, 2004, 2006). Common to these references are while mainly addressing shortcomings of the US healthcare system, these are claimed to also apply to "most other developed countries" (Herzlinger, 2006, p. 58), or that "[t]he rest of the world isn't far behind" (Christensen *et al.,* 2009, p. xvi). But is it so? Mintzberg (2012) argues that to some extent, what is portrayed is nothing but myths, and that many healthcare systems in the developed world of today are doing rather well. The latter may be particularly the case for Swedish healthcare; Sweden scores highly in cancer survival rates compared with other Western countries (Coleman *et al.,* 2011; Gatta *et al.,* 2000); highly in survival rates after a myocardial infarction or ischemic stroke with other OECD countries (SKL, 2015); and has relatively low infant mortality rates compared with other European countries and the United States (MacDorman *et al.,* 2014). In addition, and contrary to US healthcare (Porter, 2009), costs – as in share of GDP – of Swedish healthcare have remained steady for the last decade (Socialstyrelsen, 2014a).

A certain degree of pessimism may be justified, however, if the focus is shifted from medical outcomes to how healthcare is executed. For example, of all OECD countries, Swedish patients with complex care needs are least likely to report positive perceptions of involvement, including such as interactions with healthcare staff (Schoen *et al.,* 2011). Addressing lack of involvement, compared to other Western countries, Swedish healthcare scores poorly in informing patients, enabling them to participate and take on a more active role (SKL, 2015; Vårdanalys, 2014a). At the same time, a growing body of literature suggests that having well-informed and participatory patients lead to more effective and efficient healthcare delivery, lower costs, better medical outcomes, and increased perceptions of quality and satisfaction (Bergman *et al.,* 2015a; Gallan *et al.,* 2013; Groene *et al.,* 2009; Holman and Lorig, 2000).

Moreover, the above examples of positive medical outcomes in relation to other countries, reveal nothing about *who* benefits, or *who* does not, within the diverse Swedish population. The aggregated data provide a generic picture, but not how data such as survival rates are distributed between various groups in Swedish society (exclusive of categorizations based on diagnoses or illnesses for example). The same applies to *how* healthcare is executed – are perceptions between groups in society the same, or are there differences? Unfortunately, scholars investigating healthcare on a group level – whether focusing on process or outcome – are not particularly optimistic.

- Screening programs have proved to reach the targeted groups with varying success. For example, participation is lower for foreign-born women than Swedish-born women in cervical cancer screening (Azerkan *et al.,* 2011), as well as mammography (Lagerlund *et al.,* 2002).
- A lack of skills in Swedish might explain the level of self-reported health (Wiking *et al.,* 2004), whether basic needs are provided (Björk Brämberg *et al.,* 2010), or when treatment is given (Santos *et al.,* 2013).
- Survival rates for men and women in non-sex-specific cancers show disparities, and mortality rates for cancer patients with low education are higher than for others (Socialstyrelsen, 2011a).
- Few elderly inhabitants are included in clinical studies, with the potential consequence of inadequate treatment of the particular group (KJV, 2015).
- Inhabitants born outside of the European Union and inhabitants with low education are treated less often with recommended and/or prioritized medications after stroke than inhabitants born in Sweden or respectively highly educated inhabitants (Vårdanalys, 2014b).
- Patient complaints are reported in greater numbers by women compared to men (Socialstyrelsen, 2009).
- In the decentralized Swedish healthcare system, the incidences of prostate cancer vary geographically (Stattin *et al.,* 2005).

The list, drawing solely from Swedish cases, could go on much further. As exemplified, the disparities are manifested for different categorizations of inhabitants/patients (based on age, educational level, sex etcetera), and include various aspects of healthcare (prevention, treatment, perceptions etcetera). Cumulatively, the above examples show that the Swedish healthcare system has not addressed differential needs and expectations, nor are healthcare provided with similar satisfaction between segments of the population. Indeed, it is suggested that disparities in health between groups in Swedish society have in fact increased since the 1980s (SKL, 2013).

The above equity[1] perspective is addressed in various quality models in healthcare (Institute of Medicine, 2001; Socialstyrelsen, 2005). Equity is fair, normative, and about justness for groups of people (Braveman and Gruskin, 2003; Carter-Pokras and Baquet, 2002; Whitehead, 1992). Central to equity is the needs of these people (Payne and Doyal, 2010), and consequently in a healthcare context equity does not mean "that everybody should […] consume the same amount of health service resources irrespective of need" (Whitehead, 1992, p. 441) , or "… to always treat all patients in the same way, but rather the ability to treat all patients *differently* on basis of their specific background, needs and prerequisites"

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[1] A similar concept to equity is *equality*. The dictionary definitions of equality and equity are, "[t]he state of being equal, especially in status, rights, or opportunities," and respectively, "[t]he quality of being fair and impartial" (Oxford Dictionaries, 2016). Hence, the concept of equality does not include the aspects of justness and fairness, per se, and neither does it consider differences in needs (Braveman and Gruskin, 2003; Carter-Pokras and Baquet, 2002).

(Dahlborg Lyckhage *et al.,* 2015, p. 47, my translation).[2] Addressing groups' access to a society's resources is important in order to identify and reduce potential disadvantages for a group and the causes thereof (SKL, 2013). Moreover, equity is frequently elaborated as both a means and goal in relation to the inclusion of a diversity of inhabitants to be participative in society (Kates *et al.,* 2005; Littig and Griessler, 2005; McKenzie, 2004).

At focus in this thesis are disparities particularly between Swedish-born and foreign-born inhabitants/patients and between men and women. Related to the former, the Swedish Discriminatory Ombudsman (DO, 2012) reported ethnicity as one of the two most common grounds (the other being disability) for discrimination in healthcare. A strong relationship between perceptions of discrimination and lacking mental, as well as physical health among foreign-born people living in Sweden, has been identified by a national commission (SOU, 2006). The Discriminatory Ombudsman (2012) argued that immigrants into Sweden may have a greater need for healthcare than other groups due to prior experiences in their countries of origin or as a result of immigration itself. However, compared to Swedish-born inhabitants, foreign-born inhabitants refrain from seeking care twice as often (SKL, 2009). Concerning disparities in Swedish healthcare between men and women, it is argued that a female patient may expect to be affected by quality failings more often than a male patient in part because the male body has constituted the norm in medical research (SKL, 2007). Moreover, it is argued that biological explanations prevail over social (Hamberg, 2004), thus neglecting the so-called *gender system* (Hirdman, 1988), including (un)conscious and normative attitudes about men and women's characteristics. Consequently, there is a risk of bias in which men and women are treated – in both a medical and social sense – based on these assumptions (SKL, 2007).

1.1.1 A need to rethink healthcare

Yet other future challenges of Swedish and other Western healthcare systems stem from demographical factors. The Swedish population as a whole is aging, and subsequently the number of older patients with multiple diseases will increase, requiring more resources and rising costs (Socialstyrelsen, 2013); at the same time the tax base will decrease (Lifvergren, 2013). Additionally, escalating prices of drugs and technology (Dent and Pahor, 2015) and a neglect of public health and prevention (Marvasti and Stafford, 2012) also contribute to cost increases.

Achieving change in healthcare may be easier said than done. Glouberman and Mintzberg (2001) emphasized the complexity within healthcare being caused by different, sometimes conflicting, perspectives or "worlds," impacting care-providing organizations: *care*, constituted particularly by the nursing profession; *cure*, referring to medicine and physicians; *control,* executed by management; and *community,* constituted by politicians. These four perspectives must be united in order to reach sustainable change in healthcare, the two authors argued (ibid.). Such agreement may be reached by focusing on the patient as a guiding principle, as suggested by Hellström *et al.* (2015).

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[2] A further distinction is between *vertical* and *horizontal* equity (Macinko and Starfield, 2002; Starfield, 2011); the former includes preferential treatment for those with greater health needs, whereas the latter indicates equal treatment for equivalent needs.

However, many challenges are not exclusive to the healthcare sector, but are rather to be considered societal issues of concern. As two examples, currently there is a large number of refugees into Sweden (Migrationsverket, 2016; SKL, 2016), and sick leave continues to rise in Sweden, particularly among women (Socialdepartementet, 2015). These are but two challenges not only for the healthcare sector to address, but for the Social Insurance Agency, employers, schools, and other related parties. Societal matters such as these require healthcare (and other public organizations) not to act in silos, but rather to increase collaboration with other players (Quist and Fransson, 2014; Socialstyrelsen, 2011b). Consequently, rethinking and changing how today's healthcare is designed is crucial; the current organization of healthcare is arguably not sustainable (Mohrman *et al.,* 2012).

1.1.2 Recent developments in Swedish healthcare

In the 1980s, *Public Administration* – hitherto the predominant organization model within the public sector – with its bureaucratic and hierarchical structure and foci on rules and policy implementation, endured increasingly intense scrutiny. During this period many Western countries gradually replaced their public sector management with a cluster of ideas, commonly labelled *New Public Management* (Lyckhage, 2015; Osborne, 2006). These ideas favored private sector management in which markets, competition, and contracts were believed superior to "the old way," and in which costs and quantifiable control and evaluation of input/output was central (Osborne, 2006), often at the expense of trust in the professions (Lyckhage, 2015). The Swedish healthcare sector, as well as the public sector at large, saw the introduction of *New Public Management* ideas in the 1980s, such as with the decentralization following the expansion of primary healthcare (Eriksson *et al.,* 2013), and financial responsibilities being delegated to individual hospitals (Green-Pedersen, 2002). In the 1990s the adoption of more market-orientated reforms, such as implementation of purchaser-provider models and primary healthcare reform that made more room for private actors and thus competition (Eriksson *et al.,* 2013; Green-Pedersen, 2002). The appropriateness of competition in the Swedish healthcare system, referred to as a *quasi-market*, have been brought into question (Levin and Normann, 2001; Nordgren, 2003). Not least since it is argued that competition in Swedish healthcare, thus far, has contributed neither to improved efficiency nor to quality (Hartman, 2011). In line with the increased individualization of society (Nordgren, 2003; Wikström and Arman, 2013), the market-orientation of *New Public Management* included a consumerist view of the patient (Dent and Pahor, 2015), manifested as the individual's increased possibilities to choose from providers, to place well-informed demands on providers, and to take greater responsibility for one's own care (Nordgren, 2003; Wikström and Arman, 2013). Overall, the public-private hybrids in Sweden – besides healthcare, most notably schools and elderly care – have also been identified as lacking the common demands of public administrations, for example concerning transparency (Lundquist, 2001).

A Swedish government report (Regeringen, 2014) states that rather than making public sector more effective, *New Public Management* has resulted in increased administrative burden and decreased influence of professions. Specific to Swedish healthcare, the reforms have been criticized for creating fragmentation by being too focused on costs and neglecting issues *between* different organizational units (Eriksson *et al.,* 2013), despite the increased use of such approaches as process mapping in the public sector to straighten that out (Quist and Fransson, 2014). Similarly, Osborne (2006) argues that *New Public Management* has had limited impact mainly because of its intra-organizational foci on processes and management in an increasingly plural world, or put differently, to have "produced very internally efficient but externally ineffective public service organizations" (Osborne *et al.,* 2015, p. 424). Moreover, the emphasis on control and evaluation brings with it a necessity of predefined and delimited measurements, asserted to be particularly difficult in healthcare (SOU, 2016:2).

Osborne *et al.* (2012) argue that many of the problems with *New Public Management* as described above, stem from its origin from the private sector's logic in producing goods, and that public services simply cannot be managed in the same way. It has been proposed that *New Public Management* has only been a transitional phase between the preceding *Public Administration* and the emerging *New Public Governance* (Osborne, 2006). *New Public Governance* is argued to focus on networks, social capital, and inter-organizational issues emphasizing process and relationships. In these emerging management ideas the design of inter-organizational relationships is central because it can be argued that a multiplicity of inter-dependent actors contribute to the delivery of public services (ibid.) – this includes engagement of the public service user (Osborne *et al.,* 2012).

Indeed, many of these core features of *New Public Governance* echoes in current Swedish reports of how healthcare has failed and what needs to be done. For example, it is argued that "[a]n industrial logic characterizes healthcare of today in a way that organization and processes normally are the same independent of the characteristics and needs of the patient" (SOU, 2016:2, p. 21, my translation). Recently a *Patient Act* (SFS 2014:821) was instituted with the objective of strengthening and clarifying the status of the patient and to promote ideas such as the patient's self-determination and participation. Moreover, the patient ought to be regarded as "part of the team" (SOU, 2016:2, p. 28, my translation). It is also emphasized that healthcare efforts, especially for groups with greater needs, need to be co-organized with a variety of actors based on a holistic view (Norén, 2015).

1.1.3 Different logics in healthcare

Early developments in service research in the 1980s often presented services as being different from, or even the opposite of, goods (Grönroos, 1982; Parasuraman *et al.,* 1985). Later, a service logic has commonly been argued to frame a goods logic (Normann, 2001; Vargo and Lusch, 2004a, 2004b). Rather than arguing in terms of either/or, or placing different logics on different levels, research has highlighted the importance of a combination of perspectives as the most appropriate approach when improving healthcare (Berwick, 2008; Lifvergren, 2013). Inspired by Habermas, Bergman *et al.* (2015b) argued that healthcare improvement needs to emanate from multiple perspectives: *technical perspectives*, which are dominant in the prevailing medical research; *hermeneutical perspectives,* including the development of language and interpersonal understanding; and *emancipatory perspectives*, including reflection and questioning of current conditions, also giving the patient a more active role than traditionally has been the case.

In a similar fashion, Stabell and Fjeldstad (1998) argued that many value logics may co-exist and be important in different situations, proposing three distinctive such generic logics: the value shop, the value-chain, and the value network. Christensen *et al.* (2009) translated the three models to a healthcare context, concluding that all value configuration models are relevant. The shop metaphor includes a diagnosis through testing hypotheses through blood and tissue samples and examinations, and experts recommending solutions (Christensen *et al.*, 2009). In the shop, resources and skills are gathered for the patient to have easy access to relevant competencies for handling the specific illness (Lifvergren *et al.,* 2012), or to quote Stabell and Fjeldstad (1998, p. 414): "value is created by mobilizing resources and activities to resolve a particular customer problem." In a healthcare context, many procedures after definite diagnosis would be sorted into the chain metaphor in which diagnosed problems are being treated through a relatively standard sequence of steps, in a value-adding process, such as orthopedic procedures (Christensen *et al.*, 2009). These include care processes and patient pathways with linked resources to create value *for* the patient (Lifvergren *et al.,* 2012). In the network model, value is created *with* the patient; staff and patients exchange with and help each other, and the patient is considered an active co-creator of value. The network model may be appropriate for chronic illnesses in which patients may also learn from each other (Christensen *et al.*, 2009; Lifvergren *et al.,* 2012).

It is important to stress that within this thesis, all three logics are argued to be important in healthcare. By so doing, not only the complexity of healthcare – and society at large – is recognized, but also a multitude of alternatives to improve healthcare is acknowledged. However, a network perspective is considered the logic least developed and applied in Swedish healthcare, thus entailing the greatest potential to enrich our framework of improving healthcare and in addressing some of the future challenges given account for in the above. Service management ideas address some of these challenges.

1.2 A service management perspective in healthcare

As mentioned, just as in the public sector at large (Osborne *et al.,* 2012; Quist and Fransson, 2014), the management of healthcare has often retrieved inspiration from manufacturing industry (Batalden *et al.,* 2015; SOU, 2016:2), in which the concepts of *standardization* and *mass-production* are often central, and the customer is relegated to a passive role as a receiver (Levin and Normann, 2001). Or in the words of Normann (2001, p. 124, my translation), in healthcare "… one notices the influence of the value-chain model in which the customer is a passive receiver whom by the end of the chain receives the product in shape of 'cure' or 'reparation'." In the late 1980s, Berwick (1989) elaborated on transferring industrial quality management ideas to a healthcare context. In the decades that followed, different quality models from industry were introduced to various healthcare settings (see, e.g., Gremyr *et al.,* 2012; Young and McClean, 2008). Overall, it has been argued that few such initiatives led to actual improvements in patient outcomes (Berwick *et al.,* 2002; Lifvergren, 2013).

The seminal paper of Berry and Bendapudi (2007), based on an in-house research project at a US medical institution, is important to service research in healthcare. The authors argued that healthcare shared unique characteristics (see *IHIP* in the next subsection) with many other services. However, they also identified a number of dissimilarities. To start, patients are often ill, and consequently are likely to be more emotional, demanding, and dependent than other service customers. As opposed to other services, those the customer *wants*, medical care such as taking tests or undergoing surgery are things a patient may need but approaches reluctantly – not least because patients are more at risk compared to customers in other service sectors. This may also impact their role as participant – both in answering questions honestly during encounters as well as in taking prescribed medication afterwards – important for a favorable outcome. Healthcare is also personal, and patients need to "bare themselves physically and emotionally" (ibid., p. 115). Further, a "whole person" service needs to be offered, meaning that services need to be customized not only to fit the medical condition, but also to fit the patient as well as her or his family circumstances, preferences, and age (ibid.).

1.2.1 Service management

Having grown more or less steadily since the 1980s, today the service sector dominates Swedish economy, making up almost 73 percent of the GDP in 2014 (Utrikespolitiska Institutet, 2015). In parallel, *service management*[3] has emerged as a field retrieving inspiration from areas such as marketing, operations management, organizational theory, human resources management, and quality management, and also from business executives and consultants (Grönroos, 1994). However, within the public sector it is argued that it is mainly marketization, including the "customer's" ability to choose, that has been transferred from the private sector service management in the 1990s, and that this has led to a failed understanding of the potential contribution of other aspects of service management in the public sector (Osborne and Strokosch, 2013).

In the early developments of the 1980s, service scholars argued that quality[4] of services was different from quality as conceptualized within a manufacturing context (Grönroos, 1982, 1984; Parasuraman *et al.,* 1985). *Service* quality was described as an abstract construct with unique characteristics, commonly shortened as *IHIP*: *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 in interaction during service delivery; and *perishability*, because it is impossible to stock (Parasuraman *et al.,* 1985; Reeves and Bednar, 1994). Given these service characteristics, the preferred definition of quality was "the extent to which a product or service meets and/or exceeds a customer's expectations" (Reeves and Bednar, 1994, p. 423).

However, the way scholars conceive *service* has developed during the last decades. In the above, addressing service quality, the customer, or groups of customers, was mainly regarded as a source of information, as in providing feedback on their perception of quality. Later developments have emphasized the customer's relationship with the provider and her

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[3] *Service management* is the term commonly used in Europe, whereas in the US the term *service marketing* is more commonly used (Kristensson, 2009).

[4] For an overview of the *quality* concept, see e.g. Garvin (1984) or Reeves and Bednar (1994).

or his active role (Normann and Ramírez, 1993), particularly with the introduction of the so-called *service logic*[5] (Normann, 2001; Vargo and Lusch, 2004a).

Given the diversity of areas of influence, *service management* in the 2000s is argued to include a variety of characteristics, some of which address an understanding of the customers' value creation and perceptions of quality, and how an organization may work and be developed and managed in order to support the customers' value creation and perceived quality (Grönroos, 2007). In contrast to traditional manufacturing management's foci on structure and intraorganizational matters, service management is argued to emphasize processes, systems, or interorganizational matters focusing on consequences for customers and other parties (Grönroos, 2007; Osborne *et al.,* 2012).

Within this thesis, the definition of *service* is adopted from authors Vargo and Lusch (2004a, p. 2) as "… the application of specialized competences (knowledge and skills) through deeds, processes, and performances for the benefit of another entity or the entity itself." In a healthcare context, Nordgren (2008) argued that such an entity is the patient. Consequently, rather than as a noun, *service* within a service logic should be regarded as a verb in which participatory and interactional aspects are at heart (Quist and Fransson, 2014).[6] Hence, in order to enable integration of these (intangible) resources, interaction and relationship between the actors becomes important (Normann, 2001; Osborne *et al.,* 2012). Given the systems perspective, or interorganizational focus, the provider can neither produce nor deliver value to passive customers. Rather, the provider can only offer potential value, and true value may only be realized by the customer (Vargo and Lusch, 2008), often when he or she combines or integrates resources from sources other than the main provider (McColl-Kennedy *et al.,* 2012; Normann, 2001; Quist and Fransson, 2014).

A central feature in a service logic is the creation of *value,*[7] described as a process through which the customer becomes or feels "better off than before" (Grönroos, 2008, p. 303), or through which the customer's "well-being has somehow been improved" (Vargo *et al.,* 2008, p. 150). Because the main provider is considered but one actor in the customer's value-creating network (McColl-Kennedy *et al.,* 2012; Normann, 2001), understanding the customer's value-creation process from her or his perspective is at focus for healthcare providers that want to enhance the customer's perceived value (Nordgren, 2008, 2009; Quist and Fransson, 2014). That is, the "overall aim should be to create value by complementing, supporting and matching the value creation process of the customer (patient)" (Nordgren and Åhgren, 2013, p. 107), by mobilizing and putting together the resources of a variety of actors to match the customer's value-creating process (Levin and Normann, 2001). As argued by Quist and Fransson (2014), this implies reconfiguring how the provider could better support the greater picture, or the inhabitant's life situation.

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[5] The definition by Vargo and Lusch (2004a) is service-*dominant* logic. Normann (2001) and Grönroos (2006, 2011) suggested the term *service logic.* Following my previous reasoning, in which a multiple of logics need to be recognized, I believe it is not necessary – counter-productive, even – to argue in terms of domination. Thus, *service logic* is used throughout the remainder of this thesis.

[6] Sometimes, the noun "service" is emphasized, for example "service" is interpreted as synonymous with the perceived value of the customer when using/realizing value propositions from various actors (Kristensson, 2009). As I argue, this is more in line with the definition of *value.*

[7] For an overview of the *value* concept, see e.g. Vargo *et al.* (2008) or Ramiriez (1999).

Rather than focusing on what happens within the organization, a service logic puts focus on what happens for the customer (Kristensson, 2009; Osborne *et al.,* 2012).

1.2.2 The relevance of service research in healthcare

One aspect of a service perspective that is important to highlight is the inhabitant's or patient's active role, in contrast to a passive receiver of value. Within this thesis the role of the customer is twofold: in *service quality*, the customer is mainly an *evaluator*. Here, quality of healthcare is judged as perceived by her or him. In a *service logic* the customer is provided a role beyond sheer evaluation, most specifically as a *resource integrator*. The role also includes that he or she may take over responsibilities from the provider or be part of the provider's processes (Normann, 2001), ranging from monitoring one's own levels to contribute to improvements for other patients (Elg *et al.,* 2012; McColl-Kennedy *et al.,* 2012). In this thesis, interaction – face-to-face interaction in particular – with the provider is important for the patient to be participative and active (Normann, 2001). As the focus of this thesis explicitly includes both concepts of quality and value, I should make some clarifications. Specifically, I use *perceived* quality and value. The way I construct these, and their relation, are that the patient's perceptions of quality include solely the episode with the healthcare provider. The created value goes beyond the healthcare episode – here, the perceived quality is only one factor that has an impact on the individual's perceived value, such as on her or his well-being, in which health may be just one factor.

Another aspect of a service perspective of importance to healthcare is the integration of the social context, providing a *holistic* view. This is a consequence of value being realized by the customer in her or his lifeworld.[8] In service research this is often manifested as the inclusion of resources not only from the main provider, but also from other actors in the customer's network, such as family, acquaintances, and the local community (McColl-Kennedy *et al.,* 2012; Vargo and Lusch, 2008). In case of the life situation of getting a disease, rarely is the healthcare provider the only party to contribute to the well-being of the customer (Bergman *et al.,* 2015a; McColl-Kennedy *et al.,* 2012; Quist and Fransson, 2014).

However, in line with the increased individualization of society (Nordgren, 2003; Wikström and Arman, 2013), mainstream[9] service research (Normann, 2001; Vargo and Lusch, 2004a, 2008; Grönroos, 2011) offers a rather enchanting notion of the active customer as a free actor. Or in the words of (Nordgren, 2008, p. 517–18): "[t]he construction of the customer position has been based on the assumption that customers have an ability to make independent choices. It also presumes that people are able to and have a will to procure the essential knowledge about their health and about treatment options, reflect on them, choose

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[8] A term borrowed from Habermas (1990), in which such a world addresses "the everyday social world within which individuals interact with others to decide and organise their affairs in the private sphere of their own families or households or in the wider public sphere" (Greenhalgh *et al.,* 2006, p. 1171).

[9] It should be noted that Vargo and Lusch's update of the service(-dominant) logic (2011, 2016) do acknowledge social context, including social structures. However, "mainstream" refers to research inspired by the earlier, and seminal, works of Vargo and Lusch (2004a, 2008) – in a healthcare context, for example Elg *et al.* (2012), Gill *et al.* (2011), and Hardyman *et al.* (2015) – which are relatively patient–provider focused and in which social structures are more or less absent.

between alternatives and co-operate in their own treatment." Initially, few scholars challenged the individualized notion. For example, Eggert *et al.* (2006) stated that providers need to consistently meet changes in customer value demands among *different* customers and customer segments; Edvardsson *et al.* (2011) brought attention to the neglect of the social aspect in value co-creation theory and suggested that value and the creation thereof should be understood as socially constructed; and Helkkula *et al.* (2012) argued that value may emerge intersubjectively in individuals' social contexts. Consequently, Edvardsson *et al.* (2011) position the customer in social context as an intersubjective actor and resource integrator, and consequently: "[v]alue co-creation is shaped by social forces, is reproduced in social structures, and can be asymmetric for the actors involved" (Edvardsson *et al.,* 2011, p. 327). That is, not all patients have the possibilities or prerequisites to be active and well-informed patients (Bergman *et al.,* 2015a). Levin and Normann (2001) argued that the variation of individuals' resources – including networks, competence, and information – to be active co-creators constitutes a risk of inequities and less democracy in healthcare. Therefore, to increase the possibilities for disadvantaged groups is a great challenge for the healthcare system (ibid.).

As argued by Osborne *et al.* (2012), it is important to acknowledge that sometimes there are greater complexities in the public sector compared to the private sector, from which much of the service management literature stems: making profit is simply different from meeting societal needs (ibid.). In a Swedish context, the Healthcare and Medical Act (SFS 1982:763) stipulates that those with the greatest needs should be prioritized. Consequently, in adopting a service management perspective in the public sector, healthcare specifically, while at the same time meeting needs of aggrieved groups, the social context needs to be integrated.

To sum up, a service management perspective offers patients not only a greater say, but a more active role. Paired with social context, including a multiplicity of actors as well as the impact of social forces, a service management perspective implies that perceptions among groups need to be understood. It also implies that individuals have different prerequisites, possibilities, and desires to be active. Consequently, increasing the prerequisites and possibilities for all inhabitants to be active becomes a major challenge.

1.3 Purpose and research questions

Two challenges to Swedish healthcare have been specifically addressed so far in the introductory chapter. First, to a greater degree than other Western countries, Swedish patients perceive their opportunities to participate and be involved in healthcare as unsatisfactory, particularly interpersonal aspects of care. Second, disparities between groups in Swedish society are reported, including access to information, possibilities to participate in one's own care, and experiences of encounters with staff.

In addressing these issues – and as argued by previous researchers (Batalden *et al.,* 2015; Bergman *et al.,* 2015b; Quist and Fransson, 2014) – I argue that an additional perspective may be needed to improve and manage healthcare: a service management perspective, emphasizing *interactional* aspects of care from the patient's point of view. It has been argued that examples of a service logic in a healthcare context are lacking (Helkkula *et al.,* 2013), particularly empirical research (Zhang *et al.,* 2015). However, in order to address collectives, a mainstream service perspective will not suffice. In a social constructionist fashion, one must ask: who benefits and who suffers from such service management perspective? Taking this question into consideration, a service management perspective must integrate the social context – including a multiplicity of actors as well as norms and structures – to offer a *holistic* approach, as called for by Edvardsson *et al.* (2011). However, despite the increasing recognition of social context in service research (Vargo and Lusch, 2016) few scholars have asked what the consequences are, and few empirical cases have been provided to elaborate on service management in social context (Edvardsson *et al.,* 2011). As far as I can ascertain, the impact of social context on individual or group perceptions of value, and how value is actually co-created has not been thoroughly elaborated. This is where I believe a social constructionist approach of service research may offer possibilities, not least by enriching *improvement science* (Batalden et al., 2015; Berwick, 2008), an emerging field aiming at improving healthcare.

Stemming from the above-articulated areas of concern, the *purpose* of this thesis is to increase understanding of how a service management perspective may contribute to improvement science in addressing groups of people. In so doing, I address two questions that guide the research: (1) How do groups of inhabitants/patients perceive interpersonal aspects of healthcare?; and (2) How can group representatives contribute to locally relevant healthcare improvements?

In this thesis I argue that service management offers promising possibilities to enrich our understanding of managing and improving healthcare. However, given the variety of areas of inspiration for service management, this thesis does not by any means claim to provide full coverage of service management. Rather, it elaborates *a perspective* of service management,[10] borrowing mainly from *service quality* and *service logic* literature. Literature from *service ecosystems* and *transformative service research* is used in a way that complements service logic by particularly emphasizing social context. By so doing, this thesis contributes by focusing on groups rather than individuals, thereby aiming to increase knowledge of perceptions in healthcare among groups of patients/inhabitants, but also their potential contribution in healthcare improvement.

1.4 Contexts of the studies

Five research papers comprise the backbone of this thesis. The contexts for these papers will be presented in this section; all took place in the Western Region of Sweden.[11] From a service perspective, the foci are varied: Paper A, addresses the broader lifeworld of the inhabitant; paper B is the only paper where the patient is/has been sick and in a healthcare process with emphasis on interactional aspects of value co-creation; papers C and D focus on the co-creation of the actual value proposition (the traditional "service"); and paper E

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[10] Referred to as "a service management perspective" or simply "a service perspective" in this thesis.

[11] 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.

relates service logic to two other theories, highlighting the multiplicity of perspectives. The purposes and the contexts of the appended papers are summarized in Table 1-1.

Table 1-1 Purposes and contexts of the studies

Paper	Purpose	Healthcare area	Geographical area
A	Identify perceptions of motherhood among three groups – and differences and similarities between the groups – important to recognize when improving healthcare	Child health services	Two smaller cities and northeastern Gothenburg
B	Investigate patients' and their relatives' complaints concerning interpersonal matters in cancer care, and differences between men and women	Patient complaints [cancer care]	Western Region of Sweden
C	Explore how multiple actors may work together to improve screening programs to better meet local residents' needs and expectations	Cervical cancer prevention	Northeastern Gothenburg
D	Explore how community representatives may contribute to increasing participation in screening programs		
E	Highlight the importance and usefulness of multiple interpretations in a healthcare context	Patient complaints [post-delivery]	A hospital in the Western Region of Sweden

Paper A is part of *The Birth of a Parent*, an ongoing project to promote equity and equality in parenting in the Western Region. For this paper, perceptions were collected from Somali- and Swedish-born mothers visiting child health centers in two smaller cities in the region, as well as the northeastern part of the main city of the region. In addition, staff perceptions from these child health centers were examined. The role of the child health centers is to promote the health, development, and well-being of pre-school-aged children by offering voluntary and free programs to children and their parent(s) (Socialstyrelsen, 2014b). However, inequities in access to, and satisfaction with, the child health centers have previously been addressed (Jansson *et al.,* 2002; Wells *et al.,* 2013). In this paper, the three groups (Somali-born mothers, Swedish-born mothers, and nurses at the centers) highlighted different aspects of motherhood: the community, the child, and the mother.

Papers B and E cover patients' complaints. Paper B comprises complaints reported to the local Patients' Advisory Committees in the region. According to the law (SFS 1998:1656, 2014:821), 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 investigated the reported complaints, totaling 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 highlighting the lack of interaction and participation in Swedish 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 quality dimensions (Murad *et al.,* 2009). The one complaint constituting the empirical material of paper E was reported to the advisory committees' database and the deviation system of the concerned hospital. Given the fact that the study consists of one case only, further contextual information about the case will not be provided for the sake of anonymity.

The cervical cancer screening study (papers C and D) was part of the campaign *Bring a Friend* and 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 *et al.,* 2011). For the situation to change, the local *doulas* were invited to participate in the study. *Doula* is a Greek word that means "[a] woman who gives support, help, and advice to another woman during pregnancy and during and after the birth" (Oxford Dictionaries, 2016). In the northeastern part of Gothenburg, doulas were already well established, supporting parents by sharing their cultural background during pregnancy and childbirth. The doulas spoke approximately 10 languages among them; just as importantly, they functioned as interpreters of culture. The involvement of so-called *paraprofessionals* and *volunteers*[12] in sharing background with community members receiving healthcare may help bridge the cultural gap (Allen *et al.,* 2006; Reeb, 2006). Other than benefitting the community members, the involvement of the doulas was also believed to benefit the doulas themselves; for example, to experience increased self-efficacy by making a difference in their community (Ferrari *et al.,* 2006). Focus groups with the doulas were conducted to identify barriers hindering women in the community from taking the test, and to develop possible interventions that would enable women to make an informed decision and also 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 local participation in the screening program by 42 percent. Based on experience gained from the project, the campaign *The Pap Smear Week* is launched one week during spring every year, with half of the Swedish county councils participating.

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[12] 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*.

Figure 1-1 offers a timeline of the three studies and appended papers. More about the individual papers is found mainly in the thesis' fourth chapter.

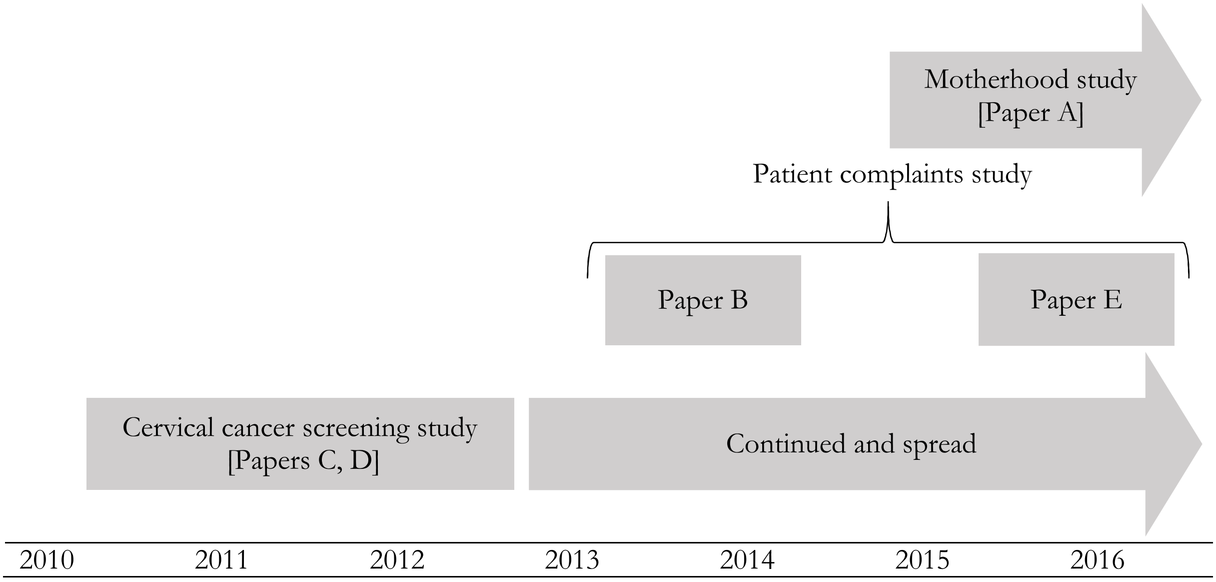

Figure 1-1 Timeline of studies and papers

1.5 A note about definitions, and some definitions

I do not claim there is or even should be only one definition of any of the key concepts used in this thesis. According to Ludwig Wittgenstein, "[t]he meaning of a word is its use in the language" (as quoted in Gergen, 2009, p. 6). The foundational idea is that a word gets its meaning first within the language in which we participate (Alvesson and Sköldberg, 2008; Barlebo Wenneberg, 2001). Wittgenstein also introduced the metaphor of language as a game in which words gain their meanings through the requirements or rules of the game. Accordingly, some words are more important in some games than in others (Gergen, 2009). For instance, the meaning of *value* may mean one thing within the game of value-based healthcare,[13] another in value co-creation. Naturally, the specific meanings may overlap with the different games, yet they are necessarily not identic, varying depending on what is accepted to express within the rules of the specific game (Barlebo Wenneberg, 2001; Gergen, 2009).

Thus, each concept is embedded in a specific context. Therefore, I favor certain definitions over others, starting with the choice of *inhabitant* and *patient* in the following.

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[13] Value-based healthcare (Porter, 2009, 2010) should not be understood on the basis of the elaborations of *value* in this thesis, contrasting conceptualizations in terms of value being produced and delivered by the provider (Porter and Millar, 1985), or that the provider may only offer potential value, or so-called propositions (Vargo and Lusch, 2008).

1.5.1 Inhabitant and patient

In this thesis I favor referring to individuals in two ways: as inhabitants and patients. *Inhabitants* will be used when referring to the studies addressing health promotion and preventive activities in which the target population is not necessarily sick, whereas *patient* is used for people already in healthcare processes. Thus, in the motherhood paper (A) and cervical cancer screening papers (C, D), *inhabitants* is used. Also in paper E, in which the post-delivery phase is in focus, *inhabitant* is favored. Only in the cancer complaints paper (B) are patients addressed; however, half of the complaints were from relatives or others close to the patient.

Rather than *inhabitant*, the term *citizen* has been used in service research in healthcare (Levin and Normann, 2001) as well as in the broader public sector (Quist and Fransson, 2014). *Citizen* is discussed as being relevant by Levin and Normann (2001), particularly because people can affect healthcare by voting, but what is not considered is the decentralized organization of Swedish healthcare and the fact that one does not need to be a Swedish citizen to vote, neither at council nor at municipality levels. Moreover, Swedish legislation stipulates that not only Swedish citizens, but *anyone* in the country has right to healthcare services that cannot be postponed. For children the rights to services are even wider (SFS 2013:407). Hence, I favor *inhabitant* over *citizen* because it is more inclusive.

The choice of *patient* is a more complicated matter. I have used *patient* and *customer* interchangeably in the previous. Here, I will explain why I have done so and why I favor the former. The subordinate and passive role of the traditional *patient* has been well-addressed in previous research (e.g., Gustavsson, 2013; Nordgren, 2003). Here, the individual is regarded a recipient of medical care rather than a partner in it (Holman and Lorig, 2000; Tariman *et al.,* 2010), not least explained by such as patients' knowledge disadvantage vis-à-vis healthcare staff (Kang and James, 2004; Marley *et al.,* 2004). The *patient* position may imply dependency on health providers (Tabrizi *et al.,* 2009).

As an alternative to *patient*, *customer* is sometimes adopted in a healthcare context.[14] Advocates of this concept argue that *customer* implies a more active and equal partner in healthcare (Levin and Normann, 2001). Yet others favor *customer* because it includes – rather than traditional *patients* – preventive care users, friends and family of the patients, and others (Tabrizi *et al.,* 2009). In the context of Swedish county councils responsible for providing healthcare (SFS 1982:763), Karlsson *et al.* (2016) argued that the term *customer* may include not only traditional patients, but also visitors to hospitals and guests at the restaurants owned by the council. Customers may also be internal; for example, staff in wards may constitute customers to, say, support functions (ibid.). Moreover, contrary to the term *patient*, *customer* may imply focusing on the relationship with the provider over a longer period of time than one specific healthcare episode, providing a broader perspective on the human, beyond the diagnosis, on the individual's health-promoting activities beyond mere healthcare activities (Levin and Normann, 2001). In addition, *patient* implies a lack of power, whereas a *customer* may place demands on the healthcare system (ibid.). The introduction of quality management and service management ideas may have contributed to the advanced

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[14] Also *consumer* or *user* may be used within a healthcare context, see e.g. Greenhalgh *et al.* (2010) or Normann (2001).

position of the customer in healthcare. In the former, it is "[t]hose we want to create value for" (Bergman and Klefsjö, 2010, p. 28), and in the latter he or she actively creates value with the providers and others (Vargo and Lusch, 2008). It can be argued that a transformation "from a waiting patient […] to a customer creating value" (Nordgren, 2008, p. 510) has already occurred. The former is waiting patiently, whereas the latter is actively seeking care, asking questions and collaborating (ibid.).

Nordgren (2008) also argued that there are difficulties in use of 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 at all be applicable to healthcare. Moreover, the customer metaphor may 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 (Hudak *et al.,* 2003). Similarly, but in the words of Mayer and Cates (1999, p. 1282): "The more horizontal they are, the more they are a patient. The more vertical they are, the more they are a customer."

Returning to Wittgenstein's idea of language as a game (Gergen, 2009), initially the active customer within the game of service management is rather seductive, hard to argue against. Consequently, in my early phase of my PhD I favored *customer* and its emphasis on someone who is *not* vulnerable, *not* passive, *not* in a subordinate role. More exactly, I favored customer because it was *not* a traditional patient. I proposed it was particularly important to adopt the customer metaphor with respect to disregarded groups, not having access to healthcare to the same extent as others. Here, *customer* offered an opportunity to treat these groups of healthcare customers as active partners with unique knowledge and skills (Vargo and Lusch, 2004a). Further, the emphasis on providers creating dialogue with their customers (Normann, 2001) was appealing, which I argued should be particularly relevant for groups of patients about which the healthcare provider knows little.

Much of the reasoning in the previous paragraph still applies. I remain hesitative of *patient* and what comes with it. However, I have become even more dubious to *customer*. If language is seen as a game, *customer* is undoubtedly one of the more important words within the game of *marketization*. Similarly, but based on Foucault's (1993) notion of discourses, Nordgren (2003) argued that marketization in society has led to the constitution of a new subject position in healthcare, the customer position: "The sick is regarded as a subject having financial possibilities and jurisdictional rights to make choices…" (ibid., p. 174, my translation). Therefore, marketization as a discourse, brings with it other concepts. As I read Foucault (1993), when using *customer* one is intentionally or unintentionally nurturing the marketization discourse in which also privatization, competition and so forth are embedded. I will advocate these concepts if I use *customer*. Or in the words of Nordgren (2003, p. 174, my translation): "To regard the sick as customers means to apply the whole vocabulary from the service management discourse and that represents the individual human as customer in relation to the healthcare." With marketization comes the individual's opportunity to choose healthcare providers (Lyckhage, 2015; Nordgren, 2003; Socialstyrelsen, 2009). However, such a system builds on the assumption of people as free actors – as will be further elaborated in this thesis, this is not a matter of course. In a constructionist fashion (Gergen, 2009), one needs to ask who benefits and who suffers from the notion of the active customer. Thus, in the customer position, the individual is expected to "… lead and control their own value-creation process […] while the provider is expected to support the individual in this process" (Nordgren, 2003, p. 174, my translation). Hence, the customer is expected to be *able* to and *want* to undertake the active role (ibid.).

Moreover, only a smaller part of revenues in Swedish healthcare come from out-of-pocket fees or national government grants (on the basis of demographic, geographic, and socio-economic indicators). Because services are primarily financed through county council and municipal taxes (Anell, 2005), patients are more than customers – they are also owners by financing healthcare.

Thus, the word *patient* is favored over *customer* in this thesis. However, *customer* will be used – and has been used – when expressed within the language games of service management and quality management. Mainly from the methodological chapter I will switch over to use the concepts favored in this thesis: inhabitant and patient. One reason I favor patient is the introduction of concepts such as patient-centeredness (Robinson *et al.,* 2008), which brings with it a role beyond that of traditional patient as passive compared to staff. In this thesis, the characteristics of *patient* to a great extent borrow from the *customer* of a service logic, and may help to nurture the ongoing strengthened role of the patient. Consequently, it is proposed that often only the patient may realize value in her or his lifeworld.

1.5.2 Co-creation and co-production

The two concepts in the sub-heading are sometimes used interchangeably. Therefore, in this subsection I will account for the concepts and make clear which is favored in this thesis.

Within the broader literature of public administration, Pestoff (2006, p. 506) argues that co-production typically implies that individuals or groups contribute to the production of goods and (traditional) services, thus it "… differs notably from the traditional model of public service production in which public officials are exclusively charged with responsibility for designing and providing services to citizens, who in turn only demand, consume and evaluate them." Or, in the words of Ostrom (1996, p. 1073), co-production "… implies that citizens can play an active role in producing public goods and services of consequence to them." Osborne and Strokosch (2013) argued that co-production has developed and been reformulated within the public administration literature since the 1970s. Still, co-production is optional in the sense that people may be invited to participate in planning and production processes in order to improve public services (ibid.).

In a healthcare context, co-production often implies one's efforts for the benefit of one's self. One example of this would be the shared role responsibility between a pregnant woman and staff provided through joint training (Lengnick-Hall, 1996). The patient's contribution to collaboratively designing improvements as well as new solutions – addressed as co-production in the above broader public administration literature – is sometimes referred to as *co-design* (Bate and Robert, 2006).

Within a service management discourse the definition of co-production becomes blurry, in part because of the recent reformulation and the emphasis on co-creation. In early service research, co-production was an indefeasible – unavoidable, even – component, given the inseparability of production and consumption, to take place simultaneously (Parasuraman *et al.,* 1985). As I see it, in recent service logic literature, the distinction between co-production and co-creation may be understood in at least two ways. First, it may be mainly a linguistic turn, away from a goods and producer perspective (co-production), to a service and customer perspective (co-creation) lexicon (Vargo and Lusch, 2008). Second, just as a service logic is proposed to frame a goods logic (Normann, 2001; Vargo and Lusch, 2004a), co-creation is suggested to frame co-production, as one of many co-creation activities. McColl-Kennedy *et al.* (2012) argue that a service logic's co-production in a healthcare context includes assisting with administering drugs or other treatments with the staff (self-service), giving the provider new ideas such as how to reduce waiting times, assisting in the redesign of treatments, and reconfiguring the composition of the medical teams. Somewhat differently and not context-specific, Vargo and Lusch (2008) argue that co-production included participation in developing the core offering.

To avoid confusion, *co-creation* will be used in the remainder of this thesis. Co-creation will be used broadly as in the joint efforts of the inhabitant/patient, provider, and others in creating value. Given the service management legacy in which production and consumption takes place in parallel, the face-to-face encounters, or *moments of truth* (Normann, 2001), are important and highlighted in value creation. Here, value is created mainly for the individual herself/himself. However, value co-creation is also used in this thesis when referring to the application of the individual's knowledge and skills in order to improve (or design, or develop) healthcare. Here, value creation is mainly addressed to increase value for others. To the best of my capacity, I will be as straightforward as possible (addressing 'patient–provider interaction,' 'improving healthcare,' etcetera) when elaborating on co-creation, without mixing in confusing service logic lingo.

Finally, I sometimes drop *co-* in co-creation. While I believe the premise that "the customer is always a co-creator of value" (Vargo and Lusch, 2008, 2016) to be important because it puts emphasis on the customer's active part, it is not always the case. There are possibilities for the customer to create value using her or his own mental resources, such as reframing or psyching oneself up (McColl-Kennedy *et al.,* 2012). Here, value is created by the customer, not necessarily created *together with* anyone else. From the provider's perspective, it is argued that the provider may very well create value for itself, for example by improving its internal processes (Gummerus, 2013). Neither in this case is value necessarily *co*-created with the patient.

1.5.3 Perceptions and social context

The concept of *perceptions* is not straightforward. The dictionary offers two rather different definitions of perceptions, as "[t]he ability to see, hear, or become aware of something through the senses" and "[t]he way in which something is regarded, understood, or interpreted" (Oxford Dictionaries, 2016). As argued by Bueno (2013, p. 323), "[t]he former is a basic [non-epistemic] form of seeing, whereas the latter is conceptual in nature," thus he distinguishes between perception and conception. Turvey (1975, p. 1) argued that "… perception is predicated on conception: one must exploit one's knowledge about the world in order to perceive it." Related, but avoiding the word *conception*, Giddens (1984) gives account for the subjectivism-objectivism division in theories of perception. In overcoming this divide, the importance of time (or memory) and space are often stressed. Here, perception is to be regarded as "a flow of activity" and "organized via anticipatory schemata whereby the individual anticipates new incoming information while simultaneously mentally digesting old" (ibid., 46). Moreover, Giddens argues the main point of reference to be "neither the single sense nor the contemplative perceiver but the body in its active engagements with the material and social worlds" (ibid., 47).

Customer perception is a key concept in service quality, although rarely defined. Giddens' time aspect is explicitly addressed in early and contemporaneous service quality models (Grönroos, 1984; Parasuraman *et al.*, 1985), in which perceptions equal the comparison between expectation and experience. Later models of service quality (Brady and Cronin, 2001; Dagger *et al.,* 2007) often omit expectations, argued not to be necessary (or difficult to collect) for understanding customers' perceptions of quality.

In this thesis, *perceptions of quality* address the inhabitant's or patient's assessment or evaluation of the provided healthcare, or dimensions thereof. Further, disparities between expectations and experiences are regarded as embedded, or even unavoidable, in perceptions of quality. *Perceptions of value* (to the best of my knowledge not problematized in the same way as in the above) address the individual's evaluation of the value he or she experiences in her or his broader lifeworld. In constructionist fashion, both perceptions of quality and value should be understood as intersubjective; rather than stemming from the individual mind, they derive from relationships among people in their social contexts (Gergen 2009; Gergen and Gergen, 2008).

Social context is often thought of as constituted by constructs such as family, workplace, and community, as well as rules, norms, etcetera, that people may be unaware of (Coleman, 1988; Shanahan and Hofer, 2005). Similarly, in a healthcare context, Burke *et al.,* (2009) argued that social context includes organizations/institutions (such as school, healthcare, family) as well as social structures. Social context has been deemed important to include in health-promoting strategies because they "directly and indirectly affect health and behavior" (Pasick and Burke, 2008, p. 359), thus interventions need to address family, community, etcetera, in addition to the individual (ibid.). Franzini and Spears (2003) argued that conditions including the degree of social inequalities, availability of social capital (see *Future research* for definition), and demographic factors need to be included in social context because these may affect health. Similarly, Helliwell and Putnam (2004) concluded the importance of social context as measured by the strength of family, neighborhood, and community ties, to support both physical health as well as perceived well-being. Thus, Pasick and Burke (2008) call for a need to recognize the impact of social aspects in healthcare, in addition to biological and psychological aspects.

The definition of *social context* adopted within this thesis includes family, community, and so forth with which the actor interacts. It is also constituted by societal structures, such as norms and rules, with an impact on actions and interactions. As mentioned, the impact of social context may be oft-neglected in a service logic (Edvardsson *et al.,* 2011).

1.6 Chapter summary and outline of the thesis

This introductory chapter has highlighted challenges for Swedish healthcare, in particular the patient's perceived lack of involvement, and disparities between groups in society. I propose a service management perspective integrating social context, with the potential to contribute to improvement science in addressing groups of people. First, bringing forth perceptions of individuals is important to address areas in need of improvement, or identifying groups not reached by certain healthcare activities. Second, the patient or inhabitant may be active to a greater extent than as an evaluator, ranging from actively participating in the service meeting to bringing her or his knowledge and skills into the improvements of healthcare. The chapter has also provided an introduction to the contexts of the five appended papers, and provided an elaboration on definitions, as well as the research purpose and questions guiding the research of this thesis.

The remainder of the thesis is organized as follows. In the next chapter, *Theoretical framework,* the service management perspective is elaborated as an additional view to conceive and improve healthcare. The third chapter, *Methodology,* expands the need to pay attention to the impact of social context within which service takes place, introducing social constructionism. This chapter also elaborates on research approaches, collections and analyses of empirical material, and quality of research. Next, a summary of the papers appended to the thesis is provided, as is common themes among the papers in regard to a service management perspective in healthcare. This perspective is broadened in the following *Discussion* chapter to address the purpose and research questions posed in this introductory chapter and by elaborating on the consequences and possibilities of integrating social context to service management ideas in healthcare. The *Conclusion* presents the proposed theoretical, methodological, and practical implications and contributions. Ideas for future research make up the remainder of this thesis.

2 THEORETICAL FRAMEWORK

Initially in this chapter, theories aiming at improving healthcare are presented, in particular the so-called improvement science. Aspects from service management believed to complement and contribute to the development of improvement science follow, as is some criticism of service management. The key concepts of value and value creation, understood through a social constructionist lens, follows. The conceptual frame of theories ends this chapter.

2.1 Improvement science

Since the early 1990s, the *quality* concept has grown in importance in healthcare, not least because of the efforts of Berwick (1989) to advocate for industrial quality management ideas in healthcare, sometimes in collaboration with industrial companies (Berwick *et al.,* 2002). At the outset, it should be recognized that "industrial quality management ideas" are anything but a unified concept; thus Dean and Bowen (1994) attempted to construct a framework of quality management characteristics based on principles, practices, and techniques. *Principles* provide general guidelines that inform everyday actions. Customer focus, continuous improvement, and teamwork constitute important such principles. Expanding on the customer focus example, such principles are implemented through *practices*, commonly used activities, including promotion of direct contact with customers, collection of information about customer needs, and spreading this information within an organization (ibid.). Various *techniques* are used to accomplish these practices, such as customer focus groups, surveys, and complaint lines (Dean and Bowen, 1994; Hackman and Wageman, 1995). Nevertheless, Godfrey and Halder (1997, p. 339) stated: "Despite much discussion about customers, health care remains remarkably internally focused […] provid[ing] general care paths with little tailoring to individual need." As I have argued in the present thesis, this is still relevant – and also applies to groups of people.

In the early 2000s, *improvement science* emerged, a field in which initially quality management ideas were applied to a healthcare context (Batalden and Davidoff, 2007; Berwick, 2008). Still emerging, improvement science has in a Kuhnian way been addressed to be in a pre-paradigmatic stage, in which an agreed upon definition is absent (Bergman *et al.,* 2015a; Marshall *et al.,* 2013). In particular, focus on reducing variation in processes and creating value for the patient were central features in the early developments of improvement science (Eriksson *et al.,* 2013; Lifvergren, 2013). To address healthcare's challenges, complementing quality management ideas with various other methodologies has been suggested (Berwick, 2008; Marshall *et al.,* 2013), including qualitative methods from other fields, to offer better prospects of "information on both mechanisms (i.e., the ways in which specific social programs actually produce social changes) and contexts (i.e., local conditions that could have influenced the outcomes of interest)" (Berwick, 2008, p. 1183). Berwick (2008) argues that rather than "the evidence" as a guiding principle in medicine, changing a care process is mainly about a social change. Lifvergren (2013) suggested that challenges to the emergent field of improvement science included "epistemological issues where advocates of the traditional natural scientific paradigm question the rigor and validity of research on social systems change" (ibid., p. 25).

Naturally, the concept of quality is not new to the context of healthcare. As early as the 1960s, Avedis Donabedian (1966) published a model for the evaluation of quality of care 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; this includes elements such as qualifications of healthcare staff, facilities, and equipment (ibid.). Bergman *et al.* (2015a, p. 20) argue that "a science of improvement has to address improvements on all levels of the Donabedian model." Interestingly, and similar to this thesis, "structure" deviates from the original model in that Bergman *et al.* (2015a) also include norms and other "soft issues" in their definition.

The prerequisites to generate local, yet transferable, knowledge requires collaboration between researchers and frontline healthcare staff – important because improvement initiatives are argued to often lack in scientific rigor (Marshall *et al.,* 2013.). Batalden and Davidoff (2007, p. 2) address the contributions of a multiplicity of actors in their definition of quality improvement in healthcare: "the combined and unceasing efforts of everyone – healthcare professionals, patients and their families, researchers, payers, planners and educators – to make the changes that will lead to better patient outcomes (health), better system performance (care) and better professional development (learning […]." That is, improving quality in healthcare should be "seen as normal and inspiring parts of the daily life in an organization" (Bergman *et al.,* 2015a, p. 19), and to be a matter for everyone, and thus "everyone in healthcare really has two jobs when they come to work every day: to do their work and to improve it" (Batalden and Davidoff, 2007, p. 3). These actions are argued to require both professional knowledge and improvement knowledge (Batalden and Stoltz, 1993).

Batalden and Davidoff (2007) identified five knowledge systems (generalizable scientific evidence, local context, performance measurement, plans for change, and execution of these planned changes) important to improve healthcare. Similar to Dean and Bowen (1994), these knowledge systems were believed to be underpinned by different principles (or 'domains of interests') and connected practices and techniques ('tools' respectively 'methods'), Table 2-1:

Table 2-1 Principles, practices, and techniques (adapted from Batalden and Davidoff, 2007)

Principles	**Practices and techniques**
Healthcare as processes within systems	Diagrams that illustrate flow, inter-relationship and cause-effect; narrative descriptions; case examples
Variation and measurement	Data recorded over time and analyzed on run charts and control charts
Customer/beneficiary knowledge	Measurements of illness burden, functional status, quality of life; recipients' assessment of their quality of care
Leading, following, and making changes	Building knowledge, taking initiative or adaptive action, reviewing and reflecting; developing both leadership and follower-ship skills

Collaboration	Managing conflict, building teams and group learning; acquiring specific communication skills
Social context and accountability	Documenting unwanted and unnecessary variation; widespread public sharing of information
Developing new, locally useful knowledge	Making small tests of change (PDSA cycles)

The need for systems understanding in improving healthcare has been addressed (Batalden and Davidoff, 2007; Bergman *et al.,* 2015a), including how different levels in the system interact (Mohr and Batalden, 2002). Commonly, such systems' levels are constructed as *micro* levels, including patient–staff interaction; *meso* levels, including the organizational unit in which this interaction occurs (department, ward), or explained as "interrelated microsystems" (Nelson *et al.,* 2008, p. 7); and *macro* levels, including the organization framing the previous levels (senior leaders at hospitals, councils). The task of macro and meso levels is to support microsystems, considered to be the most vital part of the system (Lifvergren 2013; Nelson *et al.,* 2008).

Despite the increased attention on quality improvement in healthcare, most initiatives are argued not to have been successful (Lifvergren, 2013). For example, Berwick *et al.* (2002) could only report a few improvements in patient outcomes in their research applying quality management to 21 US healthcare organizations.

2.1.1 Potential developments of improvement science

Berwick (2009) criticized quality models such as the six-dimensional model of Institute of Medicine (2001) or the Swedish government agency for healthcare (Socialstyrelsen, 2005) focusing on quality from the professionals' point of view, rather than from the patients'. Similarly, previous research (Bergman *et al.,* 2011, 2015a; Lifvergren *et al.,* 2015) argued that often literature is operations focused rather than patient focused, resulting in a "relative lack of a patient's perspective" in improvement science (Bergman *et al.,* 2015a, p. 21). Not that patients' assessment of care so much is missing in improvement science (Batalden and Davidoff, 2007), but I argue it should be more in the forefront. In line with this, improvement science could have more to learn from the knowledge area of service management (Bergman *et al.,* 2015a). Service management ideas will be elaborated later in this chapter, but in short, service management's focus is on the patient's perspective on quality in care, and not the provider's point of view. Rather than the focus on process management in goods logic – and consequently a notion that value is delivered to the passive customer (Eriksson *et al.,* 2013) – value in service management cannot be delivered to the customer; he or she is regarded someone contributing and active in co-creating value (Vargo and Lusch, 2008).

Improvement science often treats healthcare in isolation. This may sometimes be appropriate, or at least sufficient, but in managing many of the future challenges, more holistic, societal approaches may be necessary (Quist and Fransson, 2014; Socialstyrelsen, 2011b). Despite mentioning the "efforts of everyone" (Batalden and Davidoff, 2007, p. 2), and the importance of local context (Batalden and Davidoff, 2007; Berwick, 2008), a more explicit treatment of collaboration with actors outside of the immediate healthcare sphere could enrich improvement science. Such collaboration between actors within as well as outside the healthcare system is a central feature of a service logic (McColl-Kennedy *et al.,* 2012). Moreover, and as pointed out Lifvergren (2013), in meeting the demands of improvement science to produce local and transferable knowledge with multiple stakeholders (Batalden and Davidoff, 2007; Marshall *et al.,* 2013), participatory research may enrich improvement science.

Related to the previous paragraph, it may be argued that the suggested macro level of healthcare systems within improvement science (Mohr and Batalden, 2002; Nelson *et al.,* 2008) may be too narrowly defined. Indeed, the macro level is suggested by sociologists (e.g., Blackstone, 2012) to constitute the societal level, in which the hospital or council is a part. Moreover, research on *service ecosystems* and *transformative service research* often borrows from sociologist Giddens (1984), in that the macro level includes informal and formal rules that impact (and is impacted by) meso and micro levels. In short: macro (laws, norms), affects meso (groups of people, men or women, Swedish-born or non-Swedish-born) differently, and influences micro (interaction between people, staff and patient). The impact of such higher level of abstraction on a macro level (henceforth referred to as *social context* to avoid confusion), beyond the immediate healthcare sphere, needs to be more prominently recognized in improvement science (as well as mainstream service research), described further throughout the thesis. Such focus allows targeting groups of patients/inhabitants, thus identifying inequities in healthcare. It can be argued that Batalden and Davidoff (2007) elaborate on the broader social context with their knowledge system of local context, to include "social and cultural identity" for one example, including habits and traditions (ibid., p. 3). However, recently the impact of social context is more explicitly elaborated in improvement science. For instance, Batalden *et al.* (2015) has recently highlighted the importance of social context in improvement science, in which interactions between patients and professionals are "supported and constrained by the structure and function of the healthcare system and by the large-scale social forces and other social services at work in the wider community" (ibid., p. 3).

In this section I argue that improvement science, as it often is described, will not suffice for managing future challenges. The proposed potential developments of improvement science includes enhanced patient focus, collaboration of actors beyond healthcare, and explicit recognition of social context – including social structures – in improvement initiatives. Indeed, a consequence of the integration of social context is that groups, rather than single individuals, may be the focus; this is promising especially for improvement of healthcare for disregarded groups. In fact, the importance of patient segmentation was called for by Berwick *et al.* (2002), especially because healthcare "… often recites a belief that every patient is different, but then proceeds to treat everyone the same […] as if one size fits all" (ibid., p. xxix).

2.2 The patient's perspective

Before presenting the aspects of a service perspective suggested to contribute to the development of improvement science, I will next briefly present yet other concepts within healthcare, some of which overlap with a service perspective. As mentioned in the introduction, the positive aspects of the active and involved patient commonly include more effective and efficient healthcare delivery, lower costs, better medical outcomes, and increased perceptions of quality and satisfaction (Bergman *et al.,* 2015a; Gallan *et al.,* 2013; Groene *et al.,* 2009; Holman and Lorig, 2000). Hence, the driving forces to promote patient involvement are many, and so are the concepts.

2.2.1 Deliberative healthcare

In a broader societal perspective, the Swedish national *Commission on Democracy* – provided with the subtitle *Participation and equal influence* – explores individuals' opportunities for influence in society between elections every four years (SOU 2016:5). This commission – as did the previous commission (SOU 2000:1) – highlighted *deliberative democracy* as an important source of influence by aiming at increasing inhabitants' opportunities to participate in local matters through free dialogue between equals (SOU 2016:5). Jürgen Habermas' (1990) *Communicative action* has been important for the development of deliberative democracy (Williams and Popay, 2001). To Habermas (1990), the intersubjective dimension in which people communicate is pivotal (Kemmis, 2008). Ideal communication takes place in free dialogue between involved participants (Alvesson, 2014) and occurs when "… participating actors' actions are not coordinated by egocentric estimations of success but by achieving mutual understanding" (Habermas, 1990, p. 165, my translation). Contrary, in strategic action communication is distorted and success-oriented rather than aiming towards understanding (ibid.). In ideal deliberative dialogues, individuals, groups, and organizations are invited into the decision-making process, helping to "make decisions more deeply rooted and increase their legitimacy" (SOU 2016:5, p. 682). Abelson *et al.* (2003) argued that "[c]ollective 'problem-solving' discussion is viewed as the critical element of deliberation, to allow individuals with different backgrounds, interests and values to listen, understand, potentially persuade and ultimately come to more reasoned, informed and public-spirited decisions" (ibid., p. 241).

In a healthcare context, increased deliberative democracy has been argued for to engage the population in issues concerning healthcare prioritization (Rawlins, 2005) and for developing proposals for reform and policy (Raisio, 2010). To Dent and Pahor (2015), in deliberative democracy, patients or inhabitants collectively have access to deliberative forums; it includes their active involvement on decision-making bodies. However, this approach may not always be differentiated from other forms of patient involvement approaches, such as designing healthcare services (ibid.). Safaei (2015) offered a broader range and argued that the idea of deliberative democracy in healthcare may involve individuals as taxpayers, community members, and/or patients. It is argued that rarely the term *deliberative democracy* itself is used, but rather concepts such as community participation, user involvement, patient-centeredness, and shared decision-making among others (ibid), some of which will be further elaborated on next.

2.2.2 Inhabitants'/patients' perceptions and participation

During the last decades there has been increasing attention on concepts emphasizing the patient's perspective. Rather than quality from the provider's point of view, the patient's perceptions in healthcare have been highlighted, such as in *patient-reported outcome measures* (PROM), in which the patient's view of symptoms, functional status and health-related quality of life is measured (Black, 2013; Doward *et al.,* 2010; Greenhalgh *et al.,* 1998). Patient-reported *experience* measures (PREM) may also be measured, including patients' interactions with providers (being encountered with dignity, being informed, staff friendliness) (Manary *et al.,* 2013; Stewart *et al.,* 2007), but have been addressed not to be as well investigated as outcome measures (Black, 2013). A possible reason for the emphasis on outcome measures may be due to the increasingly popular concept of *value-based healthcare* (Porter, 2009, 2010), in which such outcome measures are central.

A more active or participatory patient, beyond mere assessment as in the previous, is addressed in *patient-centered care* or *person-centered care*; in both the focus is shifted from a prevailing disease-centered view to a more holistic view of the patient (Epstein, 2000; Socialstyrelsen, 2009). Fundamental characteristics of both these constructions are patient involvement and individualization of care (Health Foundation, 2014; Robinson *et al.,* 2008). *Shared decision making* is an oft-mentioned aspect of these concepts, an approach that includes helping people take an active role making decisions concerning their health, treatment, and support (Snyder and Engström, 2016; Socialstyrelsen, 2012). Yet an aspect of involvement concerns healthcare *delivery*, in which ways of actively engaging patients in delivery of their own care are emphasized, such as self-care, medication, and self-monitoring (Snyder and Engström, 2016). Similarly, in *patient empowerment*, patients are not just recipients of medical decisions, but responsible for their own choices, including the consequences of these choices (Aujoulat *et al.,* 2007). Empowerment also signifies healthcare staff to offer information, expertise, and support in order for patients to make adequate self-management decisions (Anderson and Funnell, 2005). *Health literacy* focuses on a person's ability to understand information and the availability of adequate information (Berkman *et al.,* 2011; Mårtensson and Hensing, 2012). The patient's perspective may also be incorporated in the development and design of healthcare (Snyder and Engström, 2016), such as in the concept of *experience-based co-design* (Bate and Robert, 2006; Gustavsson, 2016).

An increasingly popular concept focusing on the group, rather than on the single individual, is *cultural competence in healthcare*, a strategy to decrease unmotivated cultural differences in access to care and encounters (Betancourt *et al.*, 2002). It is argued that more knowledge is needed about how culture affects encounters in health care, as well as are tools to overcome these differences (Kagawa-Singer and Kassim-Lakha*,* 2003), and that healthcare providers must better account for various groups' specific needs based on social and cultural differences (Betancourt *et al.,* 2002). This is a vast concept including related issues such as culture-specific communication within basic education and staff training (Betancourt *et al.*, 2003; Kagawa-Singer and Kassim-Lakha, 2003), recruitment of staff with varying ethnic backgrounds (Betancourt *et al.,* 2003; Brach and Fraserirector, 2000); maintaining well-developed interpretation services (Björk Brämberg *et al.,* 2010); incorporating information and activities adapted for a variety of languages and cultures (Abdullahi *et al.,* 2009; Betancourt *et al.,* 2003; Brach and Fraserirector, 2000); and the inclusion of family, organizations, and local persons in the care process (Brach and Fraserirector, 2000). Kleinman and Benson (2006) raise a warning that mere provision of knowledge about certain groups may increase stereotypical encounters with certain groups. Rather, through dialogue with the patient, the staff should gain knowledge and understanding of what is important to the particular patient, and how her or his background affects perceptions and treatments provided (ibid.). To Campinha-Bacote (2002), cultural competence is an ongoing process, in particular the staff's self-reflection of how one's own professional and cultural background affects preconceptions.

Cultural competence can arguably be seen as provider focused. As an alternative to addressing diverse populations, *community participation* is suggested. Engagement with individuals with a shared cultural background to disseminate information in a community has proven beneficial (Bullock and McGraw, 2006; Kiger, 2003). One reason is that values and perceptions among members of the community are integrated into healthcare, which then may better address their needs (Smith, 1998; Stone, 1992). In addition, a shared cultural background may create access, credibility, and visibility for the population in need (Khamphakdy-Brown *et al.,* 2006).

The various concepts in this subsection focus more or less on individual or a collective. Is there a contradiction in addressing both? Saha *et al.* (2008) compared both patient-centered care and cultural competence. The emphasis of patient centeredness has been on "individualizing quality," including a focus on provider-patient relationship, improving quality for all patients. Cultural competence has focused on "balancing quality" by reducing disparities and increasing equity by improving healthcare for disadvantaged groups. Despite these differences, the authors also highlight the overlaps. For example, individualizing care must take the diversity of patients' perspectives into consideration; and targeting groups' specific needs includes taking into account the varieties within that group, addressing individual patient's preferences. In their conclusion the authors state: "… efforts to enhance patient centeredness, without adequate attention to the needs of minority and other disadvantaged groups, have the potential to exacerbate existing disparities in care" (Saha *et al.,* 2008, p. 1283).

2.2.3 Who represents whom?

Returning to aspects of democracy, the insufficiency of representative democracy may be argued to lie in the disparities of representation itself, for example women and foreign-born inhabitants' underrepresentation at some (women) and all (foreign-born inhabitants) levels of the political system in Sweden (SOU 2016:5). Political theorists (e.g., Hernes, 1987; Phillips, 2000) have argued that increased representation of certain social groups is a matter of *justice* (representation should mirror society), *interests* (interests of the particular group are more likely to be addressed), and *resource* (experiences differ between groups and thus their knowledge and skills).[15] With this background – and by focusing on deliberative approaches in which the input of a selected few are to represent a broader population – it becomes more crucial to ask who takes part in these deliberative forums, and whom do they represent?

Barnes *et al.* (2003) argued that representing individuals may be motivated to participate by "collective experiences of oppression or exclusion, by altruistic motives associated with

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[15] These, and similar, arguments are not exclusive to political representation, but also apply to representation of social groups among officials in the public workforce (e.g., Tahvilzadeh, 2011).

seeking service improvements for others or the wish to develop skills and self confidence" (ibid., p. 380). However, the authors argued that new mediating collectives may emerge in which participants' boundaries (between official and 'expert' community members) are less important than who is present and respectively absent from such forums, creating new exclusions (ibid.). Similarly, Church *et al.* (2002) raise concern about elitism in which a few voices only, often "better-off individuals," are heard at the expense of socially marginal groups. Martin (2008, p. 37) argued that "particular groups are to be involved in their particularity – of situation, experience or identity" and suggests "a rationale for participation beyond 'democracy' in the narrow sense, premised instead on an understanding of the views of particular groups." Similarly, Young (1997) argued that deliberative democracy will not see power asymmetries and inequalities if groups, rather than individuals, are the focus of deliberation. To Young, social groups' differences in perspectives and positions are regarded an important resource (ibid.).

In the report *Closing the gap in a generation*, chaired by Michael Marmot, it is articulated that "an integral feature of the right to health is the active and informed participation of individuals and communities in health decision-making that affects them" (CSDH, 2008, p. 160). Participation by disadvantaged and marginalized inhabitants is particularly emphasized in the report, and elsewhere (SOU 2016:5). Similarly, in the review of inequities within a European context – ranging from transnational to local levels – and recommendations, Marmot *et al.* (2012, p. 1024) highlighted the importance to "[e]nsure that the different needs, perspectives, and human rights of groups at risk of marginalisation and vulnerability are heard through their involvement in decision-making processes. Accompany this by effective mechanisms for adequate participation, engagement and consultation with all parts of civil society."

2.3 A service management perspective

Below, aspects of service management believed to possess the potential to contribute to healthcare improvement will be presented. The three first subsections (2.3.1 to 2.3.3), draw mainly from *service quality* research, focusing on perceptions from inhabitants'/patients' points-of-view. Here, the individuals or groups of individuals are a source of information concerning *their* perceptions of quality. In the following subsections (2.3.4 to 2.3.6), inhabitants and patients are given an active role beyond mere information sharing. This often involves a multiplicity of actors, drawing mainly from research on *service logic.* My construction is that service logic frames service quality, or put differently: service logic emphasizes the individual's broader lifeworld, whereas service quality is focused on the patient–provider dyad. Emerging theories of *service ecosystems* and *transformative service research* are brought into a further broadened service logic by explicitly integrating the social context's structures, norms, etcetera. A subsection offers some criticism of the selected service management theories presented (mainly a service logic). The interrelation between the theories will be elaborated on in the *Conceptual frame of theories* section below.

2.3.1 Perceived quality

As a complement to improvement science often focusing on internal operations (Bergman *et al.,* 2015a; Lifvergren *et al.,* 2015) and quality from the professional's horizon (Berwick, 2009), service quality is about quality as perceived by the customer, similar to patient-reported experience and outcome measures. In most of the recent service quality models, both process and outcome are evaluated.

During the 1980s, two models common to various sectors were developed as the foundations of service quality (Grönroos, 1984; Parasuraman *et al.,* 1985). Common to both models and the many to follow was customer-focused quality: her or his perceptions of quality through a comparison between expectations and perceptions with respect to a number of quality attributes or dimensions. Parasuraman and associates developed their original model (Parasuraman *et al.,* 1985) and presented the SERVQUAL model/instrument (Parasuraman *et al.,* 1988) – a questionnaire examining 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). Different from the SERVQUAL model/instrument, which evaluates service *process* characteristics only,[16] Grönroos' (1984) model includes customers' evaluations of received services based on the dimensions of technical and functional quality. Technical quality addresses the outcome, or *what* the customer receives. The functional quality represents the process-related dimension, or *how* the customer receives the technical outcome (Grönroos, 1984).[17]

Since the 1980s, more dimensions have been added to the two "original" models, for instance a dimension concerning environmental or physical aspects of service (the so-called *servicescape*), such as equipment or a building (Brady and Cronin, 2001; Zifko-Baliga and Krampf, 1997); or an administrative dimension facilitating the production of a core service (Dagger *et al.,* 2007). Similarly, Edvardsson (1998) argued that customer perceptions of both process and outcome are dependent on the *prerequisites* for a service, including resources, administrative routines and procedures understandable for the customers. In particular, interpersonal interaction has been suggested to constitute a dimension of its own because of the important effect on the perceptions of service quality (Brady and Cronin, 2001; Dagger *et al.,* 2007). Lehtinen and Lehtinen (1991) argued that interactions with other customers may be more important than interactions with staff. Researchers have attempted to hybridized the two "original" models (Brady and Cronin, 2001; Kang and James, 2004; Swartz and Brown, 1989), not least by introducing various sub-dimensions, recognizing that evaluation may be more complex than previously conceptualized (Brady and Cronin, 2001; Kang and James, 2004).

Moreover, the emphasis on the (mis)match or the (potential) gap between expected levels of services and customer experiences in the two "original" models seem to have lost

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[16] In the original 10 dimensions (Parasuraman *et al.,* 1985), the outcome dimension was represented. However, in the development resulting in the SERVQUAL model (Parasuraman *et al.,* 1988), only five dimensions remained, none of which cover the outcome dimension.

[17] Grönroos (1984) 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 experiences.

importance, because measuring experiences of performances alone – as in the so-called SERVPERF scale (Cronin and Taylor, 1992) – have been argued to be sufficient, or even superior to difference measures (Brady and Cronin, 2001; Dabholkar *et al.,* 2000). Later, Grönroos (2007, p. 88) argued that "[t]heoretically, a comparison of experiences and expectations still makes sense," but that a customer's experiences alone "may be the best and most valid way."

The relationship between service quality and *satisfaction* has been greatly debated, whether perceptions of service quality or satisfaction come first, for example. Indeed, many of the constructions of perceived service quality also address satisfaction. Here, quality perceptions are often considered to precede the evaluation of satisfaction (Dagger *et al.,* 2007; Kang and James, 2004). Golder *et al.* (2012, p. 4) defined customer satisfaction as "a postconsumption judgment that compares an offering's evaluated aggregate quality with its quality disconfirmation." Moreover, satisfaction is suggested to be a mediating variable between service quality and behavioral intentions, such as complaints or loyalty (Fornell *et al.,* 1996).[18] Other scholars have suggested the reverse, where satisfaction precedes quality (Taylor and Cronin, 1994). Dabholkar (1995) suggested a framework based on a literature review and a qualitative study, recommending that satisfaction include both cognitive and affective evaluations, whereas service quality is a cognitive evaluation only. Fornell *et al.* (1996) suggested that satisfaction – but not quality – takes into account customer sacrifices, price in particular, during an evaluation.

Because previous research has concluded that customers in healthcare, as in other professional services, may have difficulty separating service quality and satisfaction (Lapierre *et al.,* 1999; McAlexander *et al.,* 1994), these two concepts are used interchangeably in this thesis. That is, if a patient evaluates a specific quality dimension such as interaction with staff, as *good*, it is also assumed that the same interactions are *satisfactory* for that patient. Contrary to the suggested absence of affective judgments in service quality (Dabholkar, 1995), such feelings are believed to be less easily separated and thus assumed to be included in any judgement of a service or specific dimension thereof.

2.3.2 Perceived quality and segmentation

Improvement science's principles (in Table 2-1 above) of social context address unnecessary and unwanted variation (Batalden and Davidoff, 2007). However, to identify these variations and address inequities, perceptions of groups, rather than single individuals, need to be at focus. Here, the notion of customer segmentation of service management (Storbacka, 1997) may contribute by formulating strategies for dealing with segments of customers with different needs (Erevelles *et al.,* 2001; Silva *et al.,* 2013). Indeed, it has been highlighted that in the (traditional) service sector, customization quality – the degree to which the organization's offering is customized to meet heterogeneous customer needs – is particularly important (Anderson *et al.,* 1997).

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[18] As an alternative, Tronvoll (2007) offers a less linear view, suggesting that evaluations, for example complaining, may very well – or are likely, even – to be understood as an adjustment process that occurs *during* service interaction.

Incorporating customer segmentation strategies, the various service quality models have been used to identify differences and similarities in quality perceptions between groups of customers. For example, differences in perceptions of various quality dimensions have been studied based on the customer's sex (Afthinos *et al.,* 2005; Lee *et al.,* 2011; Spathis *et al.,* 2004), cultural background (Agarwal *et al.,* 2010; Armstrong *et al.,* 1997; Furrer *et al.,* 2000) or characteristics including age, marital status, occupation, education, or income (Bishop Gagliano and Hathcote, 1994; Webster, 1989). Thus, segmentation based on inhabitants'/patients' demographics may be a fruitful strategy in identifying disparities and inequities, or differently put: "unwanted and unnecessary variation" (Batalden and Davidoff, 2007, p. 2). Indeed, these differences could be used productively to improve healthcare for segments of patients.

Service quality combined with segmentation has similarities with *consumer culture theory,* focusing on "… the heterogeneous distribution of meanings and the multiplicity of overlapping cultural groupings" (Arnould and Thompson, 2005, p. 869). Rather than the focus on individual level or provider–customer relationship, the unit of analysis in consumer culture research extends to the social level (e.g. subcultures) in which consumers co-create value via interaction (Pongsakornrungsilp and Schroeder, 2011). In that sense, "… consumer collectives are the site of much value creation" (Schau *et al.,* 2009, p. 30). Research within consumer culture theory focusing on social structures has similarities with the focus of this thesis. For example, focusing on gender, Fischer and Arnold (1990) found that women more so than men were involved in Christmas gift shopping, however men were more likely to do so if holding positive gender equality attitudes. Concerning ethnicity, Wallendorf and Reilly (1983) investigated the contents of garbage and found, contrary to traditional assimilation models, that rather than simply being a blend between Mexican and American food consumption, Mexican-American's consumption patterns were unique and different from both their culture of origin as well as culture of residence.

2.3.3 Perceived quality and segmentation in healthcare

At the end of the 1990s, Berwick and associates called for an increased use of service quality in US healthcare, proposed to be "the world's largest service industry" by the authors (Kenagy *et al.,* 1999, p. 661). This parallels Choi *et al.* (2005) arguing for a need to complement the traditional medical approach, stressing medical outcomes from the provider's perspective, with a service approach in which care from the patient's point of view is emphasized.

Technical or outcome quality may be difficult for patients 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). Besides lack of expertise, lack of opportunity and equipment may complicate evaluation of traditional medical outcome quality, as well as the fact that the outcome is not always immediately detectable (Kang and James, 2004; Marley *et al.,* 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: "[i]f patients do not feel cured in their minds, then indeed they have not been cured" (ibid.,

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 (ibid.).

Rather, 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 *et al.,* 2004). Not only is it easier to evaluate, but functional quality (FQ) may be more important to patients than technical quality (TQ) or, to quote Fiala (2012, p. 753): "FQ trumps TQ, for many patients." This is supported by other research in which the interpersonal skills of healthcare staff are argued to be particularly important (Berry and Bendapudi, 2007; Hasin *et al.,* 2001). 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 dimensions they find difficult to evaluate.[19] In an earlier paper, Dagger *et al.* (2007) suggested that interpersonal aspects are particularly important in healthcare and should constitute a dimension of their own. However, patient perceptions of interpersonal quality may differ depending on profession of the staff. Choi *et al.* (2005) suggested that patients may pay more attention to technical quality when judging quality of physicians, as compared to paying more attention to process-related factors concerning other staff, including perceived courteousness, responsiveness, and empathy.

Moreover, the healthcare sector is diverse, and thus, service quality dimensions may vary with type of healthcare. For example, Akter *et al.* (2013) suggested that customers of healthcare heavy on information technology particularly emphasized system quality, interaction quality, and information quality. Investigating service quality at hospitals, Mensah *et al.* (2014) found that empathy, tangibility, reliability and affordability were the dimensions most important to patients. Thus, what quality dimension patients emphasize as important may depend of type of healthcare.

Segmentation strategy of service quality perceptions does not seem to be particularly commonly addressed in a healthcare context. However, researching family planning clinics in the United States, Becker *et al.* (2009) found that interpersonal issues were particularly important for women receiving care, and for Spanish-speaking Latinas language-appropriate service provision was important. Yet other researchers have investigated service quality perceptions in Thai hospitals among groups of patients from different continents (Thawesaengskulthai *et al.,* 2015), or potential differences in service quality of healthcare services based on gender and age (Choi *et al.,* 2005), the latter example with no particular differences identified.

2.3.4 An interactional focus on value creation: The active customer

As mentioned, improvement science may need to be more patient-focused (Bergman *et al.,* 2015a; Lifvergren *et al.,* 2015). Perceived quality as in service quality is one way in so doing. However, a service logic extends the role of the customer beyond evaluation of healthcare.

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[19] Similarly, Donabedian (2003) argued that good staff–patient relationships (not least by showing concern and empathy and taking time to explain) are important to the patient, not least by reassuring her or him that these attributes are evidence that the more technical aspects – difficult for the patient to evaluate – are also good.

Indeed, this is more than patient involvement as commonly addressed in concepts such as patient-centeredness; here, the provider gets involved in the *inhabitant's* value-creation process. In addition to improvement science, where outcomes are often limited to health (Batalden and Davidoff, 2007), value is judged by the inhabitant in her or his broader lifeworld.

In the early 1990s, Normann and Ramírez (1993) criticized Porter's *value-chain* model, a metaphor where interlinked value-adding activities within the organization were central (Porter and Millar, 1985), and proposed a model where value was co-created and regarded as "synchronic and interactive, not linear and transitive" (Ramírez, 1999, p. 50). Consequently, the notion of the customer shifted from someone passively waiting for value to be produced and delivered at the end of a chain, to someone actively participating in joint value creation (Normann and Ramírez, 1993).

As previously pointed out (implicitly by Gummesson and Grönroos [2012], and explicitly by Michel *et al.* [2008]), the ideas of Normann (2001; Normann and Ramírez, 1993) have many similarities with the succeeding seminal works of Vargo and Lusch (2004a, 2008). To both Normann (2001) and Vargo and Lusch (2004a, 2008), intangible resources are central in value creation. The focus on knowledge, skills, competencies, information etcetera (Edvardsson *et al.,* 2011) implies a notion of the customer as someone who possesses unique resources important in the creation of value, where the customer becomes "better off than before" (Grönroos, 2008, p. 303), or through which the customer's well-being improves (Vargo *et al.,* 2008). In order for the customer's resources to come to use in value creation, interaction and relationship between provider and customer are important enablers (Normann, 2001). The so-called *moments of truth*, referring to face-to-face interaction between frontline staff and customer, was emphasized as particularly important in value creation by Normann (2001).

As a consequence of value neither being produced nor delivered, the provider could offer *potential* value as so-called *value propositions* (or *offerings* to user Normann and Ramírez' [1993] vocabulary), understood as resources to enable for customers to create value for themselves – *real* value (Grönroos, 2008; Grönroos and Voima, 2013; Vargo and Lusch, 2004a). Or in the words of Normann and Ramírez' (1993, p. 69): "the goal is not to create value for customers but to mobilize customers to create their *own* value from the company's various offerings."

Normann (2001) argued an important strategy is to identify clusters of customers with commonalities because it may require specific value propositions. Jüttner *et al.* (2010) argued that segmentation may reveal joint value creation opportunities with customers. However, later developments of a service logic have been argued to lack segmentation as a strategy (Grönroos, 2006; Jüttner *et al.,* 2010; Silva *et al.,* 2013). However, there are a few exceptions, suggesting how segmentation may be understood within a service logic. For example, Hollebeek and Brodie (2009) suggested that segmentation of wine customers may suggest varieties of how much they were willing to participate in product development and interaction with frontline staff. Similarly, customer segmentation concerning involvement in value co-creation within a hairdresser and aesthetics sector were also addressed by Silva *et al.* (2013). Yi and Gong (2013) suggested that segmentation may be useful to gain information for maximizing customer value co-creation behavior, paying attention to exploration of the influence of culture on customer value co-creation behavior.

Thus, the notion of the customer within a service logic implies someone possessing important resources, but also someone integrating resources from the provider in the effort to create value. This active notion of the value-creating customer – as contrasted to the awaiting customer by the end of a value chain – extends what the customer can do. Indeed, Normann (2001) argued that the customer may participate in all phases of an organization's process, blurring the boundaries between what are considered tasks of the staff versus the customer. Specifically, what the value-creating customer does will be further elaborated on and exemplified in a healthcare context in subsection 2.3.6.

2.3.5 A holistic focus on value creation: The social context

"A holistic view" in many healthcare concepts implies a focus not only on the disease, but the whole person (Epstein, 2000). Similar to improvement science (Batalden and Davidoff, 2007), in a service logic such holism also includes multiple actors. But more so a service logic emphasizes actors beyond traditional healthcare, and in some recent elaborations on service research, social structures as well.

The early elaborations of Vargo and Lusch (2004a, 2008) were argued to be too simplified and too narrowly focused on interactions between customer and provider (Edvardsson *et al.,* 2011; FitzPatrick *et al.,* 2015). However, already in the 1990s Normann (2001; Normann and Ramírez, 1993) introduced value-creating *systems,* emphasizing value to be created in complex constellations or combinations. From the customer's perspective, such systems imply that he or she often integrates and combines resources from actors or sources other than the main provider (Normann, 2001; Quist and Fransson, 2014). These other sources may include other providers and customers, associations and other public entities, private sources such as friends and family, and even self-activities such as reframing and psyching oneself up (McColl-Kennedy *et al.,* 2012).

As opposed to the sequential value chain metaphor, the customer's value-creation process may be put in the middle of a so-called *value star*, integrating resources from a multiplicity of actors (Normann, 2001). It is argued that the value star is more relevant than the value chain when service exchange is increasingly concerned with information and knowledge (Wikström and Normann, 1992), a statement preceding Vargo and Lusch's (2004a) emphasis on intangible resources such as knowledge and skills. To Grönroos (2008, 2011; Grönroos and Voima, 2013), providers may be regarded as value facilitators of the customer's value-creation process, implying that the provider needs to understand value creation from the customer's perspective (Nordgren, 2008, 2009; Quist and Fransson, 2014). In a value-creating system view, such knowledge may be used by the provider to mobilize and put together a variety of actors' resources to match the customer's value-creating process (Levin and Normann, 2001; Normann, 2001). By *zooming out,* the provider may get a better overall view of the system and thus, other actors' resources received by the customer in its value-creating system may become visible and possible for the provider to integrate. Such out-zoomed system often expands beyond a sector (Normann, 2001). From the provider's perspective, the value star is important in that other propositions for the customer are illustrated, see Figure 2-1 below.

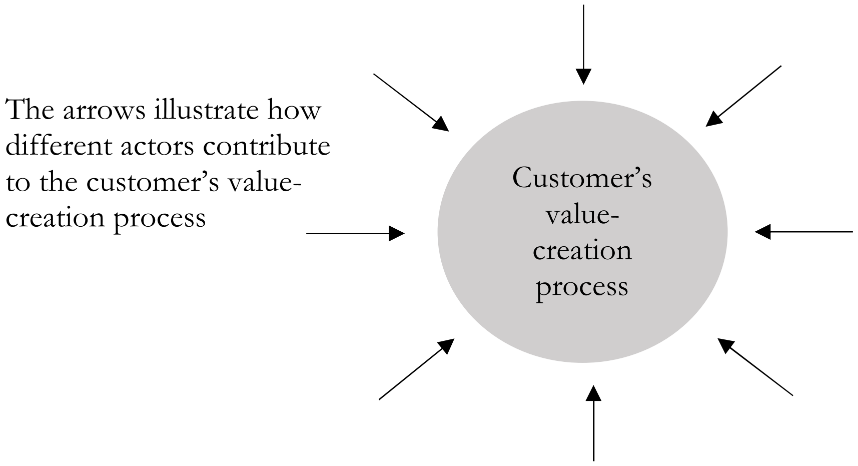

Figure 2-1 Value star (Normann, 2001)

Recently, the idea of a *service ecosystems* approach has garnered attention to understand the interaction and resource integration among various actors in value creation (Vargo and Lusch, 2011, 2016). Vargo and Akaka (2012, p. 207) define *service ecosystems* as "relatively self-contained, self-adjusting systems of resource-integrating actors connected by shared institutional logics and mutual value creation through service exchange." Because a service ecosystems approach offers an interconnected, networked, and recursive view of value creation, all actors are seen as collaborative resource integrators and co-creators of value (Akaka *et al.,* 2013). Thus, emphasis is put on the "processes by which value is created through interaction among multiple stakeholders" (ibid., p. 7). The collaborative nature stresses interaction as an important enabler of resource combination and integration (Grönroos, 2011; McColl-Kennedy *et al.,* 2012; Normann, 2001; Tronvoll, 2007).

Other than a multiplicity of actors, a holistic view of value creation is also argued to include the impact of social forces (Edvardsson *et al.,* 2011). The tendency in service management literature is to focus on the individual as a free actor (Nordgren, 2008). Mainstream service logic (Grönroos, 2011; Normann, 2001; Vargo and Lusch, 2008) has been claimed to treat the value-creating customer in a similarly "context-free" fashion, where value often is treated "as an individualized (or even unique) perception that is apparently independent of the social context in which the reciprocal service provision takes place" (Edvardsson *et al.,* 2011, p. 329). Consequently, an increased understanding of the complexity of context where value creation takes place has been called for (Chandler and Vargo, 2011; Vargo and Lusch, 2016).

Recent streams of service research increasingly address the social context in which resource integration occur, especially *service ecosystems* (Akaka *et al.,* 2013; Vargo and Akaka, 2012) and *transformative service research* (Anderson and Ostrom, 2015; Anderson *et al.,* 2013). Scholars contributing to both research of service ecosystems (Akaka *et al.,* 2013) as well as transformative service research (Blocker and Barrios, 2015) have often drawn inspiration from Giddens' (1984) *structuration theory*, in which a contextual model is proposed that considers both actor and structure.[20] Giddens (1984) elaborates on the reciprocal and constant relation between actors and structures; structure is both a medium and an outcome of individuals' social practices. That is, actors' actions reproduce the structure, and social structures produce rules within which the actors operate, and by acting in compliance to these rules the structures are reinforced (ibid.).

Similarly, in the *service ecosystems* approach, actions and interactions are seen to both influence and be influenced by a multitude of social structures and norms (Akaka *et al.,* 2013; Vargo and Akaka, 2012). Because perceptions of value as well as value-creation processes are influenced by social contextual factors (Rihova *et al.,* 2013), value emerges intersubjectively (Helkkula *et al.,* 2012). In this notion, the interaction among multiple actors throughout dynamic networks occurs under the impact of social structures and norms, which is pivotal for interactions and actions enabling value co-creation (Vargo and Lusch, 2011, 2016). Despite recognizing that structures may negatively impact an individual's actions and interactions, I argue an ecosystems view often favors highlighting the potentials, as evident in the notion of such structures as drivers of interactions *enabling* value co-creation, or to be considered intangible *resources,* or to *aid* collaboration (Vargo and Akaka, 2012; Vargo and Lusch, 2016). More than service ecosystems, I perceive that *transformative service research* highlights the potentially negative aspects of social structures.

As mentioned, *transformative service research* also brings forth social context, often by focusing on such context – exemplified as policies, cultures, or environments (Anderson *et al.,* 2013) – to achieve change (Blocker and Barrios, 2015; Skålén *et al.,* 2015). A central feature of such research is the investigation of the relationship between service and well-being (Anderson and Ostrom, 2015). However, contrary to the individualized focus on well-being in "traditional" service research, well-being is important also on the collective level, such as families or communities (Anderson *et al.,* 2013; Rosenbaum, 2015). Anderson and Ostrom (2015) argue that transformative service research offers potential to "[m]oving beyond the usual focus in service research on the (consumer-provider) dyad", and that the "social and collective level is a much-ignored area of service research that has considerable influence on well-being" (ibid., p. 244). As such, well-being can include health, literacy, access, and absence of discrimination (Anderson and Ostrom, 2015). Thus, as exemplified by the examples, in transformative service research well-being may be negatively affected by interactions (Anderson *et al.,* 2013). Indeed, it has been recognized that other groups may be affected negatively due to efforts emphasizing a specific group (Anderson *et al.,* 2013; Anderson and Ostrom, 2015), not that different from the argued focus in medical research

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[20] Whether actor or structure should be the focus under study has been long debated in social sciences (Alvesson and Sköldberg, 2009). In the *actor* position, the individual (or organization) is conceived as a free being, capable of shaping her or his own existence (Lundquist, 1984). In the *structure* position, the individual is under the influence of conditions that he or she cannot do much about. Here, the emphasis is on how societal structures – such as traditions, formal and informal rules etcetera – affect people's lives (ibid.). However, *structure* is diversely defined, but may be constructed as "a pattern in the relation among actors" (Lundquist, 1984, p. 3, my translation), or informal guidance for social interplay (Giddens, 1984). Common for the definitions is that structures are conceived as empirically abstract, thus not directly observable, that has emerged as a result of interactions between actors – that is, structures are social constructions (Baaz, 2008; Johnson, 2001).

on the male body (SKL, 2007), or the neglect of the elderly population in clinical studies (KJV, 2015).

This thesis adopts the notion of social context as described in later streams of service research. In addition to acknowledging a multiplicity of actors, such context also includes social structures and norms that are influencing and being influenced by resource integration (Vargo and Akaka, 2012). Consequently, a focus on the collective level may be important in order to identify how resource integration may benefit one collective more than another (Blocker and Barrios, 2015). Other than the process of value creation, definitions and perceptions of value are also influenced by social structures (Edvardsson *et al.,* 2011).

2.3.6 Value creation in healthcare

Naturally, the healthcare sector is not excluded from a service logic's notion of the active, rather than the passive, customer creating value with a provider and others (Levin and Normann, 2001; Vargo and Lusch, 2008). To Normann (2001), it is crucial for healthcare management to organize value creation and to support "the health-promoting processes instead of focusing on curing the disease" (ibid., p. 124, my translation). Discussing *value* in healthcare, Nordgren (2009) argued that patients appreciate and contribute to value in areas including health, quality of life, reduced unnecessary suffering, accessibility, and trust. Analyzing a sample of the unstructured answers (there are also fixed answering alternatives) from inpatients in the Nationwide Patient Surveys of patients' perceived quality and experiences, Nordgren and Åhgren (2013) found that receiving professional care and a good level of (traditional) service was the most prominent perceived values, but also expectations to be respected and acknowledged as an individual by the staff.

What is it specifically that value-creating customers in healthcare actually do? In Nordgren's (2009) words, in value-creation processes, "customers are subjectified into being active co-producers in public services, becoming responsible for maintenance of health, eating healthy foods, exercising and self-care" (ibid., p. 121). Through interviews and focus groups with cancer patients, McColl-Kennedy *et al.* (2012) identified what patients did in creating value: acceptance of provided information and compliance with the basics; sorting and assorting information; using supplementary medicine, exercise, diet; providing feedback and seeking information from other sources; maintaining relationships by connecting with family and friends, support groups; co-designing treatment programs and reconfiguring the composition of medical teams; and cerebral activities, including positive thinking, and psyching oneself.

To a certain extent, it can be said that value creation in healthcare means that parts of routine tasks in healthcare are made by the customer rather than by the provider (Nordgren, 2003). Due to modern information technology, this task-shifting may be more relevant than before. Normann (2001; Levin and Normann, 2001) argued that such technology has broadened the scope of what the customer can do related to *when* things can be done, *where* they can be done, and by *whom* and *with* whom they can be done. The consequences therefore in this context include that the customer can check their own level at home, monitored by staff, or that patients may be interconnected and even help each other (ibid.).

Hardyman *et al.* (2015) argued that a service logic's focus on individual encounters is particularly relevant in healthcare by highlighting the quality of the interaction between healthcare staff and patient. Other research adopting a service logic in healthcare includes Rehman *et al.* (2012), who examined customer participation in the value co-creation process and its impact on perceived quality of life support services by oncology patients. Zhang *et al.* (2015) suggested a model of value co-creation in healthcare to improve service quality by the collection of patients' perceptions and by interpreting the feedback on health-promotion strategies.

Most of the activities mentioned above benefit the patient herself/himself. However, the patient's knowledge and skills may also be used to improve or even design healthcare, not for her or his own sake but for other patients (Grönroos and Voima, 2013; Vargo and Lusch, 2008). Using patient diaries to collect empirical material, Elg *et al.* (2012) suggested a "co-creation for others" approach involving patients in healthcare service development.

It has been argued that there are few examples of a service logic in healthcare (Helkkula *et al.,* 2013). In particular, empirical research is lacking; existing healthcare applications to this are thus far largely theoretical (Zhang *et al.,* 2015). Moreover, research – conceptual or empirical – surrounding a multiplicity of actors and social structures on value creation within a healthcare context is sparse. However, Helkkula *et al.* (2013, p. 22) argued that it is important to understand that "value is co-created, calculated, and experienced" by actors on different levels within the healthcare system to maximize value creation within the entire system. Frow *et al.* (2014) suggested that healthcare providers need to offer value propositions that are co-created, reciprocal, and dynamic, changing their model from "… an 'expert prescribed' business to a 'person-centered' practice" (ibid., p. 16). In so doing, collaboration with agencies, community organizations, and others may be necessary (ibid.). Similarly, Sweeney *et al.* (2015), argued that healthcare takes place with the customer's network, extending well beyond the patient–provider dyad. From a transformative service research perspective it is argued that healthcare should move beyond the original objective of improving *individual* health, to put greater focus on sociocultural context (e.g. community, family) on an individual's preferences and experiences, and health disparities between different groups of people (Anderson *et al.,* 2013; Blocker and Barrios, 2015). Similarly, it has been argued that transformative service research has the potential to improve health and well-being for disregarded groups (Kuppelwieser and Finsterwalder, 2016), and on the contrary, that the neglect of offering such as "culturally sensitive service quality during an interaction" may risk negatively influencing patients' health (Anderson *et al.,* 2013, p. 1205).

2.3.7 Critique of a service management perspective

As with any discourse, equally important to what is mentioned, is what is not mentioned. According to Foucault (1993), the negative aspects of the discourse, in this case service management, are left out. In this section, related points that are rarely mentioned are discussed: the *destruction* of value, patient–provider interaction as a *constrainer*, and negative aspects of patient involvement.

The overly positive notion of value *creation* – and seemingly the impossibility of value being either destructed or diminished – have been notified by previous researchers (Alvesson, 2011; Kashif and Zarkada, 2014). One reason for many service researchers' (Levin and Normann, 2001) refusal to talk in terms of value destruction may be the often strong urge to move away from manufacturing linguistics where "… customers were seen as destroying the value which producers had created for them" (Ramírez, 1999, p. 49). However, if a provider's value propositions are inappropriate, then surely value must be understood as something destructible – or at least static in some cases (Echeverri and Skålén, 2011). That is, if value creation is to be regarded as increasing a customer's well-being (Vargo *et al.,* 2008), or as a process in which the customer becomes better off (Grönroos, 2008), then surely, through unsatisfying propositions, the customer may be worse off? Alvesson (2011) argued that co-destruction is a possible consequence because *value* is a social construction through "social competition" in that what one is doing or possessing is judged relative to others.

Related to the above, the concept of interactions as something automatically positive can be scrutinized. Reijonsaari (2013) has brought attention to the implicit assumption that if only provider–customer interaction takes place, value is co-created. In a healthcare context, despite interaction, value is not always co-created, and increased capability and improved health may not occur (ibid.). Indeed, Gummerus (2013) acknowledged that value-creating processes may clash, because the actions between the actors may not be aligned, causing unintended or even negative consequences. Hardyman *et al.* (2015) noted that patients, providers, and others may have different perceptions of value as well, which may affect their interactions.

The service logic's notion of value being co-created by the customer, rather than delivered to a passive customer (Vargo and Lusch, 2004a, 2008), may seem enchanting. Seldom is it argued that participation may not always be voluntary, or that patients cannot perform check-ups on themselves (Nordgren, 2008, 2009). Because of the blurred lines between production and consumption, and consequently between staff and patients (Nordgren, 2008), Prahalad and Ramaswamy (2004, p. 7) ask: "If consumers are active co-creators, should they shoulder responsibility for risks as well?" However, criticism of the notion of active value creating customer parallels with the overall trend in the current healthcare discourse of patient involvement. For example, Dent and Pahor (2015) argued that there may be consequences of involvement leading to patient disempowerment. Moreover, a survey in 15 European Union member states (EC, 2012) revealed that practitioners and patients alike believed that patient involvement could lead to an increased burden on staff's time, and that there was a risk that patients would disagree with the opinion of physicians. Practitioners also saw a risk in patients attempting to diagnose or treat themselves (ibid.). Similarly, Donabedian (2003) argued that patients may want certain treatments that may be unnecessary, that may be bad for them, or that are impossible to offer given the limited resources in healthcare. Moreover, this also conflicts with equity principles (Whitehead, 1992) and Swedish legislation (SFS 1982:763), in which those with the greatest needs should be prioritized. In both cases, whether such as patients' perceptions are always an appropriate measure in healthcare may be questioned.

There may also be reasons that some patients do not have, or even wish to have the possibilities and prerequisites to be active participants, not least due to sickness (Batalden *et al.,* 2015). Involvement may be constrained by conflicting professional interests, information imbalances, practical barriers, and/or costs (Safaei, 2015). In addition, the possession of tangible resources (such as a computer for finding information), level of risk-taking (testing new drugs) or expertise may affect the possibility of being active and participative (Kristensson, 2009). Moreover, involvement may require certain levels of health literacy, or the individual's skills in understanding written and verbal information, (Berkman *et al.,* 2011; Mårtensson and Hensing, 2012), and similarly, the degree of patient involvement may also be affected by cultural differences, gender, education, or age (Bernabeo and Holmboe, 2013). To boil it down, social context matters.

2.4 The social construction of value (creation)

Stating that value definitions and perceptions, as well as the process of value creation, are influenced by social structures also indicates that these notions must be understood as socially constructed (Edvardsson *et al.,* 2011). Social constructionism[21] offers possibilities to include both actor and structure in analysis, which was evident already in *The social construction of reality,* the pioneering work of Berger and Luckmann (1966, p. 61): "Society is a human product. Society is an objective reality. Man is a social product." Thus, not only do individuals create their reality, but the reality also creates the individuals, the latter trough *socialization* through which social norms and knowledge is internalized by individuals (ibid.).

2.4.1 Constructionism and perceptions of value

In parallel with social constructionist ideas, in his 1999 paper, Ramírez concluded that value does not reside in an individual independently: "Values are thus contingent, more than subjective" (ibid., p. 51). However, the mainstream service logic that followed implicitly assumes the individual as a free actor, as evident in the articulations of *value* as "perceived in an individualistic way" (Grönroos, 2011, p. 282) and to be "uniquely […] determined by the beneficiary" (Vargo and Lusch, 2008, p. 7). This is in line with Nordgren's (2003) suggested transformation of the welfare system towards individualization, based on the market as a model, in which the customer is believed able to be an active individual making informed and rational choices. This ideal is argued to exaggerate an individual's ability to shape oneself – rather, individualism as of today is more of a socially sensitive and adaptable type, in which comparing and positioning oneself, or what is "valued," toward others are central (Alvesson, 2011).

Rather than value as a subjective assessment, researchers have argued for the intersubjective side of value. Thus, social forces' impact on value perceptions is recognized: For example, value is seen as intersubjective as it "emerges from individually determined social contexts" (Helkkula *et al.,* 2012, p. 4) and "social forces have a major impact on value co-creation, and

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[21] A distinction is sometimes made between social constructionism and social constructivism (see, for example, Alvesson and Sköldberg, 2008). However, for the purpose of this thesis such distinction is not necessary. For the sake of clarity, only *social constructionism*, or simply *constructionism*, is used throughout the remainder of the thesis.

on how value is defined and perceived (Edvardsson *et al.*, 2011, p. 333). These two examples of value perceptions are arguably more in parallel with constructionism, in which value perceptions is understood as socially context-dependent (Berger and Luckmann, 1966); shaped and residing in relationships (Gergen, 2009), or historical and cultural processes (Gergen and Gergen, 2008).

2.4.2 Constructionism and the creation of value

Moving from perceptions of value to how value is created – the value creation – there are more similarities between mainstream service logic and constructionism than in the previous. Most notably is a similar emphasis on the importance of face-to-face interaction, as articulated in a service logic in which such or *moments of truth,* are important in the value-creation process (Normann, 2001), and constructionism in which such interaction are prominent in an intersubjective world, shared with others (Berger and Luckmann, 1966). Regarding all actors as resource integrators, and resources as mainly intangible (Vargo and Lusch, 2008), suggests similarities with constructionism in which everyday knowledge is regarded as just as important as expert knowledge (Berger and Luckmann, 1966; Gergen, 2008).

Also, aspects in which social factors/structures influence and are influenced by service-for-service exchange/actors' actions are – despite differences in wordings – acknowledged: "social factors […] influence, and are influenced by, service exchange" (Vargo and Akaka, 2012, p. 207) and similarly, to Giddens (1984)[22] an actor's actions both influence and influenced by structural conditions. Naturally, this also applies to interactions, acknowledged in recent service research to occur under the impact of social structures and norms (Akaka *et al.,* 2013). Indeed, structures are argued pivotal for interactions and actions enabling value co-creation (Vargo and Lusch, 2011). However, more than is the case in service research, in social constructionism such structures are addressed to enable – and constrain – actors' decisions and actions differently (Giddens, 1984; Lundquist, 1984).

2.5 Conceptual frame of theories

Table 2-2 below highlights concepts and key components of a service management perspective important in this thesis.

Table 2-2 Conceptual frame of theories, concepts, and key components

Theory	Concept	Key components	Reference
Service quality	Quality	The customer's *perceptions* of technical, interpersonal, environment, and administrative quality dimensions	Dagger *et al.,* 2007
		Segmentation to identify perceived quality among groups of customers	Lee *et al.,* 2011

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[22] The works of Giddens is often not referred to as social constructionism. However, it bears many similarities.

Service logic	Resources	Integration of *intangible resources* (knowledge and skills) from the customer, the provider, and other actors	McColl-Kennedy *et al.,* 2012
	Value creation	*Interaction* – particularly face-to-face – is an important enabler in value creation, including resource integration	Normann, 2001
	The provider	Can neither produce nor deliver value, only potential value, as in *value propositions*	Vargo and Lusch, 2008
Service ecosystems	Social context	Social *structures* are important for actions and interactions enabling value co-creation	Vargo and Lusch, 2016
		Value and value creation are shaped by *social forces*	Edvardsson *et al.,* 2011[23]
Transformative service research		The *collective level* is important in identifying disparities in efforts to integrate resources	Blocker and Barrios, 2015

I adopt the service quality definition of *quality* as perceived by the customer (e.g., Grönroos, 1984). Given the current state of Swedish healthcare, where patient-staff interaction (Schoen *et al.,* 2011), and participation is suggested to be lacking (SKL, 2015; Vårdanalys, 2014a), particular focus is brought to dimensions dealing with *how* healthcare is executed, particularly quality dimensions addressing interactions with staff (Fiala, 2012; Marley *et al.,* 2004; Dagger *et al.,* 2007). Interaction can also be important in enabling the customer's value creation, including resource integration (McColl-Kennedy *et al.,* 2012; Tronvoll, 2007; Vargo and Lusch, 2008). Naturally, perceived quality of *how* (process) and *what* (outcome) are likely to be connected: satisfactory interaction with staff may enable the patient to better understand information about how and when to take medication, which may result in better health outcomes, medically as well as perceived. Given the challenges in Swedish healthcare, in which groups experience healthcare differently – for example, encounters or treatment – I argue it is important to combine perceptions with *segmentation* strategy (Lee *et al.,* 2011), thus entailing a potential to identify disparities between groups.

In this thesis, the differences between the concepts of quality and value are articulated as follows: the patient's/inhabitant's perceptions of *quality* include only the healthcare episode and are limited to the *patient–provider sphere*[24] (that may be fed back to the provider, e.g., as a complaint). Value perceptions, on the other hand, move beyond the isolated patient–provider dyad. Here, the provider may only offer potential value (value propositions), and perceived quality is but one factor affecting the value realized by the individual herself/himself in her or his broader lifeworld. Thus, perceptions of value frame

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[23] Edvardsson *et al.* (2011) is not explicitly elaborating on service ecosystems. However, this particular paper precedes – and is oft-referred to – in later ecosystems literature.

[24] I am aware this is not always the case. For example, Lehtinen and Lehtinen (1991) argued that when judging interactional quality, other customers may be more important than staff – their provided disco-example is rather self-explanatory! Moreover, concepts such as quality of life (Dagger *et al.,* 2007), clearly suggests perceptions of quality well beyond the walls of the healthcare provider's.

perceptions of quality.[25] Indeed, the value-creating customer is likely to include knowledge and skills (and also tangible resources) from sources others than the provider (McColl-Kennedy *et al.,* 2012; Normann, 2001). From a provider perspective there may be a need to reconfigure its network to offer the best possible value proposition, thus collaborating with other actors. Building on the above example of the connectedness of process and outcome quality, interaction with staff may be perceived as satisfying (interpersonal quality), and lead to perceptions of improved health (outcome quality). The provided healthcare, combined with the concern of close ones helping the patient with practicalities in daily life, or easily accessible chat groups online with other patients, may lead to enhanced perceptions of well-being (value) for the inhabitant/patient.

However, inhabitants and patients possess unique knowledge and skills themselves, important to enhance well-being for oneself, but also with the potential for improving and developing healthcare for other inhabitants and patients (Elg *et al.,* 2012; McColl-Kennedy *et al.,* 2012). As mentioned, there are numerous ways in which inhabitants/patients may create value (McColl-Kennedy *et al.,* 2012). Central in this thesis is feedback of *perceived quality* and participation in *improving* healthcare.

The individualization in mainstream service logic implies a view on the customer as a free actor, fully capable of being well-informed and active (Fellesson *et al.,* 2013; Nordgren, 2003). However, the notion that social structures – informal rules, as in norms, and formal rules, as in legislation and regulations – affects individuals' prerequisites and possibilities to be well informed and active is not explicitly mentioned in mainstream service logic discourse (Foucault, 1993). In line with more recent developments in service research, a more complex understanding of value (creation) is suggested (Akaka *et al.,* 2013; Blocker and Barrios, 2015). Moreover, and similar to Edvardsson *et al.* (2011), the social context not only impacts the prerequisites and possibilities for an individual to integrate resources and interact with various actors (*how* value is created), but also the way value (or quality) is *perceived* and *defined.* These aspects have only been superficially elaborated on thus far. In the next chapter, social context becomes central.

2.6 Reflection

It is not my purpose to state that we are in the middle of an extraordinarily innovative and dynamic time, in which a service perspective is going to radically change things. Indeed, every decade has claimed that such huge and radical changes are exclusive to that particular period; the idea of being in a middle of a "paradigm shift" has been attractive for a long time (Alvesson, 2011). Is there really something new about "a service management perspective?"

Indeed, there is overlap with some of the theories introduced in this chapter. To a certain extent, these may have developed from different backgrounds, reflecting the different "worlds" as constructed by Glouberman and Mintzberg (2001). For example, person-

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[25] Similarly, Osborne *et al.* (2012) argue that service quality and the unique *IHIP*-characteristics of (traditional) services is a second-order characteristic of service logic.

centered care and patient-centered care come from the healthcare professions themselves, whereas deliberative democracy may be understood as reflecting the *community* world. The service management theories then, may be sorted under *control*. Despite the differences there are also similarities between a service perspective and the other theories presented – for example the focus on person beyond disease (person-centered), or people's intangible resources (empowerment). Moreover, there are also similarities to quality management, where customer focus is a central component important in designing and delivering traditional products and services that fulfill customer needs (Dean and Bowen, 1994). The subjective side of quality has been stressed within quality management (Kano *et al.,* 1984), and already in the 1930s, Walter Shewhart elaborated on the subjective side of quality, suggesting, "it is impossible to think of a thing as having goodness independent of some human want" (Shewhart, 1931, p. 53), and that these wants may be different for different individuals. Also, the more active participant in developing and designing healthcare has been highlighted (Lengnick-Hall, 1995). The fact that similar ideas are conveyed from various domains emphasizes its relevance. As I see it, a service management perspective, more than the others, moves beyond the walls of healthcare. This is important when addressing challenges of societal concern rather than those isolated to healthcare.

Returning to the specifics of a service logic and the different ways a customer may co-create value, as suggested by McColl-Kennedy and associates (2012), perhaps the accurate question to ask is: What is *not* considered co-creation? The range of co-creation activities are broad, ranging from very active activities such as reconfiguring the composition of medical teams, to not-so-active activities such as accepting information from the provider and complying with the basics. This covers virtually all possible activities that a customer may undertake. What is the point of a concept if it embraces virtually everything?

2.7 Chapter summary

In this chapter, improvement science, in which mainly quality management ideas have been transferred to healthcare, has been introduced. Potential areas of development have been highlighted, including emphasis on the inhabitant's or patient's perspective and her or his more active role, as well as expanding the macro level beyond organizational or geographical boundaries to include social context, including formal and informal rules.

Aspects from service management have been introduced and suggested to address the above areas of development in improvement science. These include foci on quality from the patient's point of view (*service quality*), the inhabitant's/patient's active role as integrating resources from multiple actors (*a service logic*), an emphasis on social structures' impact on perceptions of value as well as how value is created (*service ecosystems* and *transformative service research*). Moreover, the service management discourse often does not mention that value may be destructed (as opposed to value being created), or that people's action and interactions may be constrained (and not only enabled). Some similarities between a service research and social constructionism have been presented, more recent service research, for example, arguing that social factors affect value perceptions as well as how value is created. This chapter has also presented the theoretical frame in which service quality (limited to healthcare assessments) is framed by a service logic (in which the broader lifeworld of people is pivotal).

3 METHODOLOGY

In this chapter a moderate version of social constructionism is elaborated because it comprises the foundation to the methodological standpoints of this thesis. The research approaches used in the appended papers are then presented. The chapter continues with a section of how empirical material was collected and analyzed. Research quality and ethical considerations related to the inquiries follow, with reflections and a chapter summary to conclude.

3.1 My perspective and social constructionism

In this thesis I adopt a *moderate* constructionist position, or a "light version" of constructionism argued by Alvesson and Kärreman (2007, p. 1265) to imply that "… there may be better or worse ways of addressing things, but also that the frameworks, preunderstandings, and vocabularies are central in producing particular versions of the world." Thus, although I believe there existed a reality before we as humans could know anything about it – a realist ontology – this reality is always studied from a perspective rather than being dealt with and imaged in a neutral or objective way. Hence, there is no theory-free empirical material (Alvesson and Kärreman, 2012). Consequently, my own preunderstanding – explained by Gummesson (2000, p. 57) as "people's knowledge, insights, and experience before they engage in a research program" – needs to be presented.

Mainly during the last year of my political science studies, I got interested in diversity issues in public administration, and ended up writing a master's thesis about the (under)representation of foreign-born inhabitants in the public labor market. Twelve years have passed since finalizing the thesis. Since then I have been working primarily with healthcare-related issues; first at the national Social Insurance Agency, and then with healthcare administration at the councils in Stockholm and the Western Region, my current employer. When summing up my impressions of working with healthcare-related issues over the last decade, one aspect in particular highlights the lack of a holistic view of the sick person's situation. At the Social Insurance Agency I held various positions, but all were related to absence due to sickness. In order for the person to get back to work, endless meetings followed with healthcare staff, employers, the union, and other parties, each focusing on their duties in the matter, given the specific rules and regulations they had to obey. The problem was that the totality of the person's life situation was a matter for no one.

After a few years I started to work at local government level. At the first position I was working with contracts, public purchasing, and to follow up the work of the providers. During these latter meetings, I and my colleagues were presented one slide after another of bars and charts describing the number of patient injuries, the number of treated patients, and so on. I can recall only one meeting in which we were presented the patients' perceptions, a survey measuring satisfaction – not that surprising, given that we did not ask for it.

Eventually, concepts such as "patient-centeredness" have come into fashion and documents, reports and so forth, constantly remind us of the importance of involving the patient. However, rather than asking patients, to great extent we continued to assume things

– be it based on previous research (sometimes old, often in distant contexts), or on the experiences of staff. Thus, solutions tended to be produced and delivered, without really knowing if the solutions met the needs and expectations of the people to whom it mattered the most.

The last six years I have been working at the Western Region of Sweden, mainly with healthcare improvement by focusing on equity issues. Often these projects are initiated by statistics indicating disparities between groups in society, and sometimes staff have had a feeling that something needed to be done for a particular group. Often, interviews or focus groups with these group members have followed to identify barriers to the specific group as well as interventions to launch, for example how to design waiting rooms or offering training and education for staff.

3.1.1 A moderate constructionist position

To Van de Ven (2007), constructionist perspectives (as well as others sorted in the broader category of relativism) "… break away from the positivist assumption that scientific knowledge is a cumulative, unmediated, and complete representation of reality" (ibid., p. 47). To me, constructionism acknowledges multiple perspectives rather than one transcendent "truth," and that these perspectives are always embedded in traditions and preferences. Consciously as well unconsciously, the above experiences have led me to adopt some of the central notions of social constructionism in my research.

As mentioned, diversity and equity issues have been more or less prominent in both my academic efforts and working life over the last decade. In addressing inequities, people are often *categorized* into different groups. Young (1990) defines a social group as "a collective of persons differentiated from at least one other group by cultural forms, practices, or a way of life" (ibid., p. 43). Due to similar experiences or way of life the members of a particular social group have a specific affinity to one another, which makes them associate with each other more than others (ibid.). Phillips (2000) offers a more nuanced view in arguing that within a group such as the broad categories of "foreign-born" or "women," there may be a feeling of a special social group, but there are also differences within that group. For the foreign-born persons, not least because of the enormous variety of countries of birth, but also the reasons for migration (Essén, 2002). Similarly, the perceptions of gender are different among societies, affecting expectations of men and women within these particular societies (Brito, 1999; Wilson and Huntington, 2006).

In this thesis people are categorized into groups based on where they live, what diagnosis they have, what language they speak (or do not), their sex/gender, or what profession they have.[26] In a constructionist fashion, my main stance is that these social categories are not given by nature (Barlebo Wenneberg, 2001; Hacking, 2000). However, I argue it is not

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[26] Naturally, individuals belong to many such groups. Two (or more) socially constructed categories may intersect, and the disparities that a single category could not achieve are illuminated. In so-called *intersectionality,* a dynamic between the socially constructed categories is assumed, thus making categories to potentially interact or even change one another (Mair, 2010; Walby, 2007). Intersections are addressed in some transformative service research, such as studies recognizing groups that have a marginal status within a marginalized group (Rosenbaum, 2015).

straightforward: sometimes it is all about *social* explanations (for example 'mother tongue' or 'Swedish-born mothers', as in papers A, C, D),[27] sometimes it is both about *social* and *natural* explanations, as in sex/gender. Concerning the latter example, I do not believe it is all about nature (sex), *or* all about social construct (gender). Rather, whether gender and/or sex should be studied depends on what is asked, as pointed out by previous scholars (Hamberg, 2004; Krieger, 2003). This is a stance particularly important in a healthcare context, in which equal (in a literal sense) healthcare for men and women is not always desirable given the biological differences (Payne and Doyal, 2010). In paper B, *sex* was used to identify female and male patients and relatives, and *gender* in trying to understand the socialized characteristics and expectations.

To talk in terms of groups may be difficult in healthcare. My experience is that a rather common assumption is that meeting each person as a unique individual will suffice for interactions to be inclusive for everyone. Indeed, categorization of people is not unproblematic, and so I do it rather reluctantly. Within the frame of this thesis, the approach of categorization has been strategic (McCall, 2005); categories have been used to investigate disparities between social groups to address areas of concern and ways to deal with these issues. Categorization is considered unavoidable; for example, if there are no "foreign-born women" how can one address foreign-born women's underrepresentation in screening programs? Thus, the emphasis on *groups* does not mean that the individual is neglected. Quite the contrary; the individual's possibilities and prerequisites to act in one way or another are dependent on, and shaped by, the social group(s) of which he or she is a part. Moreover, this also impacts how others perceive them, what is expected from them, and so forth.

Summarizing my working experiences, it has become clear to me that all of us – including employers, staff, and patients – are carrying with us *normative*[28] expectations and imaginations of the characteristics of individuals sorted into certain categories. Consequently, these norms allow for certain categories of individuals to get a job, be an involved patient, and so forth. These norms also constrain some other categories of individuals to achieve these things (Dahlborg Lyckhage *et al.,* 2015). Or differently put, structures favor and disfavor certain actor characteristics over others (Baaz, 2008; Lundquist, 1984). As an example from my working life; aiming at improving youth clinics to attract teenage boys and young men to visit the clinics it was revealed that some staff regarded them as troublesome and disorderly. Such normative conceptions may affect encounters[29] at the clinics and consequently teenage boys' and young men's decisions of

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[27] The somewhat parallel constructions of ethnicity and race are more commonly used in the literature (e.g., Cornell and Hartmann, 1998). However, according to the Swedish Personal Data Act (SFS 1998:204), registering data that reveals race or ethnicity is prohibited. A 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).

[28] I am aware that norms are treated rather pessimistically in this thesis. Naturally, certain norms are crucial in society, guiding us in how to act in various situations and so forth (Dahlborg Lyckhage *et al.,* 2015).

[29] Berger and Luckmann (1966) argued that (stereo)typifications are the most prominent in face-to-face encounters.

revisiting the clinics.[30] I believe that questioning these taken-for-granted realities or norms (Alvesson and Sköldberg, 2008; Barlebo Wenneberg, 2001) is a major task when working with equity and improvement in healthcare.

My experiences of working with healthcare-related issues in different organizations and in different positions have led me to the conclusion that often there is no transcendent or objective "truth," but rather that what we claim to be a fact, or "truth," is shaped by social processes (Gergen and Gergen, 2008). Thus, interpretations of reality are relative because they relate to specific social contexts (Berger and Luckmann, 1966), including different traditions or preferences (Barlebo Wenneberg, 2001; Gergen, 2009). For example, at the local government level I was presented with the "truth" in council reports of escalating numbers of people suffering from illness, based on statistics of sick leave. When working at the Social Insurance Agency, these statistics seemed to mirror the political parties in power just as much as the actual state of people's illnesses.

Given the above, it becomes crucial to acknowledge, understand, and include multiple perspectives when working with improving healthcare together with staff, other organizations and inhabitants, voicing "truths" from various perspectives (Gergen, 2009). As mentioned, my experience is that the "truths" from the patients' perspectives are often neglected. Building on the youth clinic example above, in order to attract young male visitors many Swedish youth centers have special opening hours for the group. Some of the clinics involved in the project thought that was a good idea. However, in talking to group representatives, not only did they misunderstand that they could only visit the clinics during these hours, but several interviewees said that their greatest fear and barrier to visiting the clinics was meeting other (often older) male visitors in the waiting room. Consequently, the knowledge of staff and myself as a researcher are important – but equally important is knowledge of "common people" (Berger and Luckmann, 1966; Gergen, 2009).

To sum up, in this thesis a moderate constructionist position implies that based on people's characteristics, social structures enable and constrain an individual's prerequisites and potentials to be an active patient *differently*. In order to identify such disparities between groups, categorization may be used strategically due to shared experiences among that particular group, thus sharing perceptions of value and *how* they act and interact in integrating resources in their efforts to create value. The constructionist position also emphasizes the importance of acknowledging and to including multiple perspectives to understand and improve healthcare. In particular, the inclusion of the voice of inhabitants or patients is important.

3.1.2 Critique of constructionism

My above moderate version of constructionism is merely a fragment of the various and sometimes conflicting positions of constructionism (Alvesson and Sköldberg, 2008; Gergen, 2009; Hacking, 2000). Indeed, the notion in some of the more radical

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[30] In addition, categories may be *interactive*, as opposed to indifferent, meaning that objects and ideas interact (Hacking, 2000). For example, the "troublesome" young men may very well be aware of how they are categorized and change their behavior accordingly.

constructionist positions that the physical reality itself does not exist without human knowledge about it may seem refreshing to some, offering great potential (‘Standing before us is a vast spectrum of possibility, an endless invitation to innovation’ [Gergen, 2009, p. 5]), dubious to others (‘What is left is a rather volatile and elusive social world’ [Barlebo Wenneberg, 2001, p. 67]). Having a realist ontology, I believe some doubts are justified: if it’s all about constructions – is nothing real? Or, if reality as we know it is dissolved, what exists? In Barlebo Wenneberg’s (2001) view, the void caused by deconstruction, is often replaced by offering theoretical models of explanations of how social reality and concrete social phenomena are structured and functions; the fact that there are social structures. However, these structures are also social constructions. Again, reality is dissolved.

It should also be pointed out that relationships have both positive and negative aspects. That is, in constructing a desirable world together we also create a less desirable world: “For everything in which we place value, there is also […] the not-valued […] [T]he world of the not-valued is primarily inhabited by others, those who are not part of us” (Gergen, 2009, p. 110). Naturally, creating an Us-Them dichotomy may cause conflict.

3.2 Research approaches

Stemming from a moderate constructionist view, in different ways – and to varying degrees – three different research approaches used in the appended papers are introduced in this section.

3.2.1 Comparative approach (papers A, B)

The purpose of paper A was to identify perceptions of motherhood among three groups – and differences and similarities between the groups – important to recognize when improving healthcare. The purpose of paper B was to investigate cancer patients’ and their relatives’ complaints concerning interpersonal matters in cancer care, or lack thereof, as well as investigating differences between female and male complainants.

The unmasking or revealing function of social constructionism (Alvesson and Sköldberg, 2008) may be reached by strategically using categories to investigate disparities between social groups (McCall, 2005). The comparative research approach offers possibilities to compare groups’ perceptions, suggesting that these perceptions are socially constructed. Thus, social forces are suggested to impact on perceptions on value and quality alike, but also the process of creating value. The reason for conducting the research in papers A and B was to illuminate perceptions for segments of patients and to identify similarities and differences between social categories. Quantification is commonly assumed in comparative research; however, it may very well have a qualitative approach (Bryman and Bell, 2007; Maxwell, 2005), as in both these papers.

In paper A, the purpose was to compare and contrast child health nurses, Somali-born and Swedish-born mothers’ perceptions of motherhood. The child health nurses were selected because of research highlighting the importance of the nurses as well as the risk of norms and attitudes being conveyed from nurses to visiting families (Sarkadi *et al.,* 2009). The

Swedish-born mothers were selected as a group because they constitute the most common group of visitors to the centers. Finally, the Somali-born mothers were selected because research has highlighted difficulties for Swedish healthcare to reach that group (Carlson *et al.,* 2012; Svenberg, 2012), and also because of the lack of knowledge about Somali-born inhabitants' perceptions in the particular context. The focus of *motherhood* was deemed appropriate in order to understand how child health centers may "fit into" the women's broader lifeworlds, rather than "squeezing" these lifeworlds into the walls of the child health centers.

In paper B, sex (in identifying complainants) and gender (in understanding the complainants), as categories were specified at the outset due to previous research on disparities between men and women in healthcare generally (Socialstyrelsen, 2011a), as well as concerning dissatisfaction in healthcare specifically (Wessel *et al.,* 2009). Yet other social categories were planned to be included, but due to database limitations this could not be achieved. The focus on interpersonal matters was deemed important, especially because this is where Swedish healthcare scores poorly compared with other countries (SKL, 2015; Vårdanalys, 2014a), not least within cancer care (SOU, 2009:11).

Returning to the overriding approach of constructionism, identifying differences between groups and addressing these groups as social constructions does not change a bad situation for the better. For this purpose, constructionism is presented as insufficient (Barlebo Wenneberg, 2001). A more normative position is suggested by Barlebo Wenneberg (2001); *how* the fact that something is socially constructed could be used to give instructions about what the research can be used for. I agree, but would like to take it even further; *achieving* change in relationship with others (patients, staff) could be the aim for social constructionists. This will be elaborated further in the next, introducing the approach of participatory action research.

3.2.2 Participatory action research (papers C, D)

The purpose of paper C was to explore how different actors may work together to contribute to improve screening programs to better meet local residents' needs and expectations, and in paper D how community representatives may contribute to increasing participation in such programs.

In social constructionism, the context in which the interactions between people take place is pivotal (Berger and Luckmann, 1966). Similarly, the participatory action research approach zoom out by including the community level (Coghlan and Brannick, 2010; McIntyre, 2008). Social constructionism and participatory action research also have in common the *equity* aspect. In social constructionism, investigating who suffers and benefits is central (Gergen, 2009); in participatory action research, equity and access to resources for research participants is central (McIntyre, 2008), and moreover, to change a certain situation for the better (McIntyre, 2008; McNiff and Whitehead, 2009). Acknowledging the social context enables us to understand that improvement of healthcare may be conducted at the group level. By integrating knowledge and skills from the particular group, the likelihood exists that healthcare is created that better meets the needs and expectations of the people in a particular social context.

Papers C and D are also of comparative nature; comparing the number of Pap smear tests in an area with many foreign-born residents with other areas, or comparing tests before, during, and after interventions. However, the main objective of this study have not been to identify differences, but rather to achieve improvement. One common cornerstone of action research as an umbrella concept is that to make action more effective, the research is carried out in a collaborative manner – action research is research *with* practitioners and others (Bradbury, 2010; Coghlan and Brannick, 2010; McIntyre, 2008). This cornerstone is particularly relevant for the branch of *participatory action research*.

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. Similarly, Fals-Borda (1991) rejected traditional academic research that he argued was characterized by relationship asymmetries. Instead, he advocated participatory research in which the "… relationship must be transformed into subject/subject rather than subject/object" (ibid., p. 5).

Thus, 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, focus is typically on social structures and an emphasis on equity, absence of oppression, and access to resources (McIntyre, 2008). Thus, the participatory action research project often 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).

Already in 1940s, Kurt Lewin (1946) argued that action research was not a linear process and proposed an action research cycle.[31] Similarly, the screening study of papers C and D was cyclic in nature. Together with 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 goal of increasing awareness of cervical cancer prevention in the local context and, hopefully, as an extension, in increasing participation in the screening program. The local doulas identified barriers and proposed a number of interventions that were jointly launched during one year. Many interventions were continuously evaluated and adjusted, whereas other interventions were evaluated first after the year-long campaign, but were still fed back to improve the cervical cancer preventive program.

Participation in the screening program increased by 42 percent compared with the previous year, and the participating local doulas reported that the locals seemed to understand the reasons for cervical cancer prevention. However, 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 and learning that

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[31] The similarities between action research cycles and DMAIC(L), PDSA or other cycles used in quality management have been pointed out by previous scholars (Gustavsson, 2016; Lifvergren, 2013).

influenced improvement processes (McNiff and Whitehead, 2009), not least one's own learning as an action researcher about self and the collective (McIntyre, 2008). Hence, action research also includes 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).

3.2.3 Multiple interpretations (paper E)

The purpose of paper E was to illustrate how multiple and parallel interpretations can be used in a healthcare context. In a constructionist fashion, the paper seeks to recognize the multiplicity of perspectives rather than one transcendent "truth" (Gergen, 2009).

In all of the above papers, rather large amounts of empirical material were used and analyzed, whether collected as quantifiable numbers or qualitatively as words. Mainly, the interpretations were conducted by using one theoretical frame to make sense of the empirical findings, or separate theories were merged.

A different approach was used in paper E. So as not to present reality as unambiguous, which may be a risk in conducting research using but one theoretical frame of explanation, multiple interpretations were used by offering three frames of theories from three different fields (Alvesson, 2014; Alvesson and Sköldberg, 2008): value co-creation, communicative action, and gender theories. In a constructionist fashion, the objective of multiple interpretations was to elaborate on the empirical material from various perspectives. Thus, rather than merging the different theories, distinct interpretations were made (Alvesson, 2014).

The benefit of multiple interpretations is that the various perspectives offered by the distinct and parallel theoretical interpretations provide a richer understanding (Van de Ven and Poole, 2005). Moreover, the complexity and ambiguity of social reality is recognized to a greater extent than is commonly the case, and the reader is stimulated to make interpretations on her or his own (Alvesson, 2014). However, combining multiple interpretations with a hermeneutical approach, moving between the "parts" (each distinct interpretation) and the "whole" (interaction in healthcare), also provided new insights of the separate theories as well as a more complex understanding of healthcare interactions.

3.3 Collection and analysis of empirical material

This section provides an account of my role in the studies, how the empirical material was collected, and how the sometimes large amounts of empirical material were dealt with.

3.3.1 Roles in research

Naturally, my own personal background and values previously highlighted were brought into the projects and might very well explain certain choices made. In three of the papers (A, B, E) my role as researcher was rather traditional in collecting empirical material from databases and/or analyzing and interpreting the material myself or with colleagues, having only occasional meetings with personnel. However, in papers C and D, the role was more complex. Thus, this section will elaborate further on my own role as the action researcher.

Elden and Levin (1991) elaborated on the roles of the action researcher coming from the outside and the local participants being located inside the organization or community. The outside researcher recognizes patterns and has training in systematic inquiry and analysis and in creating new knowledge, whereas the inside participants are experts in the specifics of the situation or setting and, from personal experience, know about values, attitudes, and how things work locally. Ideally, through dialogue, the insider's and outsider's respective frameworks intermingle to create a third framework of *local theory*. This theory is tested and improved, and the goal is to eventually generate general theory that is neither local nor context bound (ibid.). However, the action researcher may very well be considered on the inside, as a researcher within one's own organization (Coghlan and Brannick, 2010), or as in *participatory* action research, in the local *community* under study.

My employer is the organization of the Western Region of Sweden, the second largest council in the country. My department is at a central level, working with quality improvement in healthcare over the entire region, whereas the local hospital and the three antenatal clinics involved in the screening study (papers C and D) had a local concern. Moreover, most of the participating staff were clinicians (midwives, nurses, gynecologists) whereas I am not; they may face similar daily obstacles – such as time constraints, resource and staff shortage – and share an organizational culture, 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 (Coghlan and Brannick, 2010). Clearly, I was an outsider in this study.

However, the second author of both papers C and D could be considered an insider working at the local hospital. Our roles were overlapping as well as different. Both planned and conducted the focus groups, participated in various meetings, sent reminders to those who had not taken the test in five years, and so forth. I did more analysis of empirical material, review of literature and writing up, whereas my colleague had more contact with the local actors and in preparing and coordinating the practicalities of the local interventions. She and her colleagues had to solve occurring problems on the local context, enable and encourage collaboration, and change ways of doing things.

Rather than taking on the role of experts, both my colleague at the inside and I on the outside facilitated the project by mobilizing the organization's and community's own expertise (Coghlan and Brannick, 2010; McNiff and Whitehead, 2009). This was clear at the outset because the project depended on the professional knowledge and skills of the involved gynecologists, nurses, and midwives, as well as the local and cultural competence provided by the doulas. Hence, the expertise of those working and living in "the field" was brought into the project.

3.3.2 Collection of empirical material

In paper A, the statement responses were collected using so-called focus prompts (Jonker *et al.,* 2014; Szaflarski *et al.,* 2014). The two groups of mothers and the child health nurses were asked to respond to two statements in writing – one about perfect motherhood, and a second about motherhood in everyday life. The statements about motherhood were chosen to illuminate the groups' life situations, rather than focusing on the child health centers. Responses from 105 mothers or child health nurses were collected mainly by the second author and a Somali-speaking doula. Each respondent could provide multiple answers; thus in total 543 responses were collected. All responses were read through and categorized by myself and the second author.

In paper B, 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. They varied significantly in length, from a few sentences to several pages. 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.

The one complaint selected for paper E was identified while going through the material for paper B. Different from many other complaints in which an official retrieving it had written down the complaint, the one selected in paper E was written by the complainant herself. Moreover, a reason for selecting it was the relative detail and length of the complaint, thus deemed appropriate to interpret thoroughly by using a multiplicity of theories.

As in the above papers, the selection of participants for papers C and D were purposive (Bryman and Bell, 2007). This project included both healthcare providers and local community representatives for the purpose of empowering locals to make informed decisions and to improve the situation in the local context. The doulas were chosen as community representatives because they were believed to possess knowledge relevant in the local context, and also because their shared background with community members could potentially bridge the cultural gap (Allen *et al.,* 2006; Reeb, 2006). Similar to previous studies (Ferrari *et al.,* 2006), the doulas participation was proposed not only to benefit locals, but also the doulas themselves. For example, in papers C and D: 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 providers who gained a better understanding of the needs and expectations of the local inhabitants. Overall, the participation of the doulas proved to be crucial, both during the project and also for long-term benefit (Castillo-Burguete *et al.,* 2008); more than four years after the campaign in papers C and D ended, the numbers of tests remain on the same level as during the campaign year. One reason may be that the doulas have not left the local community after the project ended.

In papers C and D, mainly focus groups with the doulas were carried out to collect empirical material. Those were conducted in a similar approach to *informal interviews* in Gummesson (2000), in which the situation and the conversation guided the questions asked. 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 healthcare in the United States, Saint-Germain *et al.* (1993) found focus groups to be an appropriate method and argued that such things like community attitudes and behavior may be reproduced within the focus group. As in previous studies (Lasch *et al.,* 2000), the method was believed to serve the purpose of effectively developing tailored information for locals. 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 participating doulas knew well and in which they were believed to be comfortable. Secondary empirical material in papers C and D were also collected from diaries, official documents, informal and formal meetings, and ongoing communication. The numbers of Pap smear tests taken were collected for all three antenatal clinics in the northeastern Gothenburg and the local hospital on a monthly basis during the intervention year. The numbers of tests in the two previous years were also collected in order to enable comparisons.

3.3.3 Analysis of empirical material

In papers A–D the large and unstructured amounts of texts from statement responses (paper A), written complaints (paper B), and transcribed focus groups (papers C, D) were dealt with in a similar manner. The analytical approach in these papers was based on the procedure explained by Graneheim and Lundman (2004), in which the statement responses, 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.

As an alternative to the coding and categorization procedure of the above, multiple interpretations were used for analysis in paper E. Here, rather than relying on procedures, the rather small amount of empirical material (the one complaint) were read through several times before, during, and after interpretation through the lenses of the three theories.

Quality management tools were used in the cervical cancer screening study (papers C, D). The Ishikawa diagram (Bergman and Klefsjö, 2010; Berwick *et al.,* 2002) helped identify the root causes of the low participation rate problem mainly identified in the first focus group.

The root causes were used to guide the interventions to prioritize and launch. As the study proceeded, and based on the doulas' and midwives' stories of meeting the local women, the root causes in the Ishikawa diagram were rejected or confirmed. Because the project was about to achieve an improvement, a control chart (Bergman and Klefsjö, 2010; Berwick *et al.,* 2002) 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 empirical material proved to be complementary; for example, the qualitative material 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 did occur.

An overview of the methodologies in the appended papers are presented in Table 3-1.

Table 3-1 Methodological overview

Paper	Categories inquired	Research approach	Collection of empirical material	Analysis of empirical material
A	Country of birth [of mothers] and profession [nurses]	Comparative approach	Statement responses (n=543)	Qualitative content analysis
B	Gender [of patients and relatives]	Comparative approach	Written complaints (n=116)	Qualitative content analysis
C	Mother-tongue	Participatory action research	Two focus groups (n^1=4; n^2=9), diaries, documents, statistics	Qualitative content analysis and quantitative monitoring
D	Mother-tongue	Participatory action research	Two focus groups (n^1=4; n^2=9), diaries, documents, statistics	Qualitative content analysis, Ishikawa diagram, control chart
E	Gender [partly]	Multiple interpretations	Written complaint (n=1)	Multiple and hermeneutical qualitative analysis

3.4 Research quality and ethical considerations

As described, certain approaches to conduct the research were favored more than others, and certain methods were selected over others. Of course, difficulties with my choices of approaches and methods exist. This section illuminates these risks and describes how the inquiries were conducted to ensure high quality. My construction of the notion of quality in research is threefold and based on *trustworthiness, relevance,* and *reflexivity*. Trustworthiness deals with the credibility of the research; relevance is judged based on its effect and is here mainly concerned with action research; and reflexivity addresses the awareness of how social, political, and other elements are interwoven in the knowledge-creation process. The section ends with ethical considerations, which I argue are to be considered research quality as well.

3.4.1 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. I believe my work in the Western Region of Sweden is an advantage in the sense that I am quite familiar with the overall healthcare system in the council. However, because I have neither medical nor nursing training, nor experience in working in healthcare, I am dependent on the staff I work with, to earn their trust. Of course, the risk is that I will become too involved and that my professional judgment may be influenced, not least in papers C and D, which applied research in a collaborative manner. Lincoln and Guba (1985) suggested a *debriefer*, and all studies were indeed processed with other researchers helping to focus my research on what is important, appropriate methodologies and theories, etcetera. *Member checking* was used in the presentation of the empirical material, categories, interpretations, and conclusions with the involved actors at meetings. To retell encounters and try to provide as detailed descriptions of the contexts as possible, diaries were kept 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 appended papers, I attempted to describe the contexts as detailed as possible to enable others to make judgments on the *transferability* to other contexts. However, given the paper format and word limitations that come with it, it is a difficult task.

3.4.2 Relevance

The naturalistic approach of trustworthiness is relevant in all papers of this thesis. However, action researchers are interested not only in knowledge generation outcomes but also action-oriented outcomes and the effect of the research. Therefore, I believe that applying other criteria to judge the action research approach of papers C and D 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. Using triangulation, the positive effect of the study is presented verbally by the doulas' own stories and by presenting a positive (42 percent increase) quantitative development of the number of tests in the area under the interventions year. The project received a national award from an external jury, a fact highlighting that the project *did* make a difference. The *process validity,* focusing on the extent that problems are framed and solved in a manner that permits ongoing learning of the individual and the system, was met by the effort to describe the research process in as much detail as possible. The *democratic validity* was met by involving doulas and staff as equal partners (Bargal, 2008; Bradbury and Reason, 2003), rather than the researchers acting as experts (Coughlan and Brannick, 2010; McNiff and Whitehead, 2009). The *catalytic validity* (Herr and Anderson, 2005), referring to the ability of the research process to change researchers' and participants' understanding and motivate them to engage in further social action, is addressed in the participants' transformation as described in the papers and to a certain extent in subsection *3.3.2. Dialogic validity* refers to researchers' participation in critical and reflective dialogue with other researchers, met by the research described in papers C and D, and discussed with other researchers before, during, and after the research process.

3.4.3 Reflexivity

Reflexivity is particularly important in this thesis given the prominent position of social constructionism, in which the social world is conceptualized as constructed, rather than discovered during research (Alvesson *et al.,* 2008), and the notion of research being impregnated by interests, values, and biases (Van de Ven, 2007).

To Alvesson and Sköldberg (2008), reflexivity means that the researcher shows an awareness of how linguistic, social, political, and theoretical elements are interwoven in the knowledge-creation process in which empirical material is constructed and interpreted. Empirical research reflexivity then implies a certain degree of skepticism about what at first glance looks like an unproblematic reflection of how reality functions. For example, statements from focus group participants, secondary empirical material from complaint databases, or statistics of Pap smear tests, are not to be unambiguously understood (Alvesson and Kärreman, 2012; Alvesson and Sköldberg, 2008). It is also important to be aware of the importance of language and the limitations of certain vocabularies used, as well as one's preunderstanding; both of these are important determinants behind the interpretation. Empirical material does not normally point towards one direction only, but enables a variety of interpretations and results (Alvesson and Kärreman, 2012). Rather, it is proposed that studying "slices of reality" may contribute to knowledge creation that enables understanding, rather than establishes "truths," or that "opens up rather than closes" (Alvesson and Sköldberg, 2009, p. 9).

Other than the researcher herself/himself, attention is also at the research community, society as a whole, intellectual and cultural traditions, and their respective importance in a research context. Reflexivity then, means to interpret one's own interpretations, including to be self-critical and to understand why one is making certain interpretations (Alvesson and Kärreman, 2012; Alvesson and Sköldberg, 2008).

Jeanes and Huzzard (2014) argue that reflexivity is important during the whole research process – in collecting and analyzing empirical material, creating research teams, and in writing research. However, because I was not aware of reflexivity in the sense as described in this section in the beginning of my PhD, I have used it mainly in paper E and in writing this thesis summary. It has been my ambition to impregnate reflexivity throughout this thesis. However, the chapters end with a brief section of reflexivity.

3.4.4 Ethical considerations

Ethical approval was applied and approved for the complaint study (papers B, E), and applied and decided not relevant by the ethical committee for the motherhood study (paper A). The cervical cancer screening (papers C, D) started as a quality improvement initiative, so no permission from the committee was collected. Rather than the pre-research focus on ethical issues, as suggested by the sheer idea of ethical committees, I conceive ethics in social science as an ongoing process, something the researcher must be aware of prior, during, and after the actual research project. Moreover, the iterative nature of the research process complicates the idea of an approval prior to the study – indeed, in social science it may be difficult for the researcher to anticipate, and thus to plan, for the whereabouts of the project.

Bryman and Bell (2007) 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, complainants, and statement respondents were anonymously presented. However, the doulas in the focus groups are part of a rather small association. Ensuring that their identity cannot be derived from the presented information is important. Naturally, this concept applies to the complainants and respondents in the other papers too, in particular paper E, consisting of one complaint only. To prevent *lack of informed consent*, I or a colleague informed the involved actors of the purpose of collecting empirical material. However, informing the complainants (papers B, E) was not possible, primarily because the complaints could have been anonymously lodged. In the case of the focus groups (papers C, D), 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. Similarly, in paper A, the respondents were given applicable information. In particular, papers B and E dealt with some personal and sensitive information about the individuals. Therefore, the manner in which I handled the empirical material was important to preventing an *invasion of privacy*, so the complaints and descriptions in the papers were handled carefully. *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, not least through the explicit participatory stance of papers C and D.

3.5 Reflection

Rather than hiding or denying subjectivity one needs to deal with it in a reflexive and self-critical way (Alvesson and Kärreman, 2012). In order to address disparities, this thesis and its appended papers categorizes groups, which is not unproblematic. Grouping people together simply because they share gender, language, etcetera requires cautiousness because the research risks perpetuating and reinforce generalizations and typifications (Berger and Luckmann, 1966). For example, that women automatically are more caring than men, or casting immigrants as "the others," different from "us" (Tesfahuney, 1998) in addressing foreign-born inhabitants. The existence of the sheer word (woman, foreign-born) takes away focus from the individual's uniqueness. Yet I argue it is important to highlight differences between groups and the problems some groups may face. Thus, the categorization serves a higher purpose and is deemed inevitable in addressing inequities and in illuminating disparities and, based on these, to take action to improve healthcare. I hope that my research manages to problematize the social categories through the selected theories and, hopefully, to contribute to increased knowledge.

A related concern is about representation. How representative are the voices in the different studies? For example, in reaching non-participants in the screening study (papers C, D), the doulas were included in the project. As noted by Ospina *et al.* (2008, p. 428): "… whose voice is represented is generally decided by those who control the process," and indeed we chose the doulas which also imply others were excluded. Greenhalgh *et al.* (2010) stressed that the participants may also bring with them personal biases and limitations. For example, the doulas were all rather well-integrated in society, most of them spoke Swedish rather well and had employment. This may be a reason they were not able to address some barriers (such as the out-of-pocket fee)[32] that later proved to be hindering some local women from taking the test. The doulas also believed groups in which men were included, such as Swedish classes, not to be prioritized (however, men later proved important to include in information dissemination). Moreover, the staff's perspective was not elaborated or as thoroughly collected as the representatives who participated in the focus groups. Relying heavily on the voices of the doulas – both in collecting empirical material and in spreading information orally in the community – may also be seen to take away responsibilities of healthcare providers.

Moreover, it should not be understood that the complainants represent all cancer patients/relatives (paper B) or women after delivery (paper E). Because relatively few patients report formal complaints, it should be problematized whether these should at all be used in systematic improvements in healthcare, something I could have made clearer in paper B. Yet a reason to treat the complaints with caution is based on the many interpretations of the empirical material (Alvesson and Sköldberg, 2008). Initially, the complaint, or rather the situation it stemmed from, are interpreted by the complainant, followed by the staff at the hospital or committee making an interpretation when reporting the complaint (in most cases the complainant did not write it down herself or himself). I, as a researcher, interpret a complaint that has already been interpreted twice, and finally the reader.

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[32] However, a recent study in the same geographical area could not prove any statistical significant differences in participation between women who had to pay the fee and those who did not (Alfonzo *et al.,* 2016).

3.6 Chapter summary

In this chapter I have given account of my own background because it – in a constructionist fashion – is believed to influence my research. The moderate constructionist approach also brings with it that reality is always perceived through different perspectives, rather than there being a transcendent "truth." The approaches of the studies have been presented and their relation to constructionism: a (qualitative) comparative research, used to identify differences and similarities between social groups; a participatory action research approach in order to address inequities and in improving a bad situation for the better; and multiple interpretations in focusing on different perspectives rather than giving account for reality as unambiguous. This chapter has also given account for selected methods to gather empirical material and choices in analysis, as well as how research quality has been addressed in the studies.

4 APPENDED PAPERS: SUMMARIES AND COMMON THEMES

This chapter offers summaries of all five papers appended in full to this thesis. First, the papers focusing on identifying perceptions among groups – as well as disparities and similarities between different groups – are presented (papers A, B), followed by the papers inquiring how to improve healthcare in local context (papers C, D). These foci are then further elaborated in the Discussion chapter. Paper E, with its focus on the multiplicity of interpretations, ends the summaries. A subsection analyzing some common themes related to (mainstream) service management among the appended papers follow. Reflections of the papers – and the writing process – end the chapter.

4.1 Paper A: When they talk about *motherhood*

4.1.1 Purpose

This paper sought to identify perceptions of motherhood among three groups – and differences and similarities between the groups – important to recognize when developing healthcare.

4.1.2 Main results

Among the three selected groups (Somali-born and Swedish-born mothers as well as nurses at the child health centers), *motherhood* was put in relation to different aspects: The Somali-born mothers talked about motherhood as embedded in a community context; the Swedish-born mothers primarily talked about the child; and the nurses talked about motherhood in terms of the characteristics of the mother herself.

Somewhat contradictory to the above findings, child health nurses in particular expected mothers to ask for help with the children when needed. To some extent, this also applied to the responses of Swedish-born mothers. However, many of the Somali-born mothers emphasized the independence of mothers, implying that they would manage to take care of the children themselves rather than asking for help from others.

4.1.3 Contribution

Convergences and divergences in perceptions between groups should be constructively used in offering equitable access and utilization of healthcare. Doing so brings with it the potential for meeting the needs and expectations of a diversity of healthcare visitors.

This paper also suggested it is important to understand the social context, or life situations, that vary among groups. To acknowledge social context also implies awareness of normativity and stereotypes that risk being impregnated in encounters at the child health centers.

4.2 Paper B: Interpersonal complaints

4.2.1 Purpose

This paper's purpose was to investigate cancer patients' and their relatives' complaints concerning interpersonal matters in cancer care, or lack thereof. In addition, the paper also investigated differences between female and male complainants.

4.2.2 Main results

Many of the complaints included in the paper concerned lack of information from healthcare providers, and patients who experienced not being listened to. Additionally, lack of empathy and civility caused dissatisfaction, the latter particularly among female complainants. Relatives particularly complained that they did not feel included in the care process and did not feel that they were offered proper support. Most of the complaints by relatives were reported by a female relative to a male patient.

4.2.3 Contribution

This paper suggests that providers may need to enhance interpersonal skills, which includes taking the relatives into account, and being aware of gender stereotypical expectations.[33]

4.3 Paper C: When one size does not fit all

4.3.1 Purpose

Paper C's purpose was to explore how a participatory approach of inquiry may contribute to improving a cervical cancer screening program to better meet the needs and expectations of locals. More specifically, the paper investigates how different actors may work together to jointly create more equitable healthcare.

4.3.2 Main results

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. Representatives of these women were regarded as a resource for jointly creating healthcare prevention that actually reached local residents.

Through collaboration with healthcare staff, locals, civil society, and others, 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.

4.3.3 Contribution

This paper highlights the advantage of bringing in local community members' skills and knowledge into the joint creation of more equitable healthcare. However, the paper also communicates the difficulties of simultaneously carrying out a number of interventions

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[33] The contribution here deviates slightly from the one stated in the appended paper.

during an entire year and reflects on what was learned during the project. The paper also contributes to action research methodology by demonstrating how quantitative monitoring in improvement projects may benefit participatory inquiries.

4.4 Paper D: Community collaboration

4.4.1 Purpose

The purpose of this paper was to explore how community members in an area with a large number of foreign-born residents may help increase participation in cervical cancer screening programs. This paper is parallel to paper C and describes the same project. However, paper D does not cover either the entire process or the methodological considerations of participatory action research. Instead, 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.

4.4.2 Main results

The result shows that bringing in representatives of local women and their cultural-specific knowledge and skills may help to identify the barriers that hinder local 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 qualitatively analyzed using an Ishikawa diagram, a method from the quality management toolbox.

The co-creation of preventive healthcare did not stop with the input of barriers and solutions. The involved 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.

4.4.3 Contribution

The paper illustrates the benefits of involving the local inhabitants in outreach activities, but also identifying the difficulties they may experience. Further, the paper also gave account of the doulas' learning during the project, such as gaining increased confidence, having a sense of playing an important role, and acting as a bridge between inhabitants and healthcare providers. Moreover, the benefit of incorporating tools from quality management in improvement initiatives in healthcare is presented.

4.5 Paper E: Questioning the quest for evidence

4.5.1 Purpose

This paper's purpose was to illustrate the importance and usefulness of multiple and parallel interpretations in a healthcare context.

4.5.2 Main results

The three parallel theories offered distinct interpretations of the one empirical material: a woman's dissatisfaction with postnatal care. The active customer of value creation placed the focus on her activities, in which she sought to create value, with others in her network in addition to the main provider. However, it was evident in the complaint that she often had no opportunity to create value with the provider, not least due to insufficient interaction. Gender theory was used to focus on the socialized expectations and characteristics of men and women. Here, the expectations of the woman's primary role as caretaker were clear, as were the patriarchal practices of healthcare in which she was given a subordinate role. Habermas' communicative action implies an ideal situation in which all participants are offered equal opportunities to participate in dialogue. However, the complainant was not offered that, and the goal-orientation of strategic action often took place; for example, through power asymmetries and by the staff's use of difficult technical language.

In addition, by combining multiple interpretations with a hermeneutical approach, it was not just new knowledge that was gained based on the distinct interpretations provided by the theories. In juxtaposition between the distinct interpretations ("parts") and healthcare interaction ("whole"), more profound knowledge of interactions in healthcare were generated.

4.5.3 Contribution

Hitherto, qualitative research in healthcare commonly uses only one frame of interpretation, offering unambiguity. This paper highlights the importance and usefulness of multiple interpretations, and provides a rich understanding of patient–provider interaction in healthcare.

4.6 Overview of appended papers in tabular form

In Table 4-1 the papers' main results and contributions are summarized.

Table 4-1 Overview of the appended papers

Paper	Title	Focus of paper[s]	Main results	Contribution
A	When they talk about *motherhood:* A qualitative study of three groups' perceptions in a Swedish child health service context	Identifying perceptions among groups	The respondents emphasized different aspects of 'motherhood': nurses focused on the mother; Swedish-born mothers on the child; and Somali-born mothers on community	Convergences and divergences in perceptions between groups are important to identify and in offering equitable access and utilization of healthcare

B	Interpersonal complaints regarding cancer care through a gender lens		Most of the complaints by relatives were reported by a female relative to a male patient	Enhanced interpersonal skills include to take relatives into account, and to be aware of gender stereotypes
C	When one size does not fit all: Using participatory action research to co-create preventive healthcare services	Improving healthcare for groups	Collaboration among healthcare staff, local representatives, organizations, and others may be appropriate in improvement initiatives in areas with a high numbers of foreign-born inhabitants	Participatory inquiries benefit from quantitative monitoring of improvement initiatives
D	Community collaboration to increase foreign-born women's participation in a cervical cancer screening program in Sweden: A quality improvement project		Local representatives may contribute to identifying barriers, suggesting solutions, and carrying out interventions	Learning and difficulties with involving local representatives. The benefit of incorporating quality management tools in improvement initiatives
E	Questioning the quest for evidence: The application of multiple interpretations in a healthcare context	Recognizing the diversity of perspectives	*Value creation* emphasizes the active customer, creating value with the provider and others in complex networks and through relation and interaction. *Gender theory* suggests a gendered system in which men and women are socialized into having different characteristics, expectations, and prerequisites. In *communicative action,* ideal communication in which mutual understanding and consensus is the goal, not purposive and success-orientation	Multiple interpretations offer new insights by recognizing multiple perspectives. Combined with a hermeneutical approach, a rich understanding of patient–provider interaction may be provided

4.7 Common themes of the appended papers

In this section three common themes of the five papers – or four of the papers, as in the second theme – are elaborated. The first theme addresses a service management perspective on the inhabitant/patient from which the other two themes stem: a source of information as in service quality (second theme), and a resource integrator as in service logic (third theme). It is important to mention that these themes address what I call a mainstream service management perspective, where the impact of social structures is more or less absent. The integration of such structures is instead further elaborated in the next chapter.

4.7.1 A service management perspective on inhabitant/patient

Several reports and research papers address the lack of the patient's perspective and involvement in Swedish healthcare, as relative to other Western countries (SKL, 2015; Vårdanalys, 2014a). To address these challenges, improvement science will probably not suffice because it may lack focus on the patient (Bergman *et al.,* 2011, 2015a; Berwick, 2009; Lifvergren *et al.,* 2015). A service management perspective, as defined within this thesis, provides the inhabitant or patient a broader repertoire than commonly is the case in the prevailing manufacturing logic in healthcare. Below, Table 2-2 of the conceptual frame is re-focused on how the inhabitant/patients is conceived in the appended papers through a service management perspective, along with consequences in a healthcare context (Table 4-2).

Table 4-2 The inhabitant/patient in a service management perspective

Paper[s]	Inhabitant/ patient	Concept	Key components	Consequences in healthcare
B–E	A source of information	Quality	The customer's *perceptions* of technical, interpersonal, environment, and administrative quality dimensions	Increased understanding of healthcare from the patients' point-of-view, and consequently to identify and meet needs and expectations
A–E	A resource integrator and value creator	Resources	Integration of *intangible resources* (knowledge and skills) from the customer herself/himself, the provider, and other actors	The inhabitant's/patient's knowledge and skills can be used in her or his own value-creation process, but also to improve and develop healthcare for others
		Value creation	*Interaction* – particularly face-to-face – is an important enabler in value creation, including resource integration	Understand and support the inhabitants'/patients' value-creation processes and perceptions of value
		The provider	Can neither produce nor deliver value, only potential value, as in value *propositions*	Reconfigure and zoom out to reveal other actors to collaborate with

4.7.2 A source of information

In the chapter of the theoretical framework, various service quality models emphasizing quality from the customer's point of view were presented. As argued, within this thesis *quality* is constructed as the inhabitant's/patient's evaluation of quality related to the healthcare provider. Because paper A explicitly addresses a matter of concern ('motherhood') beyond the healthcare provider's direct responsibility and data collection methods were chosen that did not address the healthcare provider specifically, this particular paper is excluded from this subsection.

In a healthcare context, Dagger *et al.* (2007) developed and empirically validated a model of perceived service quality. In the model, patients assess healthcare quality based on four main dimensions: *interpersonal quality,* addressing interaction, communication and relation between patient and provider; *administrative quality,* including such as waiting time, changing appointments, integration and coordination of care; *environment quality* including tangible as well intangible elements; and *outcome quality* concerning if treatment works, feeling better, as well as the staff's expertise and skills.

In Table 4-3, examples from papers B to E are categorized depending on dimensions addressed by the inhabitants/patients. Because papers B and E build on empirical material from patient *complaints*, and the participants in papers C and D were explicitly asked to address *barriers* hindering women to take the Pap smear test, the focus in the table is on quality dimensions *unsatisfactorily* addressed.

Table 4-3 Unsatisfying quality dimensions (inspired by Dagger et al., 2007)

Paper[s]	Interpersonal quality	Administrative quality	Environment quality	Outcome quality
B	Lacking information and consideration Feeling of not being listened to Being met with nonchalance	Waiting too long for diagnosis, surgery, etcetera Poor coordination between providers	Shared wards causing lack of privacy Disclosed the diagnosis when alone, by phone, or 'in a cold way'	Physicians did not detect cancer Given an incorrect diagnosis Not getting better after surgery, treatment, etcetera
C, D	Information barriers, including language skills or technical language Lacking relationship with the one providing information	Complicated procedures for payment and re-scheduling of appointments	Unaccustomed and afraid of the situation taking the test, including sitting in a gynecological chair	Early detection of precancerous cells
E	Lacking information Conflicting information from the different staff	Lacking continuity due to different physicians Difficult to get in touch with staff and	Awkwardness during sewing due to unsure staff	Doubting the skills of staff Not getting better

	Information difficult to understand due to technical language	to make appointments		Ointment did not work, stitches popped out, and was given the wrong type of penicillin

Many sources of dissatisfaction or barriers identified in the joint empirical material of papers B to E address *interpersonal quality.* This is not surprising since paper B explicitly addresses *interpersonal* matters in cancer care, papers C and D address barriers in the cervical cancer screening *process,* and paper E focuses on patient–provider *interaction.* A common reason for dissatisfaction or constituting a barrier within the interpersonal quality dimension address information, including not being provided sufficient information (papers B, E) making the individual unsure. Moreover, despite information being conveyed between staff and inhabitant/patient the prerequisites to understand it may be absent, due to lacking language skills (papers C, D) or the use of technical or medical language (papers C, D, E).

Also issues related to the *administrative quality* were identified in all four papers. Here the multiplicity of healthcare providers, as in individual staff members (paper E) or in healthcare units (paper B) resulted in poor continuity and coordination. The *environment quality* dimension is manifested both as tangibility, such as a shared ward (paper B) or gynecological chair (paper C, D), and as intangibility, such as getting difficult information in a detached way (paper B) or a feeling of awkwardness (paper E). Despite the explicit aim of papers B and E to address interpersonal matters and interaction, the *outcome dimension* was relatively well-addressed in these papers. Here, staff's expertise was questioned due to, for example, the patient being diagnosed with the wrong illness (paper B) or provided the wrong medication (paper E). In both papers, many patients did not feel they got any better. Despite this thesis' emphasis on *interpersonal matters,* clearly perceptions of *outcome* are commonly addressed.

To sum up, evidently healthcare delivery is important to inhabitants and patients, not least interactional and relational aspects. In the next subsection in which inhabitants/patients include those other than the healthcare provider, interaction and relation have been highlighted as particularly important because they enable customers to integrate resources in their value-creation process (McColl-Kennedy *et al.,* 2012; Vargo and Lusch, 2008). However, the importance of relationship may need to be more nuanced. For example, it may be the case that relationship between staff-inhabitant is more important in a child health services (paper A) which is regularly visited from newborn until six years of age, than at the antenatal clinic (papers C, D) in which provider and inhabitant may not meet as often.

4.7.3 A resource integrator

Quality from the inhabitants' or patients' perspective, in the previous service quality section, address only perceptions within healthcare. In a service logic, the customer is regarded as active, beyond sheer provision of perceptions as in the previous. *Service* is described as the application of intangible resources (such as knowledge and skills), and consequently the active customers are supposed to integrate these resources made available to them in order to increase their well-being (Vargo and Lusch, 2008). As mentioned, in a service logic the provider can only offer *potential* value, as in value propositions from which the customer may realize value (Grönroos and Voima, 2013; Vargo and Lusch, 2008). Indeed, the provider is often only one of many actors from which the customer integrates resources (often intangible, such as knowledge and skills) in her or his own value-creation process.

Thus, by focusing on *value,* focus shifts from the provider–patient dyad (as in perceived quality in the above), to the inhabitant's/patient's lifeworld, or life situation, in which value is realized by the integration of resources from a variety of sources. For the provider, to understand the individual's value-creation process is pivotal, not least in order to identify other actors to collaborate with (Normann, 2001). Because of the multiplicity of actors integrating resources, rather than sequential (as in the value chain), value creation is regarded interactive and synchronic (Ramírez, 1999). Consequently, rather than passively waiting for value at the end of a chain, the customer is regarded as an active participant in joint value creation (Normann and Ramírez, 1993). The so-called *value star* (as a contrast metaphor to a value chain) (Normann, 2001) in Figure 4-1, visualizes examples of actors from which the inhabitants/patients in the appended papers integrate resources in their efforts to create value.

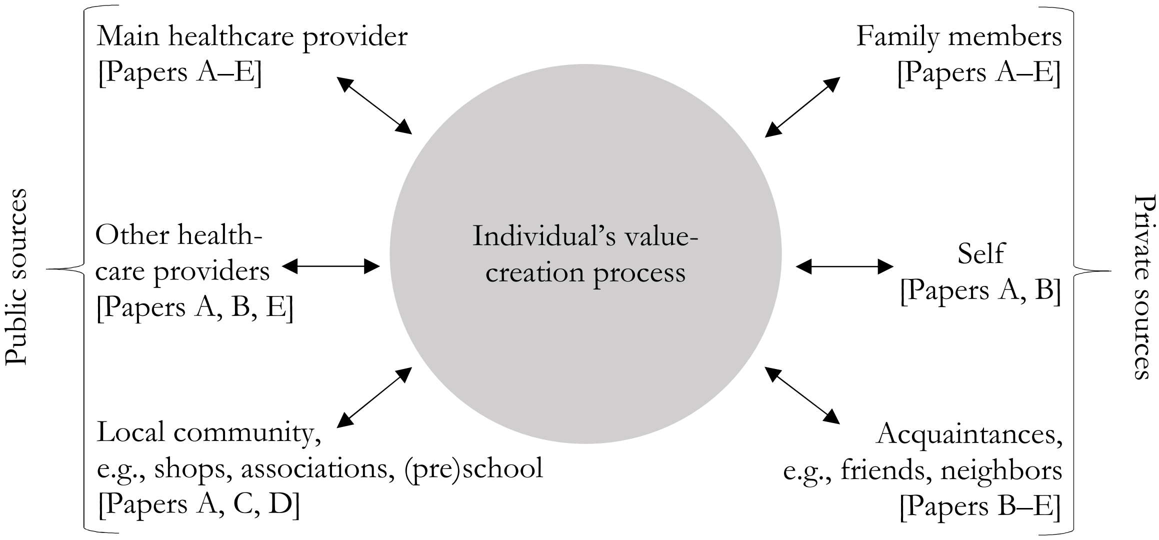

Figure 4-1 Value star based on the empirical material (inspired by McColl-Kennedy et al., 2012; Normann, 2001)

Different from Normann's (2001) value star, the arrows in Figure 4-1 go in both directions. Given the mantra from Vargo and Lusch (2008, p. 7) in which "service is exchanged for service," translating to "knowledge and skills are exchanged for knowledge and skills," I argue that not only the value-creating inhabitant or patient may benefit from other actor's knowledge and skills; these actors too may benefit from the knowledge and skills from the inhabitant/patient. In the figure, I also incorporate the private-public source division of

McColl-Kennedy *et al.* (2012) to emphasize that resource integration from both the public sphere as well as the private sphere of the individual are indeed important.

Starting with the *public sources*, and as shown in Figure 4-1, in all appended papers the inhabitant/patients have sought to integrate resources from the *main healthcare provider* in their effort to create value. These included the staff's knowledge and skills (and probably tangible resources too) at the child health center (paper A), the antenatal clinic (papers C, D), the hospital (papers B, E), or primary care center (paper B). In three of the papers, *other healthcare providers'* knowledge and skills were included: In paper A, in which the Somali-born mothers (but neither nurses nor Swedish-born mothers) argued that healthcare in general and school health are important actors with which to be in touch in their parenting efforts; in paper B other provider's intangible resources was mainly integrated when distrusting the main provider's diagnosis or expertise; and in paper E, the woman had to seek counselling help herself. In three papers (A, C, D), *the local community* was mentioned as an important source of resources. In paper A, the Somali-born mothers (but not nurses or Swedish-born mothers) rather frequently mentioned preschool, school, and work to be important aspects of their mothering. In papers C and D the impact of the local community was the most evident. Ranging from local associations, to housing, to shop-owners, these contributed with resources for women to make informed decisions.

Concerning *private sources,* in all papers *family members* have played a more or less prominent part. In paper A, child health nurses and Swedish-born mothers (but not Somali-born mothers) addressed the partner or father (and less often, parents-in-law) to be an important aspect for parenting; in paper B, relatives, typically a female family member, were identified to be important in the cancer care process as well as the complaint procedure; in papers C and D, men were interested in information about Pap smear testing – information they conveyed to their female family members; and finally, in paper E, despite being described rather passively, the boyfriend contributed in the complaining woman's efforts to certain extent. Also resources from *acquaintances* were included, such as friends to the complainants in paper B, or the doulas or community representatives themselves in papers C and D, or the neighboring midwife of paper E. *Self,* the final category of a private source[34] was identified in two of the appended papers, and addresses resources not from others but from the inhabitant/patient herself or himself. As for example in paper A, in which a mother "needs to be strong" as argued by Somali-born mothers, or to conceive the whole situation of becoming a mother as something "happy" and "satisfied" as argued by the nurses. Beyond the immediate scope of paper B, but as found in the empirical material, some patients tried to think positive and stay strong despite the cancer disease and the dissatisfactions causing the complaints.

To sum up, in all appended papers the presence of others than the individual and main provider is a fact, expanding the traditional dyad patient–provider relationship to include other actors in the inhabitant's network. Evidently, the resources from yet other public sources and private sources proved important in all papers – regardless of dealing with prevention of cervical cancer, child health promotion, or curing and caring cancer patients.

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[34] McColl-Kennedy *et al.* (2012) constructs this category as *personal* source.

Indeed, it was also evident that *whom* provided the information was important – shared background proved important in papers C and D.

To a varying degree the networked nature of value creation was evident in the studies (Normann, 2001). Naturally, in such a *zoomed out* system, not only the resources of actors other than the main provider are revealed – but also additional barriers and problems. As in papers C and D in which some practical issues – beyond the healthcare provider's immediate responsibilities – were revealed, such as unavailable childcare and potentially an economic situation hindering women from paying the out-of-pocket fee, and so not taking the test. Or as in paper E in which the physician did not understand the question about sick leave, a responsibility for both healthcare providers and the Social Insurance Agency. In the empirical material of paper B – but not included in the final paper – it is evident that many actors are concerned in the life situation of getting a cancer diagnosis. For example, after cancer treatment a woman was unable to manage the physically heavy work she had had for 36 years. The physician wrote a sick note, and because the employer could not offer other types of jobs she lost her employment. The woman was on sick leave until she lost that benefit, and then was registered at the employment office. The insurance agency is an actor that may be relevant also in other cases, for example a man and his union representative argued that he was not fully capable of working after cancer treatment, something the Social Insurance Agency had judged. Or a woman for whom the insurance agency had approved to pay for surgery abroad, but where the healthcare provider repeatedly failed to provide the necessary papers.

Moreover, with the inclusion of others comes their obstacles that may need to be taken into consideration. For example, relatives in paper B were not allowed to be involved in the care process, their well-being was not dealt with, or they had to travel long distances to participate in meetings. In addition, the community representatives in papers C and D argued that the attempt to integrate resources from others are not automatically positive. For example, they mentioned that sometimes parents or a partner could – for various reasons – want the daughter or female partner not to take the Pap smear test, sometimes by prohibiting her to do so.

4.8 Reflection

Papers B–D were written early in my PhD studies. The project for which papers C and D were written started before my PhD studies. Despite having been introduced to action research during the planning phase of the project, my knowledge must be considered to have been rather novel. I believe both the paper and the project could have benefitted from greater academic input. For example – and in a truly participatory inquiry fashion – the analysis should have been carried out *together* with the doulas. Indeed, they should have been involved in identifying the problem – Pap smear testing was already decided when they entered the scene.

Paper B was written when I had just been introduced to value co-creation ideas, and I must admit that I was rather enchanted by the ideas, and not critical enough. Moreover, merging co-creation with gender theory was more difficult than expected, and it may be argued that the results lack clarity because the ability of interpretation got weaker when merging two distinct theories. Consequently, the assumed contribution related to this particular paper has been modified in this chapter as compared to as articulated in the actual paper.

Papers A and E were written in the latter phase of my PhD, and I believe I was more critical of theories and methodologies used. Paper A was a reaction to the prevailing individualization in service research, and somewhat a retake on my own uncritical stance in paper B. Despite not elaborating on value-creation ideas explicitly, the decision to focus on an aspect beyond the healthcare provider's immediate sphere ('motherhood') here was important, given the project's continued goal of improving parenting possibilities in local context. In paper E, I sought an alternative to my previous qualitative efforts in which I had used coding and categorization of large amounts of verbal empirical material. I sensed there was a risk in relying too heavily on procedures offered by coding, at the expense of interpretation (Alvesson and Kärreman, 2012). Given my previous experience in merging theories (paper B), I believe multiple interpretations kept the clearness of each theory intact.

4.9 Chapter summary

Purpose, results, and contribution for each paper have been presented in this chapter, as well as three common themes. The inhabitant/patient concept within service management is one common theme, further penetrated in the following two themes. In perceived service quality, the inhabitant/patient as healthcare evaluator is addressed. Given the papers' foci, this thesis addresses unsatisfying perceptions, highlighting that patients and inhabitants perceive lack of interpersonal quality, but also unsatisfying perceptions of quality concerning environmental and administrational issues – and for most papers also dissatisfying perceptions of technical quality, including outcome.

Another common theme concerns the inhabitant/patient as a resource integrator. Or more specifically, from which actors the inhabitants/patients integrate intangible resources in their efforts to create value. Except for the main provider, inhabitants/patients in all papers also integrated knowledge and skills from family members, such as their support. In addition, resources from the broader community (including schools or shops) or acquaintances (including friends and neighbors) were included in four of the five papers. In some papers, resources from other healthcare providers as well as one's own resources (such as positive thinking) were integrated.

5 DISCUSSION

In the previous chapter, some common themes of the appended papers related to service management ideas were presented. This chapter extends that discussion by emphasizing the potentials of integrating social context to a service management perspective, thus addressing the thesis' purpose of increasing understanding of how a service management perspective may contribute to improvement science in addressing groups of people. More specifically, the two research questions articulated in the introductory chapter are guiding the elaborations in this chapter: (1) How do groups of inhabitants/patients perceive interpersonal aspects of healthcare?; and (2) How can group representatives contribute to locally relevant healthcare improvements? By focusing on these questions, the identified potential development of improvement science of offering the patient a broadened repertoire in the previous chapter expands to include groups of people.

5.1 Social context and service management

The common themes of the previous chapter mainly addressed a mainstream service management perspective. Such perspective is deemed to have the potential to enhance the inhabitant's/patient's perspective, argued to be lacking in improvement science (Bergman *et al.,* 2011, 2015a; Lifvergren *et al.,* 2015). As mentioned, these potentials include a move away from the notion of the passive receiver to a broadened repertoire for the inhabitant/patient, including evaluation of healthcare from her or his perspective to actively integrating resources from a multiplicity of actors. Service logic's emphasis on resources of actors beyond the immediate healthcare system (McColl-Kennedy *et al.,* 2012) is an important contribution to improvement science, which I argue should benefit from explicit inclusion of players in the broader society.

However, a mainstream perspective of service management, embedded in individualism (Nordgren, 2003), will suffice neither in addressing quality perceptions for groups of people, nor for resource integration on a collective level. As argued by Edvardsson *et al.* (2011), by ignoring the impact of social context, such mainstream ideas implicitly advocate a concept of the individual as a free actor in value creation. In a constructionist fashion, I argue that it is pivotal to elaborate on who benefits and who suffers from a mainstream service management perspective. Hence, I suggest that explicit integration of social context must be added to a service perspective, as indicated in Figure 5-1 below. Indeed, as argued by Quist and Fransson (2014), limitations to a service logic are mainly constituted of norms – rules that the actors have contributed to create and maintain themselves.

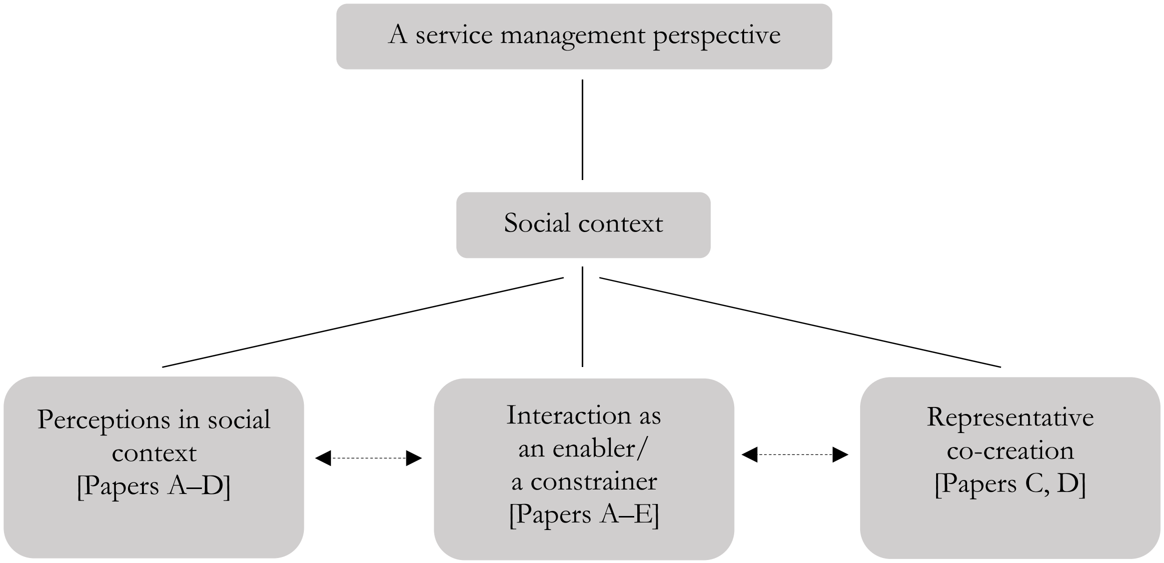

Figure 5-1 The potentials of integrating social context to service management

Integrating social context into service management extends the contribution to improvement science of the enhanced inhabitant/patient perspective – as an evaluator and as a resource integrator – by addressing groups. In such a notion disparities and similarities between groups may be identified as well as group representatives' knowledge and skills used to make healthcare more relevant for other members of that particular group. In short, a service management perspective integrating social context offers potential to identify inequities and overcome them. In this chapter these potentials are labelled *perceptions in social context* and *representative co-creation*, respectively, and will be further elaborated below. Before so doing it is necessary to elaborate on the consequences of interaction by integrating the social context, as indicated in Figure 5-1.

5.1.1 Interaction as an enabler/a constrainer

The consequences of interaction by integrating social context to service management ideas needs to be further elaborated for many reasons. In the "active customer" notion, interaction, face-to-face in particular, is emphasized as an important enabler for the customer's value-creation (Normann, 2001; Vargo and Lusch, 2008), argued to be particularly important in a healthcare context by Hardyman *et al.* (2015). This emphasis may be understood as an extension of the "service-as-contrary-to-goods" concept of production and consumption taking place parallel to (traditional) services during staff-customer interaction (Parasuraman *et al.,* 1985; Reeves and Bednar, 1994). More recent resource integration ideas follow that interaction is important not only with the main provider, but with a multiplicity of actors (McColl-Kennedy *et al.,* 2012).

Neglecting social context in which interactions take place, only the obvious may seem relevant in value co-creation, thus "[h]elpfulness, empathy, care, courtesy and friendliness are essential elements" (Tronvoll, 2007, p. 606). Adding the social context and borrowing from constructionist ideas, the enchanting notion of interaction as an enabler is not a matter of course. Indeed, interaction may be a constrainer in the individual's or group's efforts to create value. Giddens (1984) argues that social structures impact social life, both enabling and constraining inhabitant or patient interactions and actions. For example, power asymmetries between healthcare staff and patient (Maynard, 1991) could be one reason many of the complainants (papers B, E) did not perceive they were engaged in satisfactory interaction, thus experiencing lack of information; not being listened to; or being met with nonchalance, unhelpfulness, rudeness, or lack of empathy during interactions, predominately taking place face-to-face. Moreover, the use of *strategic action* – in contrast to the ideal of *communicative action* – (Habermas, 1990) through difficult technical language by staff were identified as a *potential* barrier (papers C, D) as well as an actually *perceived* barrier (paper E) to assimilate information. Literature within a service logic often omits the fact that such as power asymmetries or technical language may affect the nature of interaction. Especially in healthcare, with its traditional hierarchies (Benbassat and Baumal, 2004) and knowledge-intense nature (Fiala, 2012), not to mention vital decisions, these issues are of pressing concern.

The risk of engaging in interaction that may constrain differs between groups. Conducting a literature review, Tengelin (2013) found that factors such as having a low education level, income, or social status was negatively associated with satisfactory face-to-face encounters by patients. Other studies have found that immigrants may feel rejection in the meeting with healthcare staff in Sweden (Svenberg, 2012). Because of earlier experiences, staff, as with all individuals, carry with them normative perceptions and typifications of the patient based on gender, accent, appearance, profession, age, and so forth – which, if not reflected upon, risk being conveyed in the meeting (Dahlborg Lyckhage *et al.,* 2015). Ignorance of these factors, embedded in the social context, may result in normative and stereotypical encounters, such as women being expected to take greater responsibility in care, including the complaint procedure (paper B); male partners being neglected in the post-delivery phase (paper E); or the notion that becoming a mother should be associated with sheer happiness by some child health nurses (paper A). In the accumulated empirical material, what is revealed may be interpreted as a fragment of the gendered system, where men and women are given certain characteristics and on whose shoulders different expectations rest (Hirdman, 1988). Because individuals are not only influenced by structures but also (re)produce structures through their interactions (Giddens, 1984) – inequities may be (re)produced in these interactions.

The above suggests that not all inhabitants or patients have the prerequisites and possibilities to be active value creators because interaction is not as straightforward as commonly assumed in the service logic literature. Similar to Reijonsaari (2013), I argue that interaction is not synonymous with value being co-created. Integrating the social context, individual's demographics such as gender and ethnicity may impact information received, expectations conveyed, etcetera. Thus, interaction may serve not only as an enabler in a patient's efforts to integrate resources – it may constitute a constrainer in such efforts.

However, increased awareness of and sensitivity to such factors as normative expectations, stereotypical encounters, and use of technical jargon among providers is a start for reducing the risk of interaction constituting a constrainer. The value-creation processes of the inhabitants/patients could also be supported by providers offering information in inhabitants'/patients' native languages, opportunities for fathers to participate in the laboring process, or use of information technology including social media.

As indicated by the dotted arrows in Figure 5-1, *appropriate* interaction may enable inhabitants and patients to have positive perceptions of healthcare (including the interaction itself, as well as other aspects of care) as well as collaborate using their knowledge and skills to improve healthcare (for others). Contrary, inappropriate interaction surely complicates such possibilities. These aspects will be dealt with next.

5.2 Perceptions in social context

Perceptions of service quality were addressed in the previous chapter. Here, the concept of perception is broadened into reasoning about perceptions by bringing in the social context. In the first subsection, focus is on perceptions of groups of inhabitants/patients concerning mainly interpersonal matters, including interaction. The second subsection broadens perceptions to include people's lifeworlds.

5.2.1 Perception segmentation – within healthcare

As mentioned, marketization in society has brought with it a focus on the individual (Nordgren, 2003), expressed in such notions as the *heterogeneity* of service quality, in which performance varies from customer to customer (Parasuraman *et al.,* 1985), or that value is perceived individualistically (Grönroos, 2011; Vargo and Lusch, 2008). I argue that an individual's perceptions do not take place in a social vacuum. Rather, social context affects inhabitant's/patient's perceptions of quality and value alike. That is, perceptions may vary between groups in society (Edvardsson *et al.,* 2011).

Similar to previous research on service quality (Agarwal *et al.,* 2010; Lee *et al.,* 2011), perceptions may also be conceptualized on a group level, based on segmentation. Thus, *perception segmentation* implies that perceptions may be purposively collected for groups, to identify similarities in perceptions among group members – and differences and similarities in perceptions in relation to other groups. Such a segmentation strategy may be pivotal for identifying the perceptions of disadvantaged groups. Visualizing such disparities for groups of people is important in improving healthcare to better meet the needs and expectations of that population – and thus to increase equity.

In the appended papers, these "socially-context-impregnated-perceptions" are manifested differently. Difficulties in comprehending information about Pap smear testing due to lack of language skills were identified for some foreign-born women (papers C, D). In investigating patients' complaints, women were dissatisfied because they were not allowed to participate in the care process of a male relative more than was the case in the reverse (paper B), which was arguably a result of socialization rather than biology (Danielsson, 2010; Nameda, 2013). The suggestion that creation of value must be understood in social context (Edvardsson *et al.,* 2011) also implies a potential clash between what is conveyed by staff to inhabitants/patients. For example, in paper A, the nurses expected the mothers to work together with others, whereas this was not as commonly mentioned by Swedish-born mothers, and Somali-born mothers did not expect a mother to ask for help at all. Moreover, papers C and D revealed that the screening programs may assume the receiver of the invitations to take the Pap smear test to be familiar – as in *socialized* – to preventive healthcare. However, it was suggested that many foreign-born women could be expected not to be familiar with the test, risking failure in conveying vital information in interactions with staff. These latter examples may depend on how cultural context constructs perceptions (Abdullahi *et al.,* 2009; Comerasamy *et al.,* 2003).

In this subsection and Table 5-1 below, some examples from the empirical material are provided, suggesting that groups of inhabitants and patients in healthcare, including health promotion, prevention of disease, and cancer care, may share perceptions of interpersonal matters. Such shared perceptions are important to identify in order to improve healthcare specific to segments of the population.

5.2.2 Lifeworld-situated perceptions – beyond healthcare

Lifeworld-situated indicates a need to collect groups' perceptions of not only the provider's performance (as in service quality), but perceptions of what matters in their broader lifeworlds. By so doing, providers can get a better understanding of how they could contribute to the well-being of the inhabitants/patients and support their value-creation processes. However, and different from service quality, it is argued that segmentation is rarely mentioned in the service logic literature (Grönroos, 2006; Jüttner *et al.,* 2010; Silva *et al.,* 2013).

In paper A, what was collected may better be understood as *conceptions* rather than perceptions (Bueno, 2013), with focus on a concept ('motherhood') beyond the immediate healthcare sphere. For example, depending on country of birth, but also compared with staff, perceptions of motherhood differed between groups (paper A), suggesting that healthcare needs to be provided that is relevant for groups of inhabitants/patients given their lifeworlds. From a service logic perspective, conceptions of notions such as "motherhood" ought to be more relevant than quality aspects of the provided healthcare itself. That is, identifying what is important to groups of inhabitants in their lifeworlds may offer providers opportunities to reconfigure their networks to come up with the best possible propositions. On the contrary, evaluating perceptions of quality dimensions within healthcare only reveals little about individuals' lifeworlds. Applied to illnesses – and contrary to papers A, C, D, and E, in which the inhabitant or patient was not necessarily sick – the life situation (Quist and Fransson, 2014) of cancer patients (paper B) should be relevant to address for the provider to understand the whole picture and how their proposition may best contribute to the patient's value creation.

5.3 Representative co-creation

A central feature of a service logic is that providers cannot produce nor deliver value for individuals, because only the customer can realize value. With this comes the point that the provider may only deliver potential value, or value propositions (Vargo and Lusch, 2008). However, customers may participate in the process of developing propositions, using their knowledge and skills to improve healthcare (Grönroos 2011; Grönroos and Voima, 2013). However, previous scholars suggest that patients' knowledge and skills are not sufficiently used in the development of healthcare (Groene *et al.,* 2009; Lombarts *et al.,* 2009).[35] Because the previous subsections have highlighted that groups of inhabitants/patients may indeed share perceptions, it is important to bring in the knowledge and skills of group members, enabling improvements relevant to them.

5.3.1 The intangible resources of groups

As seen in papers C and D, value propositions may be inadequate for certain groups of individuals. For example – possibly as a consequence of a goods logic – the produced and sent out (and translated) invitations in the screening program proved faulty in reaching the local women. Social constructionist ideas imply that knowledge is created when people meet and interact, and different perspectives are brought in because of people's differences, such as cultural backgrounds (Gergen, 2009). Bringing in local knowledge and skills through the community representatives (doulas), the screening program could be improved, more locally relevant. In papers C and D, the local doulas helped generate ideas on how to improve or develop the actual value proposition. Indeed, the doulas' participation was primarily to improve healthcare for the benefit of other local women, or co-creation for others (Elg *et al.,* 2012; Witell *et al.,* 2011).

Consequently, members of certain groups may be invited to participate in the provider's development of value propositions, what I call *representative co-creation.*[36] In this concept the service logic's idea of emphasizing intangible resources, such as knowledge and skills is extended to include groups' unique knowledge and skills provided them via socially or culturally constructed processes. From the provider's perspective, a great way to offer the best possible propositions for any given group is to invite representatives from that group to co-create the proposition.

Given the networked nature of value creation (McColl-Kennedy *et al.,* 2012; Normann, 2001), the provider must realize when resources from other actors are required to be combined in a value proposition. 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 effective 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. Similarly, the recent notion of service ecosystems (Vargo and Lusch, 2016) also implies that the various actors can contribute variously in joint value propositions (Akaka *et al.,* 2013). In a healthcare context it is possible or even likely that issues under pressing concern are of such nature that one single provider is not capable of addressing the issue alone. However, use of a wide-angle lens in these instances may not automatically reveal other relevant actors. Rather, representatives' knowledge is likely to

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[35] Magnusson *et al.* (2003) suggested that involving customers in service innovation makes ideas more original and gives them a higher perceived user value. However, the authors also argued that customers' ideas are often less producible.

[36] Labelled with inspiration from *representative bureaucracy*, a concept within political science that concerns the social representativeness of the population within public administration (see e.g. Tahvilzadeh, 2011).

include knowledge of what other actors' intangible resources to include. In papers C and D, the doulas' knowledge of the specific local hair salon or kebab shop to include in spreading information would most definitely be missed if the doulas had not been included in the project.

5.3.2 Representation of whom? And why?

Starting with the why-question, it is argued particularly important to involve groups of disadvantaged or marginalized inhabitants in decision-making, participation, and consultation affecting them (CSDH, 2008; Marmot *et al.,* 2012). Borrowing from political theorists, the representation of these inhabitants is important because of *justice,* as approximately 50 percent were born abroad in the local area of papers C and D; *interest,* as the interests and needs of the locals are more likely to be addressed; and *resource,* because of the doulas' experiences they possess locally relevant knowledge and skills (Hernes, 1987; Phillips, 2000).

Then, whom do they represent? This is a more difficult question to answer. As mentioned, the doulas were relatively well integrated into Swedish society, speaking Swedish and having jobs (besides as a doula, many were studying or had additional jobs, some in healthcare). With this background, it may be argued that these women represent an "expert" community, or "better-off individuals," closer to healthcare providers than the average community members (Barnes *et al.,* 2003; Church *et al.,* 2002). However, because of their status in the local community, it was evident that many of the inhabitants had a relationship and trust in the doulas.

Indeed, the relational aspect needs to be highlighted. Customer–provider relationship is regarded important in service management, not least in order to understand the customer's value-creation process (Payne *et al.,* 2008; Vargo and Lusch, 2008). However, it may be argued difficult for providers to build such a relationship, particularly when reaching out to women who rarely, or never, attend the clinics. Therefore, the relationship already established between representatives and the locals may help to connect providers and inhabitants. Because the relationship is ongoing, the doulas were able to inform about areas in need of improvement during a long period of time. Thus, feedback was provided beyond 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.

5.4 Integrating social context to a service management perspective

In Table 5-1 I return to the areas of service management highlighted as important to healthcare in the previous Table 4-2. The current table adds the consequences when integrating the social context, as well as provides examples from the empirical material.

Table 5-1 Integrating the social context to a service management perspective

Concept	Integrating the social context	Examples in the papers
Quality	Perception segmentation: Group members may share common perceptions	Female complainants perceived civility of staff as less satisfying than male patients [paper B] Female relatives expressed dissatisfaction not being allowed to participate in care processes [paper B] Non-socialization to preventive healthcare [papers C, D]
	Lifeworld-situated perceptions: Focus on a concept beyond healthcare	Focus of *motherhood* varied among nurses, Swedish-born and Somali-born mothers: the mother, the child, respectively the local community [paper A]
Resources	Representative co-creation: The knowledge and skills of group representatives may be used to improve healthcare	The doulas possessed knowledge about barriers and solutions to Pap smear test-taking in the local area [papers C, D] The doulas' knowledge of other local actors' knowledge and skills to include in order to spread accessible information in the local area [papers C, D]
Value creation	Interaction as an enabler/ a constrainer	Enabler: Information in same mother tongue [papers C, D]; use new/old information technology, e.g. social media, films, phone [papers C, D] Constrainer: Lacking language skills [papers C, D]; complicated/technical language [papers C, D, E]; using phone to convey diagnosis [paper B]; lack of relationship/continuity [papers B, E]
	A holistic view includes not only multiplicity of actors, but also social structures, e.g. (in)formal rules	Differences in perceptions may mirror gendered characteristics and expectations in society [papers A, B, E] Nurses described mothering in 'positive' terms, whereas Swedish-born and Somali-born mothers were more nuanced [paper A] Somali-born mothers expressed that a mother should be independent, whereas nurses (and to certain extent, Swedish-born mothers) expected her to ask for help [paper A] [Un]consciously, foreign-born inhabitants may risk to be seen as 'The others,' as strange, deviant [*risk* with papers A, C, D]
The provider	Support and enable underserved groups' value-creation processes	Perception segmentation to identify group-specific barriers, representative co-creation by letting representatives improve healthcare more

		likely to address needs relevant to group members [papers C, D] Reconfiguration: Focus on lifeworld by zooming out to identify other actor's resources to include, and connecting inhabitants/patients with others [papers C, D]

5.5 A multiplicity of perspectives

Service researchers have claimed that a service logic frames a goods logic (Normann, 2001; Vargo and Lusch, 2004a). Others have argued that a variety of knowledge, or value logics, may coexist because each address various human interests (Bergman *et al.,* 2015b; Christensen *et al.,* 2009; Stabell and Fjeldstad, 1998). It is argued – and I do agree – that in the diversity of tasks labeled as "healthcare" (including prevention, surgery, palliative care etcetera) it is particularly important to acknowledge and make use of a diversity of perspectives. In papers C and D, for example, typical service logic characteristics (integrating resources from a multiplicity of actors), combined with typical goods logic characteristics (measuring output, as in number of Pap smear tests), proved positive in terms of improving the screening program in the local context. As mentioned, the studies included in this thesis mirror different aspects of "a service management perspective." For example, in paper A focus is on a concept (motherhood) situated in the broader lifeworld, beyond healthcare, where value is realized. Papers C and D put focus on the representatives' participation in improving the actual value proposition. In paper E, interaction is problematized, which is also the case of paper B, the only one of the appended papers where the patient is/has been sick.

It is beyond the purpose of this thesis to give account for what kinds of healthcare are best suited for each value logic. However, it is clear that different logics may be differently important depending on healthcare. Indeed, sometimes a value logic may benefit from being restricted to the isolated care process; sometimes a value logic needs to take the inhabitant's or patient's lifeworld into consideration. The assumption within a service logic of value always being co-created and never produced (Vargo and Lusch, 2008) needs therefore to be treated with more nuance. Indeed, in the preceding work of Normann (2001), value propositions were presented as *relieving* or *enabling*, and both are argued to be present in healthcare. In the former, the provider is creating value *for* the customer because the provider is better equipped to do it, for example concerning acute conditions or surgery. In the latter, the provider, expands the scope of what the customer can do. Here is information about health promotion or preventive healthcare included. With this reasoning, a patient is likely to experience both revealing and enabling value propositions during his or her healthcare journey – revealing during acute illness, and enabling during rehabilitation, for example. That is, value may be delivered as well as co-created (ibid.).

5.6 Reflection

Returning to different language games (Gergen, 2009), or discourses (Foucault, 1993), one may wonder whether it is at all possible to integrate the collective and intersubjective notion of "social" into a service management discourse in which concepts such as "individual," "freedom of choice," and "competition" prevail. However, the recent elaborations on service ecosystems and transformative service research offer promising potential to do so, as does the recent update of a service(-dominant) logic, in which it is argued that collaboration rather than competition is pivotal (Vargo and Lusch, 2016).

Similarly, is "proposition" at all a feasible concept in healthcare, or the public sector for that matter? Propositions imply something voluntary rather than an obligation. In the former, the healthcare provider may offer a contribution that the customer may accept or not – it is a free choice for the provider. Of note, however, is that the duties of Swedish councils and regions are not optional, but regulated by law (SFS 1982:763). In relation to this, recent elaborations – as a consequence of *all* actors being conceived as resource integrators (Vargo and Lusch, 2008) – that suggest an actor-to-actor approach on the basis of the absence of any strict division between providers and customers (Vargo and Lusch, 2011) are equally problematic.

Returning to my own perspective and preunderstanding, in this thesis and in prior work – I have been interested in equity and identifying perceptions shared within groups based on gender/sex or country of birth. And maybe that is what I have found, or constructed. It may be primarily about the *local* context in the cervical cancer screening project, and very little about where these women were born. Similarly, in the patient complaint study (interpreted numerous times, by numerous persons) a legitimate question should be: do the identified "gendered perceptions" stem from the actual situations as experienced by the complainant, the staff, by myself – or the reader?

5.7 Chapter summary

In this chapter the social context has been explicitly integrated to a service management perspective, addressing the research questions concerning perceptions of interpersonal matters in healthcare for groups of inhabitants/patients as well as group representatives' contributions to locally relevant healthcare improvements. By way of introduction, the consequences on interaction by integrating social context was elaborated, suggesting that interaction may constitute both an enabler and a constrainer in people's value creation efforts, and differently so between groups in society.

In addressing the first research question some examples from the empirical material was presented, suggesting that shared perceptions of interpersonal matters among group members are important to identify for improvement of healthcare for particular segments of the population. In addition, it has also been argued that perceptions may not be limited to inhabitants' or patients' evaluations of matters within healthcare, but to be situated in their broader lifeworlds. In addressing the second research question it is suggested that including knowledge and skills by group representatives makes improvements that are relevant to the particular group members more likely.

Stemming from the moderate constructionist position, it is argued that a service management perspective should not be regarded as an encompassing solution for all types of healthcare. Rather, a service perspective is considered one of many logics important in improving healthcare.

6 CONCLUSIONS, CONTRIBUTIONS, AND FUTURE RESEARCH

In the introductory chapter of this thesis, two areas of concern in the Swedish healthcare system were addressed: dissatisfactory inhabitant/patient perceptions concerning how healthcare is delivered, in particular interpersonal and participatory aspects; and disparities between groups in society. Stemming from these areas of concern, the purpose was to increase understanding of how a service management perspective could contribute to improvement science in addressing groups of people. In this chapter I will address the proposed theoretical, methodological, and practical conclusions and contributions of this thesis.

6.1 Theoretical conclusion and contribution

The main domain to which this thesis aims at contributing is the emerging *improvement science.* One potential aspect of improvement science development highlighted in this thesis is enhancing the patient's perspective in healthcare. Various quality models (Institute of Medicine, 2001; Socialstyrelsen, 2005) have been criticized for focusing on quality from the professional's point of view rather than the patient's (Berwick, 2009), and literature in improvement science has been posited to be operations-focused rather than patient-focused (Bergman *et al.,* 2011, 2015a; Lifvergren *et al.,* 2015). In this thesis, it is argued that ideas from service management have the potential to address this gap, offering the patient a broader repertoire than the traditional idea of the passive patient waiting for value delivery at the end of the value chain (Eriksson *et al.,* 2013).

First, in service quality, quality is judged by the patient from his or her point-of-view, not from the provider's. The patient as an evaluator and *source of information* in the empirical material of this thesis highlighted perceived dissatisfaction concerning particularly interpersonal matters in healthcare. Second, the contribution to improvement science goes beyond the patient as an evaluator. In a service logic, value can neither be produced nor delivered to the customer; instead he or she is regarded an active creator of value, including the patient as an *integrator of resources* (Vargo and Lusch, 2008). The inhabitant/patient may integrate resources (such as knowledge and skills) from others for the benefit of one's own health (for example competence of family members). In particular, improvement science should benefit from more explicitly recognizing contributions of actors outside the immediate healthcare sphere. However, the contribution of resource integration to improvement science also implies that one's own resources may be used to improve healthcare that benefits others, for example other community members.

Integrating resources from multiple actors of service management, combined with the methodological approach of action research, offers promising prospects of addressing the demands in improvement science to generate local and transferable knowledge in collaboration with various actors (Batalden and Davidoff, 2007; Marshall *et al.,* 2013). The unique knowledge and skills of group representatives should be brought into the improvements of healthcare – something particularly important for groups the provider knows little about.

The above-suggested contribution borrows mainly from what has been referred to as a mainstream service management perspective, in which the social context, social structure in particular, is not commonly acknowledged. However, this thesis aims at contributing to improvement science also by explicitly highlighting the importance of social context in healthcare improvement. In such contribution – borrowing from recent streams of service research, such as service ecosystems and transformative service research (and thus indirectly from sociologist Giddens [1984]) – it is argued that social structures need to be recognized. Such structures include formal and informal rules that affect groups of people (men or women, Swedish-born or non-Swedish-born) differently, not least in interactions with healthcare staff. However, social context also entails that members of a group may be socialized to have things in common, offering possibilities. For example, by segmenting inhabitants'/patients' perceptions disparities between groups may be identified and the need for improvements addressed. Further, in generating local and transferable knowledge, the knowledge and skills of locals should be included. However, a contribution to improvement science related to social context also involves the need to (sometimes) focus on a concept – *motherhood,* for example – beyond the immediate healthcare sphere. In so doing, knowledge that is important when improving healthcare relevant in people's broader lifeworlds may be revealed, including other actors to collaborate with in order to offer the best possible healthcare.

The thesis also contributes to *service management*, which is traditionally argued not to recognize such as social structures or the collective level (Anderson and Ostrom, 2015). Recently, service research recognizing social context has become increasingly common, although these studies are highly conceptual (Edvardsson *et al.,* 2011). Service logic research in a healthcare context is argued to be lacking (Helkkula *et al.,* 2013; Zhang *et al.,* 2015), and often the impact of social structures are left unelaborated in these studies (for example, Elg *et al.,* 2012, Hardyman *et al.,* 2015). The risk in adopting a mainstream service logic in which social context is absent is the unproblematized assumption that everybody has the same opportunities to be active value creators, and that interaction is, by definition, something positive – always an enabler in the value-creation efforts. As suggested in this thesis, possibilities and prerequisites for individuals and collectives to be active and well-informed is not a matter of course.

A service logic is yet at a rather high level of abstraction, and concreteness of *how* it may be practically applied is lacking. Therefore, this thesis shows that tools and methods often used in quality management – Ishikawa diagrams, control charts, focus groups – may be incorporated in empirical service logic research.

6.2 Methodological conclusion and contribution

Many of the papers in this thesis stem from value propositions inadequate to groups of individuals – whether dissatisfied with received healthcare or not reached by healthcare – whose voices do not receive satisfactory attention or appropriate attention. From this perspective, a conclusion is that *participatory action research* is an appropriate methodology for shedding light on inequities and improving access to resources for research participants (McIntyre, 2008). In a more general sense, this thesis contributes to using action research in healthcare, which is important not least for empowering stakeholders and including knowledge other than professional (Lifvergren *et al.,* 2015).

The experiences from the cervical cancer screening study show that presenting change quantitatively may give a mandate in a physician-led context and, not least, fuel positive energy to the group jointly struggling to improve a situation. Methodologically, the main contribution of this inquiry is from exemplifying that participatory action research projects may benefit from incorporation of tools from quality management, and measuring using numbers. Such measuring should be done and presented during the process, not only at the end as a result.

6.3 Practical conclusion and contribution

Underpinned by concepts from various domains, today inhabitants and patients are expected to shoulder responsibilities in healthcare, including such as making decisions and actively participating. However, all patients must have the prerequisites and possibilities to understand and use all the information. As suggested by the empirical findings in this thesis, including inhabitants in deciding which information to be conveyed and where to convey it may be an appropriate approach. Moreover, who delivers the information may be important. As suggested by research in other sectors, inhabitant/patient/customer involvement should be used more extensively than it is today, and this involvement may be relevant throughout the entire process, not only in the beginning or at the end (Laage-Hellman *et al.,* 2014). Similar, this thesis has provided an example of the benefit of providers to include local knowledge and skills in identifying areas of improvement, designing improvements, and in carrying them out.

As a consequence of the prevailing notion of value being produced and delivered comes that outcome measures are often predominant in healthcare. While relevant in many aspects of care, the empirical material in this thesis argues for the need to focus on inhabitants' and patients' perceptions of interactional aspects of care, important not least because interactions may both enable and constrain patients' ability to be informed and active participants. Moreover, when measuring perceived quality, segmentation should be used more than is the case today to illuminate shared as well as dispersing needs and expectations between groups in society.

The findings of this thesis also suggest that healthcare may sometimes need to zoom out of the immediate healthcare sphere. This may be achieved by focusing on a concept beyond the walls of traditional healthcare, such as motherhood. By zooming out, actors to include to offer the best possible proposition may be identified. As seen in the screening study, zooming out from the cervical cancer screening process revealed associations, shop owners, and housing to be part of increasing knowledge of Pap smear tests in the local area. In the complaint papers, family members and neighbors proved important to be included. Concerning child health services, partners, community, and school were identified by one group of mothers.

In a constructionist fashion, this thesis has argued against an either-or dichotomy (service *or* goods; biology *or* social construction; an active customer *or* passive patient). Rather, the importance of a variety of perspectives has been acknowledged. Importantly, healthcare providers and policymakers must realize there are various logics important to healthcare, what is best depends, and the skill to do variously may be the greatest challenge.

6.4 Reflection

Writing this, it has been nearly five years since I started my PhD studies. With my scholarly background in political science and with over 10 years of working experience in the public sector, I surely brought some baggage that first day at Chalmers University of Technology. As far as I can recall, most of the books in political science I had read focused on macro level at the neglect of micro level. That is one reason for my initial interest in the customer-focus principle of quality improvement, and later face-to-face interactions of service management. Eventually, I came to realize that both levels are important to illuminate, and this is something I have tried to communicate in the present thesis.

A personal reflection is that literature in political science is rather problem focused. Doing a PhD at a university of technology, I have learned to be more solution oriented. This focus may seem trivial, but it taught me to see problems differently or, to quote 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).

Finally, I have been worried that I may be perceived as eclectic, bringing in theories and methodologies from different domains in this thesis. Recently I have come to realize that the theories are not necessarily conflicting. For a long time I unconsciously argued in terms of *binaries* (Gergen, 2009) or contrasts, such as services being the opposite of goods. I think my PhD studies – in which I have met scholars, practitioners, and inhabitants with different backgrounds; taken a variety of courses; and read a lot of books and papers – has encouraged me to be less definite. One reason is that the cliché of "the more I have learned, the more I have come to realize how little I know," truly applies in my case.

6.5 Chapter summary

A mainstream service management perspective contributes to *improvement science* by broadening the repertoire of what the inhabitant/patient may do, evaluating healthcare from her or his point of view and actively integrating resources from a multiplicity of actors, often players outside of the healthcare system. Integrating the social context to service management ideas, this thesis contributes to improvement science and mainstream service management, acknowledging that structures affect individuals and collectives (prerequisites to be active inhabitants/patients) differently, which is important to consider when improving healthcare that manages diversified needs. Methodologically, *participatory action research* is appropriate in addressing such diversified needs. However, participatory inquiries would benefit from quantitative monitoring of improvements as well as incorporating tools from quality management.

Practically, it is argued that providers may need to zoom out of the immediate healthcare sphere to identify other actors important to improvement of healthcare. By so doing, locals may be identified who possess important knowledge and skills that should often be included, not only to identify improvements, but also to design and carry them out. In addition, identifying groups of inhabitants'/patients' perceptions of interactional aspects of care is deemed important, not least because interaction may enable and constrain individuals' and groups' possibilities to be informed and act differently.

Finally, a service management perspective is just that – a *perspective* that needs to be complemented and combined with other perspectives (or logics) to improve healthcare that manages current and future challenges. To handle multiple perspectives at the same time may be the greatest challenge of all. In Table 6-1, the thesis' proposed contributions are summarized.

Table 6-1 Summary of the thesis' main contributions

Area	Research field	Main contributions
Theory	Improvement science	*A service management perspective* offers patients a broader repertoire, ranging from evaluators of quality to integrators of resources (for the benefit of self as well as others) from multiple actors Integrating *social context* to service management entails that shared perceptions among group members may be identified, enabling improvements addressing such as inequities perceived by collectives. Perceptions of groups should also address inhabitants'/patients' broader lifeworlds, in which other actors relevant for the provider to collaborate with may be revealed Group members' knowledge and skills should be included in improving healthcare for members of that specific group; *participatory action research* may be a relevant methodology for so doing
	Service management	By integrating *social context*, it is revealed that interaction may enable and constrain interaction and value co-creation differently for groups of inhabitants/patients The often abstract constructions of a service logic may be accompanied by tools from *quality management*
Methodology	Participatory action research	Participatory action research aiming at improving healthcare may benefit from the tools of *quality management* and quantitative measurement of improvement
Practice	Healthcare management	The potential to better include *local knowledge and skills* at different stages such as identifying areas for improvement, designing, executing, and evaluating improvements A need to *zoom out* to identify actors where resources may be integrated to offer the best possible healthcare given the inhabitant's/patient's life situation A need to acknowledge and combine multiple perspectives/value logics

6.6 Future research

I have been fortunate to be part of a multidisciplinary environment and have received inspiration from scholars, practitioners, and inhabitants with various backgrounds. Stemming from these dialogues, this thesis has opened up numerous future research initiatives.

- It is beyond the scope of this thesis to address what kinds of healthcare benefit the most from different value logics (Christensen *et al.,* 2009). The focus of this thesis has been on a service perspective and has only superficially elaborated on other perspectives. Future research could further elaborate on and solidify different logics' relevance in local practices.
- The experiences from the cervical cancer screening study (papers C, D) have expanded to an annually reoccurring campaign one week in the spring. This (2016) fourth year, 10 of the 20 Swedish county councils participated. Future research could ask if and how the locally sensitive interventions have been transferred to other contexts. Moreover, in the local context, four years after the project, participation in the screening program remains at the same levels as during the project. Another research project could revisit the area and study post-project experiences of staff and inhabitants.
- Quality dimensions are suggested to influence customer satisfaction and dissatisfaction differently; some are *satisfiers* and others *dissatisfiers* (Kano *et al.,* 1984; Oliver *et al.,* 1997; Vargo *et al.,* 2007). This has previously been inquired in different sectors (Friman and Edvardsson, 2003; Johnston, 1995), and future research could show if and how dimensions functions as satisfiers or dissatisfiers depending on type of healthcare, and if so, why.
- Comparative research could also include interpretations. That is, analysis of the empirical material made by the researcher could be compared with analysis of the same material made by research participants. For example, in paper A, participants themselves could categorize mothers' and nurses' responses, which are interesting to compare with our own interpretations.
- It is suggested that high levels of so-called *social capital* (people's trust in other people and their participation in various institutions) correlates with a well-functioning democracy (e.g. Putnam, 1996). Further research could here inquire if willingness to participate in healthcare improvement varies with levels of social capital.
- Healthcare has been argued to be slow in adopting new information technology (Bergman *et al.,* 2015a), despite claimed possibilities of leading to more accessible and cheaper healthcare of higher quality (Christensen *et al.,* 2009). Research including information technology could ask how these tangible resources could be used for intangible resource integration, such as by connecting people (Normann, 2001). In addition, there may be potential drawbacks such as physical distance between a patient and anonymous staff (Kristensson, 2009; Quist and Fransson, 2014), important to investigate. One aspect of such research could be to investigate

economic terms[37] within the concept of value, as was included in Normann's (2001) concept of value, but often omitted in the developments of a service(-dominant) logic by Vargo and Lusch (2004a, 2008, 2016).

- In this thesis, and in service management at large, the customer's perceptions are rather unproblematically dealt with. Interviewing frontline staff, Fellesson *et al.* (2013) brought attention to customer misbehavior (deliberatively violating accepted norms of conduct), but rather than focus on individual characteristics, the authors took structural factors of the service system into consideration. Similarly, research of patient complaints could inform about patient misbehavior in social context.
- Christensen *et al.* (2009) argue that healthcare reformers in the US talk past each other because they have neither a common language nor an understanding of the problems' root causes. The Swedish public service institutions are claimed to work in silos separated from each other (Quist and Fransson, 2014). Could it be that the absence of a common language between these different institutions constitutes a barrier to collaboration? Could it be that concepts such as person- or patient-centeredness – despite important *within* healthcare – contribute to healthcare digging its own hole because the concepts are alien to other institutions? How does language serve as constrainer/enabler of improvement initiatives involving actors from different sectors?
- Service quality models typically include the customer's evaluation of both process and outcome (e.g. Grönroos, 1984). Dimensions covering the customer's perception of *participation* are often absent. Previous research (Hedegaard *et al.*, 2013) has suggested that perceptions of participation in patient–physician consultations may vary between groups. Therefore, future research could incorporate the perceived opportunities for participation among groups, assessed as *participative/involvement quality*.

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[37] An aspect explicitly embedded in the value concept of value-based healthcare, or in the words of Porter and Teisberg (2006, p. 4) in which value in healthcare is defined as "the health outcome per dollar of cost expanded."

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