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An Ambiguous Concept: On the Meanings of Co-production for Health Care Users and User Organizations?

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Abstract Neither on the level of interactions between organizations nor on the level of servicing users, co-production has a fixed meaning. It is argued that there are different meanings that unfold once one looks at the impact of narratives such as consumerism, managerialism, or participatory governance. Altogether with the traditions of state-welfare, they simultaneously influence the modes and meanings of co-production in personal services. Taking up the example of modern healthcare systems and its hallmarks in Germany, it is shown that, therefore, uncertainty and ambiguity is the normalcy rather than the exception when it comes to define co-production. Role-expectations such as the "expert–patient" or the "citizen–consumer" have a liberating potential, but may likewise marginalize issues such as trust and the need for protection. User organizations are well challenged beyond their role of helping users to cope as good as possible with given role models of co-production.

Résumé La co-production n'a de signification fixe ni au niveau des interactions entre organisations, ni à celui des services fournis aux usagers. On a avancé que différentes significations se font jour lorsqu'on examine l'impact des narratifs inhérents aux notions de consommation, de gestion, ou de gouvernance participative. Combinés avec les traditions de l'Etat-providence, ces narratifs influencent simultanément les modalités et les significations de la co-production dans les services aux personnes. En prenant l'exemple des systèmes modernes de soins et ses caractéristiques en Allemagne, on démontre que l'incertitude et l'ambigüité sont la

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norme plutôt que l'exception lorsqu'il s'agit de définir la co-production. Les attentes quant à certains rôles-types tels que celui du « patient-expert » ou du « consommateur-citoyen » ont un potentiel libérateur mais peuvent aussi marginaliser des problèmes tels que la confiance ou le besoin de protection. Les organisations d'usagers font face à des défis qui vont bien au-delà de leur role consistant à aider les usagers à s'en sortir du mieux possible étant donnés les rôles-types attachés à la co-production.

Zusammenfassung Weder im Rahmen der Interaktionen zwischen Organisationen noch bei der Dienstleistungserbringung gegenüber den Empfängern hat der Begriff Co-Produktion eine feststehende Bedeutung. Es wird behauptet, dass sich unterschiedliche Bedeutungen ergeben können, wenn man die Auswirkungen von Vorstellungen, wie beispielsweise Konsumerismus, Managerialismus oder partizipatorische Führung, betrachtet. Zusammen mit den Traditionen eines staatlichen Sozialsystems beeinflussen sie gleichzeitig die Formen und Bedeutungen der Co-Produktion bei persönlichen Dienstleistungen. Anhand des Beispiels moderner Gesundheitssysteme und ihren typischen Merkmalen in Deutschland wird dargelegt, dass bei der Definition der Co-Produktion Unsicherheit und Ambiguität folglich eher die Regel als die Ausnahme darstellen. Rollenerwartungen, wie zum Beispiel in den Fällen „Spezialist-Patient"oder „Bürger-Konsument", haben ein befreiendes Potenzial, können jedoch gleichzeitig Aspekte wie Vertrauen oder Schutzbedürfnis marginalisieren. Nutzerorganisationen stehen einer großen Herausforderung gegenüber, die weit über ihre Rolle hinausgeht, Nutzer zu unterstützen, sich bei den vorgegebenen Rollenmodellen der Co-Produktion so gut wie möglich zurechtzufinden.

Resumen Ni en el nivel de las interacciones entre las organizaciones ni en el nivel del servicio a los usuarios, la co-producción tiene un significado fijo. Se sostiene que existen diferentes significados que se revelan una vez que examinamos el impacto de descripciones, tales como el consumismo, el gerencialismo o la gobernanza participativa. Junto con las tradiciones del estado del bienestar, influyen simultáneamente en los modos y significados de la co-producción en los servicios personales. Aceptando el ejemplo de los modernos sistemas de atención sanitaria y sus características distintivas en Alemania, se muestra que, por consiguiente, la incertidumbre y la ambigüedad es la normalidad en lugar de la excepción cuando se trata de definir la co-producción. Las expectativas de roles, tales como el "experto-paciente" o el "ciudadano-consumidor" tienen un potencial liberador pero pueden marginar asimismo cuestiones tales como la confianza y la necesidad de protección. Las organizaciones de usuarios se ven desafiadas más allá de su papel de ayudar a los usuarios a hacer frente lo mejor posible a los modelos de rol de co-producción dados.

Keywords Co-production · Healthcare system · Users' roles · User organizations

Introduction

In the third sector, especially in the field of social services, co-production has become a buzzword for a set of instruments and ways of working that are meant to produce better outcomes in terms of service quality and efficiency. We understand co-production as a notion that refers to exchange relationships that include several dimensions of interaction (e.g., dialog, practical matters, and cooperation); it can relate to individual service relationships at the micro-level as well as to the links between organizations at the meso-level of the welfare system (Brandsen and Pestoff 2006; Verschuere et al. 2012).[1]

As some authors have already emphasized, as a vehicle for better, smarter, and more individualized services, co-production may play a "significant role in the renewal of democratic political systems and the welfare state" (Pestoff et al. 2006, p. 593) insofar as it calls for the democratization rather than the bureaucratization of service provision relationships, whether this is achieved through the empowerment of users or better cooperative governance of service-systems. However, faced with the whole set of definitions and interpretations of co-production, one might be tempted to ascribe it with a "cure-all potential" (Needham 2008, p. 224). As we will argue in this paper, it is useful to make a distinction between the various lenses through which co-production is seen, each of which classify different practices as co-production and ascribe a different nature to it. Perspectives on co-production relationships are colored by various background narratives such as consumerism or participatory governance. And, while all the different "flavors" of co-production claim to make service systems more effective and to focus more on end users, they nevertheless have a different impact and implications for new forms of "co-productive" service governance and user participation.

As we will argue, in a changed welfare environment, there is no dominant, coherent narrative for co-production. Owing to various changes in welfare environments—above all, the mentalities and practices of institutions, the provision and shaping of social services, their governance in mixed welfare systems and the notions of welfare users—co-production refers to a fragmented set of activities, expectations, and rationales. We will illustrate this by examining the field of health services, in general, and the German healthcare system in particular.

- The first part of this article will briefly argue that the current plurality of narratives has unfolded against a background of the waning traditional concept of preserving (health) services, in which hierarchical and paternalistic modes of service provision clearly dominate; in retrospect, one might say that something like co-production, if it ever existed at all, was in fact a synonym for "compliance" at the level of individual service provision, hierarchically ordered at the level of relationships within the public service system.
- Taking this era of "relative clarity" as a point of departure, the central second section investigates the key drivers of modernizing healthcare such as shifts toward knowledge-based services, economization, and marketization. Concepts

[1] This article is based on a chapter previously published in Pestoff and co-workers (2012). New Public Governance, the Third Sector and Co-Production, Routledge, London/New York.

of "active users" who co-produce their social services are superseding the traditional *Leitbild* of the more passive and dependent patient or welfare beneficiary. The changed environment of co-production relationships requires a new notion of the individual in the production and consumption of health and care services. In the context of the pluralism and complexity of users' relationships with social service providers (e.g., Alford 2002), the healthcare user as co-producer needs to be reassessed. Given the presence of different concepts and narratives, ranging from marketization to managed care, users, and systems are becoming increasingly fragmented and hybridized. Focusing on users, one can show how different role models take shape, such as the patient–consumer or the expert–patient. In each case, a different conception of "co-production" is relevant.

– The third section will focus on those dimensions of co-production that involve service–user relationships. It will change the level of argumentation by referring to the results of an empirical study of the ways user organizations in the field of healthcare in Germany are trying to cope with changes in practices in the system, the various types of users and concepts of reform. To what extent can they take on the role of "co-producers" who not only help patients to get what they are entitled to but also to make the best possible choices? And, to what extent does this leave room for something even more demanding—acting as *change agents*, an area where "co-production" inevitably raises questions of democratic participation?

A Heritage that Continues to Cast a Shadow: Co-production as a Question of Trust and Compliance

How can we characterize the co-producing relationships of the by-gone golden age of the welfare state (Evers 2008, pp. 229–231)? Why were they so much easier to frame? Going back to the status quo ante, one can broadly state that the embeddedness of the healthcare co-producer was less complex. Like elsewhere in Western Europe, social citizenship in Germany until the 1980s was shaped predominantly by the political–cultural context of inclusion, redistribution, and trust. For an entitled citizen (or "beneficiary"), receiving healthcare services was first of all a matter of legal claims; at the system level, the co-producer was conceived as a collective citizen participating through organizations that co-administered the institutions of the "*Solidargemeinschaft*" (Taylor-Gooby 2009, pp. 3–20), such as the system of health insurance. Within the delivery of healthcare services, however, the user as an autonomous social being was not really an issue. When it came to safeguarding "the active participation of those supposedly receiving the services" (Brandsen and Pestoff 2006, p. 496), one could by and large count on the functioning of four decisive elements:

(1) embededness in a prescriptive system of insurance financing and coverage;
(2) trust in professions;

(3) choice in terms of opting out for alternative services was seen as a privilege and reserved for the few better off; and
(4) limited knowledge of healthcare and medical issues.

At the system level as well as at the level of service provision, there was a kind of co-production as an element of interaction. However, as Alford (2009, p. 20) rightly points out, "the key point is not whether there is interaction but whether the citizen's contribution is induced by the actions or behavior of the government agency." With a strong impact of governments on traditional healthcare systems, the scope for co-production was modest or at least tightly structured. In Germany, for example, the corporatist German system was a significant force in shaping the relationships between providers and users. For the latter, who were viewed mainly as beneficiaries, full coverage of healthcare services and stable insurance membership rates were more important than freedom of choice. The trust of healthcare users in corporate actors' care has thus far been a central resource for co-production in terms of establishing a general willingness to follow the prescriptions of experts. Most of those insured worshiped equal access and universal services and relied heavily on the recommendations of experts in their choices of doctors or institutions; general practitioners transferred their patients to local specialists or hospitals without having to consult much with their patients. Hence, the main contribution of users as co-producers was to entrust professionals with their choices by proxy.

One should remember, however, that not only in Germany but also in other welfare states in Europe there has always been a small private sector alongside the public healthcare system and a minority of users that had always been used to "free choice" and different modes of "co-production" with institutions and experts. For the vast majority, however, interaction with the health system meant a kind of co-production that was embedded in dense and formalized rules and routines.

Users' limited commitment as co-producers also becomes apparent when one scrutinizes the former role models within the physician–patient relationship. As with the choice of providers, users have always played an active role in the medical treatment process. By definition, health services rely "on patients to behave in certain ways, such as resting properly and to undertake certain actions, such as taking their medicines or undergoing physical therapy" (Alford 2009, p. 1). For the type of co-production that was traditionally found here, the often-used label of "compliance" would seem rather fitting. It refers to a kind of cooperation where one side—the expert—gives the directions, while the other side has to understand and comply. Even if it is well-known that many patients rejected this role—by ignoring doctors' advices or not taking prescribed medicaments, for example—that took place in an environment of unchallenged responsibilities where the only question left was how to make co-production (defined as compliance with the instructions given by the experts) work better.

What we have outlined here is the conceptual basis of an inherited, rather unitarian model of co-production, without discussing the empirical question of the degree to which this model, based on trust in the advice of experts, hierarchy, and

compliance as well as trust in and support for public health protection has empirically lived up to its own goals and promises.

The Modernization of Social Services and Its Implications for Co-production: The Example of Healthcare

While the involvement of users in the provision of healthcare services is in principle nothing new, the question remains of why and how it has become so critical in recent decades and what has led to the increase in support for a shift from a top-down regulated health system and compliance to the advice of experts to a kind of co-production which provides for a more active role for health care users.

The more general answers are well-known and we will mention them without going into great detail. The stabilization of post-war democracies and the consolidation of welfare regimes together with the emancipation of welfare users and individualization of welfare delivery, led to a gradual increase in users' ability to cope with public services but also their expectations with regard to decent and qualitative services. Taken together, these processes have provided fertile ground for a discourse on social services including managerialism, consumerism, and participatory governance that entailed a changed perspective on users and patients in various ways (Evers 2009). As society and welfare environments have changed, the healthcare system has also been affected by new rationales.

Although we are focusing on the German case in this article, the following key drivers of modernization correspond to "global modes of restructuring health care" (Kuhlmann 2006, pp. 37–56). Each of them raises issues of co-production though in sometimes different ways:

- The shift toward knowledge-based services not only due to ongoing medical-technical progress and innovations such as the personalization of treatment processes and e-health but also due to user-oriented blueprints of health services in the light of "democratic professionalism" (Kremer and Tonkens 2006, p. 131), modes of user participation have multiplied. These developments indicate that healthcare was integrated into the logic and rationales of modern "knowledge societies" (Stehr 1994) which require the co-production of knowledge rather than the simple transfer of knowledge
- The economization of healthcare—a reform approach that weighs cost-containment and the efficiency of public healthcare services the most highly. Specifically, one can speak of restrictions placed on healthcare to make tight public funds go as far as possible. Relevant policy instruments to legitimize and ration scarce goods and services concern not only the meso-level—e.g., sickness funds and doctors that are obliged to adapt their services to capped budgets—but also the overall framework in which users co-produce.
- The marketization of healthcare—a driver that promotes healthcare as a "consumer good" by fostering competition between providers and users' choice within the healthcare system. Unlike economization policies, which inspired the need to reduce the costs of a public sector, the principle of marketization is more

about: an expansion and commercialization of healthcare services and products, a branch that cuts across the traditional lines between the public and private sectors (see also Ewert 2009). Being a co-producer in a marketized healthcare system demands consumerist behavior—i.e., making the right choices among competing healthcare services.

Insofar, as these trends are impacting on health care systems, they are first of all tending to undermine the unquestioning and one-dimensional rationale that dominated previously, as a consequence of, for example, corporatist and top-down methods of decision making and management by professional experts (the medical sciences). Market rules and market thinking, managerial and economic logics, and professional forces are competing with those of the medical professions; the previously socially protected citizen, who was treated according to the advice of medical experts, is now being asked to cooperate and invest his own money in his health, to follow medical pathways of managed care, to purchase complementary products from commercial service providers. The healthcare system is no longer part of the monolithic public sector but rather a cluster of public and private services with a great deal of room for organizations in between.

In such an environment, co-production on the part of health care users is being invited in very different ways: in addition to the old call for compliance, there is now the call for the "informed consent" to be negotiated with users that are seen as experts in their own right; in addition to the promise that welfare institutions will pay the bill, there is the hint that the users can and should act as consumers in health care markets and quasi-markets, and in addition to models and practices in which the user simply trusts the doctor of his or her choice, there are now alternatives under which citizens feel that they have to check competing offers from managed care networks. The provision of health care is being modernized as a result of the parallelism and overlapping drivers which are activating users as co-producers. They correlate to a healthcare system that is simultaneously a knowledge-based service system, part of the public sector, and a branch of the market. Users are addressed as and required to act as citizens, patients, consumers, and co-producers, all at the same time.

Within the German healthcare system, these processes of modernization have merged together into specific contexts and service arrangements. While they all share a notion of the user as a "participatory" subject, economization, marketization, and the challenges of a knowledge-based service system involve diverse and sometimes even contradictory co-production requirements. In order to illustrate the ambiguity of co-production as a concept of user involvement, we will look at two specific issues in more detail: the debate on new tariffs for healthcare insurance and the attempt to replace the traditional model of compliance in the physician–patient relationship with the concept of informed consent.

In Germany, 90 % of those insured are enrolled in the Statutory Healthcare Insurance (SHI) system. Despite universal access to and coverage of healthcare services, those insured are increasingly being challenged to co-produce their insurance coverage by choosing tailor-made tariffs or packages of healthcare services. Specifically, the abilities of users as co-producers play a key role in

making healthcare work as a social right. In light of the current healthcare reforms, SHI schemes are addressing their members more as knowledgeable, cost-sensitive, and market-savvy healthcare consumers rather than as entitled members.

While competition between SHI schemes was introduced in the early 1990s as a mechanism for cost-containment, the wooing of the insured through selective insurance contracts led to the reform of 2004. Until then, the principle has been that every insured person is to receive equal healthcare services in the case of need. Instead, the coverage of the insured person depends increasingly on the specific terms of their enrollment with an insurance company (which are hidden away in the fine print of complex contracts). The reforms gave SHIs more leeway to negotiate service packages with healthcare providers and freed them from collective contracts. The result has been the economization and marketization of insurance schemes—for instance, tariffs which reward users for the non-use of healthcare services within a calendar year or bind them contractually to certain healthcare providers or add-on insurance packages that guarantee their owners privileges such as treatments by senior physicians or coverage for complementary and alternative medicine. In all cases, the users of health insurance have to co-arrange their healthcare framework as "entrepreneurs" or even "brokers," who are required to assess their own insurance needs. Furthermore, they are required to screen the market for insurance and identify suitable offers just as, in this respect, co-producing means becoming familiar with (often incommensurable) legal clauses and contract details. Co-producers who are up to this these tasks can personalize their insurance coverage more appropriately, but those who are not could end up receiving sub-standard healthcare despite their membership of an SHI scheme.

An even more awkward position could arise in modern healthcare systems if the process of co-production is seen at the level of individual medical treatment. Here, the creeping invasion of economization and marketization—for example, through hidden financial incentives for doctors—could disturb the equilibrium of the sensitive physician–patient relationship (see Kremer and Tonkens 2006). Bit by bit, this could undermine mutual trust, the basis, and lubricant of professional–patient interaction.

A second significant change relates to the concept of "informed consent." It is based on the assumption that patients who are given "objective" information on their diagnosis and planned treatment will then be able to make an adequate decision about whether or not to use the medical interventions they are offered. Thus, co-production in the knowledge-based framework of informed consent "presumes that 'rational' decision making can be grounded on a specific type of information provided" (Felt et al. 2009, p. 88). Because this procedure does not challenge the supremacy of professional knowledge, most doctors have embraced it. The search for consensus on a routine basis, which appears to transform a patient ex ante into an informed partner, is a welcome release for professionals from the "paternalistic" responsibility of caring and protecting.

If we reconsider informed consent under present conditions, co-production becomes much more demanding. The reasons for this are twofold: first of all, decisions for or against a certain medical treatment rely on very different knowledge. As well as the different layers of knowledge relating to the purely

medical aspects—such as the appropriateness of a dental treatment—which will not vanish after ex ante information from the physician, non-medical aspects are also playing an increasing role; for instance, the link between cost, quality, and expected benefits, the opportunity to invest in private health care (services which are not covered by health insurance), or the comparison of the treatment offered by different physicians may play a role. Second the level of information is not the only issue. Patients may perceive their role as co-producers in the light of other criteria (e.g., such as how close the place of treatment is to family networks, information from informal sources), "disregarding offered formal information in their decision making and drawing on different resources instead" (ibid., p. 100). Consequently, the practice of informed consent between doctors and patients is becoming extended through the inclusion of other kinds of knowledge than medical information alone; the practice of consent seeking may also be influenced by the fact that some patients doubt professional knowledge and use their own experiences, convictions, and affiliations as a basis for decision-making, reasons that are rarely brought up in an ex ante discussion with their doctors.

The example of informed consent underlines that co-production in healthcare is unfolding beyond one-dimensional mindsets (e.g., biomedical expertise) or rather isolated patterns of interaction (e.g., the patient–doctor constellation). The whole previous system of the prescribed use of healthcare services is being submerged by the attempts of patients to navigate through the system with maps that they are required to draw themselves. With medical professionals stepping back from their former paternalistic role of deciding on the course of treatment, patients now not only have more freedom but also carry more of the responsibility for mobilizing a wide range of resources for the co-production of decision-making processes in health care. Long-standing social constructs and role models for co-producers in healthcare must be reassessed.

The Healthcare Co-producer in Complex Environments

So far, while outlining the environment of co-production in the German healthcare system, we have used the terms "user," "patient," or "insured party" more or less intuitively. However, the examples given above indicate that each of these words implies a different kind of "co-producer." The complexity of the healthcare environment described in the previous section is inscribed in the hybrid and kaleidoscopic nature of the co-producer. The identity of the co-producers is a patchwork, the defining characteristics of which depend on a combination of individual dispositions, patterns of healthcare provision, service arrangements, and different healthcare contexts. Referring once again to the examples of healthcare insurance and the physician–patient relationship, we will discuss two models of the service user that reflect this intermeshing of roles and terms in co-production: the "citizen–consumer" and the "expert–patient." While the first label reflects the impact of discourses relating to rights on choice in public services, the latter concept primarily reflects the liberal attitude in reacting to the increasingly science-based

nature of modern health services, modeling the doctor–patient relationship on the concept of a face-to-face discussion.

Taking the example of healthcare funds in Germany, co-production by citizen–consumers would ideally contribute to insurance schemes that are more efficient, effective, and individualized than standardized previous versions. As a role model for co-production, the citizen–consumer (Clarke et al. 2007) pledges both the careful use of healthcare services by solidarity-minded citizens as well as the readiness of consumers to go for the "best buy" when it comes to private insurance coverage. However, with respect to the hybridization of the rationales of the entitled citizen and the self-responsible consumer, the question of "who commands whom" becomes central. Owing to the ambiguity of service provision schemes, which come along as "opportunities" and demand knowledge from the user—or rather the mobilization of personal agency—the balancing of rationales depends on individual capabilities. In this respect, co-production means locating oneself within an area of tension, whether this is the tension between the active citizen who is able to evaluate the fine print of his insurance coverage policy independently and the passive health insurance beneficiary, or the tension between the well-informed consumer and his duped counterpart who receives poor healthcare without choices.

Once an individual is forced into a position between these poles, co-production inevitably alters its character. Utilitarian connotations of co-production, which reduce the term to its economic impact, can drive out its innovative and "value-creating" (Alford 2009, p. 18) effect. Does Alford's praise of co-production's power to create value still apply then? Once more, one's wider view of modernity may make the difference: on one hand, one can argue that economized welfare schemes, subjugated to market competition, are "value-destroying" since they lock co-producers into a utilitarian framework. On the other hand, if one views the modernization of healthcare services in a more optimistic light, value-creation in terms of co-production by citizen–consumers may trigger a process of self-assurance and self-empowerment and thus contribute to the shaping of people's social identities within complex healthcare service arrangements. According to this perspective, co-producers no longer serve abstract aims such as democratic renewal, solidarity and reciprocity, but such issues are brought into play through attempts to personalize healthcare provision.

At the level of healthcare delivery, the expert–patient and the patient–consumer can be seen as equivalents to the citizen–consumer. Once again, the old terminology, such as the classic patient, is insufficient to map the current dynamics and demands within physician–patient relationships. The old protected zone of physician–patient interaction has been altered in several ways. As discussed in the previous section, doctors face incentives to purchase services privately, while patients are involved in the negotiation of treatment plans as well as in sharing emerging costs. Being "calm and patient," then, is far from the best strategy for today's patients; doctors, meanwhile, are not only medical workers but also "citizen–professionals" (Kuhlmann 2006, p. 16) who help patients to translate the "concept of citizenship into the practice of welfare state services" (ibid.).

Classifying professionals as "facilitators" of modernity is, however, the optimistic way of viewing the processes which are unfolding. One may equally

observe that physician–patient relationships suffer from the behavior of doctors who free themselves from professional role models and switch into the role of "sellers"; other physicians may be obsessed with healthcare managerialism, such as "managed care" or "Disease Management Programs" (DMPs), and thus almost mechanically worship a balanced budget rather than professional guidelines. Users may therefore become activated through a tense situation. They may find themselves caught in a conflictual relationship, where trusting compliance is still a precondition for benefiting as a patient—the chronically ill, for example, have to adhere to strict lifestyle rules—but where, at the same time, they are permanently co-addressed as healthcare consumers and cost-bearers. For patients, being addressed by professionals in either of these ways demands profound co-producing capabilities.

This means that hybrid classifications such as the expert–patient and the patient–consumer do not refer to a relaxed intermeshing of rationales, but to a potential source of tension and conflict that healthcare users have to learn to cope with. Disposing of respective resources and competences then becomes critical. Who can provide information on the logics of evidence-based medicine, the budget-restraints that apply to a particular case or the quality of services offered that are not covered by SHI? This increasing demand for support and empowerment has been recognized as a new field of activity by insurance companies and user organizations (see next section) and has led to the emergence of new educational schemes such as "patient coaching programmes" or "patient universities" for future co-producers.

Users and User Organizations as Co-producers in the German Healthcare System

How much knowledge and competence do German healthcare users have? What are their intrinsic motivations, role perceptions, and difficulties within co-production relationships? To answer these questions, we will draw from 22 expert interviews, conducted as part of an ongoing research project with consultants working in patient organizations, self-help groups, and customer services in Germany. The empirical material, which serves as a basis, does not have the status of a quantitative survey on healthcare users' attitudes, but does indicate generalized "patterns of user behavior" as perceived by consultants.

It is obvious from the interviews that there is an emerging discrepancy between users' understanding of their own role, their actual competences and the demands on co-producers in Germany's healthcare system. Four different patterns of co-producing behavior and problems can be identified.

First, there are signs that cultural constraints prevent healthcare users from co-producing healthcare services in a knowing and self-confident way. Although they have the right to choose their doctor and switch healthcare providers freely, users are still affected by prescriptive, protective, and passivating attitudes on the part of health and welfare bureaucracies. A progressively changing healthcare environment now requires the co-creation of specific knowledge and the acquisition of competences to benefit from the healthcare and insurance systems. This is leading to an initial loss of certainty and security for most of these *well looked after users*.

With regard to the process of healthcare delivery, "Shared Decision Making" (SDM) or user involvement in managed care schemes remain "terra incognita" for most users.

Second, co-production in terms of choosing and purchasing insurance coverage and healthcare services represents a conflict for users that were socialized as entitled beneficiaries under the traditional solidarity-based SHI system, in which insurance has paid for literally every piece of adhesive tape or every journey to a health resort. Particularly, *the elderly*, who are used receiving unconditional, universal healthcare and who have paid premiums all their lives, have a strong feeling of unease regarding cost-sharing modes. Unsurprisingly, the co-payment of dental treatments and glasses, or incentives to buy extra insurance to cover some provisions out of their own pocket conflict with their personal notion of co-production in a decent healthcare system.

Third, if insurance funds and physicians adopt a partly consumerist logic, the capacity of users to "shop around" in such complementary healthcare markets becomes critical. In this respect, co-production for personal benefit means assessing one's own requirements. According to the interviewees, *younger people, who are often more healthy and market-savvy*, or more aware citizen–consumers, do much better than average people. The latter, chiefly the elderly, require "healthcare trustees" to support them in the difficult process of arranging a process and package of services that will work for them.

Fourth, a significant change in co-production patterns concerns physician–patient relationships. Patients appreciate being addressed as *interlocutors but not* as *co-responsible agents with own responsibilities*. They are still astonished if they are asked to make own complementary efforts in terms of lifestyle-changes or private investment in additional arrangements and services. This means that loyalty- and trust-based partnerships—key factors for co-production—are critical. An unintended consequence is that quite often users request healthcare services simply because a certain form of treatment is more expensive, for fear of missing out on what is available.

In conclusion, according to what professionals from user organizations reported, German healthcare users are torn between different roles. On one hand, they want to build up a trusting relationship and are ready to show compliance; at the same time, there is a growing tendency to try to become something of a self-taught expert; then again, users try to make the best buy when additional services and products are offered. Former roles, in which requests for personal agency were restricted to the task of compliance, are persistent and collide in unexpected and often unpredictable ways with the demands of modern co-production. Where the healthcare expectations and co-production skills of users were shaped during the traditional era of healthcare socialization, a relearning process will be both hard to accomplish and often frustrating. As a result, a new gap of social inequality may emerge which separates users not only with regard to their purchasing power but also increasingly according to their cognitive and practical abilities.

Co-production by User Organizations: Simple Service Providers or Also Change Agents?

Within the German healthcare system, co-production by user organizations—mainly patient and self-help groups—has traditionally served two goals: first, the creation of a sense of community between patients that share a common fate because they suffer from a (serious) disease. This role also included providing a platform for the mutual exchange of coping strategies for members. Patient affiliation to the organization also emanated from a second goal: the promotion of (alternative) blueprints for health and healthcare services. In that respect, the respective organizations have also acted as change agents, whether by promoting complementary and alternative medicine, public campaigns for new and better treatment of diseases and challenges (e.g., HIV, obesity as the new plague of lower social strata, and others).

Nowadays, user organizations are in a somewhat paradoxical situation. On one hand, collective co-production by an ever increasing spectrum of organizations, including customer services and consumer groups, is widely seen as a necessity by all actors in the healthcare system. They are part of a choir that evangelizes the knowledgeable and powerful health consumer and its organizations, and advocates a strategy of opening up healthcare to more competition and commercial practices. Since 2004, user organizations have been consultative members (without voting rights) of the "Joint Federal Committee," the highest body of the SHI system which has power of decision over the catalog of reimbursed healthcare services. On the other hand, alongside the many shortcomings, such as the overall lack of resources, user organizations may ask themselves whether they should become a consumer lobby and customer service, pursuing the ideal of the fully informed and competent consumer.

One currently finds that user organizations have a plurality of tasks. In analogy to mixed healthcare systems and multiple user identities, user organizations are also being forced to develop a hybrid profile (Brandsen et al. 2005; Evers and Ewert 2010) to respond to a complex environment. Ideally, user organizations should work in a political, consultative, and educative manner through political lobbying in the best interest of their members as citizens and prospective users. They should also provide meaningful advice and a variety of support services to actual consumers who are forced to make important decisions The twin demands of simultaneously being agents of change in a system that many see as being on the wrong track *and* acting as service-providers that help consumer–citizens to get along as well as possible within the system as it stands, are challenging user organizations in many respects, as the following insights from the expert interviews will demonstrate.

With respect to advocacy and lobbying in a healthcare system driven by public and private forces, user organizations pursue strategies that depend very much on their own position in the system. Umbrella organizations, which are entitled to join the "Joint Federal Committee," rely on the power of corporate co-governance through coalition-building with physicians and/or insurance and are able to influence decision-making processes in this way. In these cases, "old corporatism" generally prevails. However, the majority of user organizations, which have no

direct access to SHI decision bodies, choose a different approach to lobbying. For them, collective co-production could mean launching a campaign against the price policy of pharmaceutical companies by activating members online or drawing attention to perceived healthcare shortcomings in the media. According to the interviewees, an opposite dynamic is also observable, characterized by user organizations that are somehow instrumentalized by government actors with the intention of strengthening political support for special reforms such as the introduction of Disease Management Programs. In such cases of "coerced co-production" (Alford 2009, p. 22), user organizations serve as channels for the dissemination of practical knowledge (e.g., to implement the reform successfully at the level of users) and for enhancing political legitimacy through cooperation. It seems that the rewards for compliant user organizations—financial support and increased public attention—are tempting.

At the meso-level, one can find that co-production makes demands that stem from a combination of healthcare environments in terms of requests for cooperation and the division of labor and the prioritization of tasks between user organizations that makes them fit into system networks better. Consequently, experts are arguing in favor of "joined-up networks," by which they mean a healthy social ecology for organizations, in which political lobbying can be nourished by grassroots experiences—co-production as a softer means of co-optation. However, enhancing organizational profiles by building networks and promoting informal exchange between partners relies on scant resources: user organizations not only have to respect ideological differences, such as those relating to the impact of market mechanisms in healthcare, but also have to deal with the fact that they are competitors in a tough race for funds and publicity. Nevertheless, almost all the interviewees considered "being strong on all front-lines of co-production" to be an impossible task and they therefore seek to establish unique organizational features—such as lobbying, counseling, or educational services—that can differentiate them from others.

At the micro-level, user organizations have to deal with their clientele's diversity in terms of needs and competences. They have to cope with not only patients or citizen–consumers but also with individuals from different social contexts and generations who require different types of support. The heterogeneity of those seeking advice requires an "organizational elasticity" in terms of both internal policy guidelines and the range of services offered. For instance, a consultant whose specialism is dentistry—a consultation-intensive field due to permanent innovation and huge differences in quality and prices—described the two poles of its organizations' clientele as follows:

> On the one hand, I have to respond to highly educated and self-conscious patient–consumers who are seeking legal advice in order to squeeze the best out of their insurance; on the other hand, there are socially deprived people and immigrants, who do not know much about the healthcare system, care little about dental treatment and are shocked by its cost.

Obviously, each of these target groups demands very different concepts of support or "co-production" with user organizations in mixed health and welfare

systems. Experts from self-help groups reported similar experiences by identifying a growing group of smart e-users surfing for information on online forums, while, at the same time, the number of regular participants attending regular, time-consuming self-help group meetings is declining.

Coping with both ends of the clientele spectrum requires the reconciliation of two tasks: the protection of the needy, which primarily means helping them to receive basic healthcare provision, and the empowerment of those who are more capable. However, the interviews showed that forging such internal compromises may contradict the guiding principles of user organizations. Particularly, those organizations that perceive themselves as "counterparts" or "change agents" within the established healthcare system are unlikely to accept a role as an extended arm of the government, taking on a co-productive role though the delivery of services that are complementary to a challenging and difficult-to-handle medical system.

To sum up, user organizations are having to come up with answers to tough problems. First of all, they have to cope with the double role of being both a strategic partner for established healthcare actors but also a "change agent" and critic, reconciling its own blueprints for a better healthcare system with its day-to-day tasks in the current healthcare system. The diversity of types of users with different needs and expectations also has to be addressed. Finally, user organizations are having to forge alliances with like-minded user organizations.

Summary and Conclusion

In this article, we have argued that co-production is a wide notion that can take very different meanings in competing narratives. This has been shown by looking at the field of health care services and, more specifically, the German healthcare system. We have looked at the interaction between organizations in personal services and the interaction of professional providers with individual users.

There is a long tradition of hierarchical management in a public system in this area, while the co-producing role of users was restricted to what is known in medical discourse as "compliance." The development of complex knowledge-based systems, the general trend to view healthcare systems in terms of economic and managerial aspects and the increasing impact of marketization and commercial interests have, together with changing competences of the users, led to different ways of conceiving of co-production. For example, at the system level, one finds a simultaneous call for co-production in systems of knowledge-based managed care and incentives for greater competition between providers, who are forced to promote only their narrow self-interests. As far as the co-producing role of users in the system is concerned, former trust-based relationships are being challenged by addressing users as consumers as well as by concepts that see them as co-decision-makers. Although it is impossible to turn users into omnipotent healthcare co-producers and user organizations into powerhouses of multiple competences, we have pointed out that in a complex healthcare system, the "ability to co-produce" has taken on the status of a duty (rather than voluntary behavior).

We have argued, first of all, that the implications of this need for co-producing remain highly ambiguous, entailing both chances and risks. The shift toward knowledge-based services requires capable co-producers and users must therefore be provided with the tools they need to act in this role; however, users will always remain "second-class experts" in comparison to health professionals in this respect. At its best, the economization of publicly funded healthcare engages patients as cost-sensitive consumers; at its worst, users could be addressed as cost-bearers who must co-produce to receive any service at all. The marketization of healthcare equates co-production through making choices on healthcare markets, this could mean greater freedom but also being left alone as a non-expert to arrange one's own healthcare services.

Second, discussing concepts such as the citizen–consumer and the expert–patient which combine different rationales and expectations concerning co-producing roles, we have argued that many difficulties arise due to the intermeshing of such different narratives and practices. Co-production therefore requires the skillful combination of contradictory discourses and practices such as welfare consumerism and better governance by user involvement.

These new trends and environments are a challenge for users. If they are not to be burdened with sole responsibility for successful co-production, a supportive collective infrastructure that protects and empowers them in equal measure will need to be put in place. Based on interviews with representatives of user organizations in the German healthcare system, we have shown that in reality there is a large variety of attitudes, expectations and competences among citizens and users. Some correspond more closely with the older narrative of a protective system of healthcare services and of professionals with rather limited expectations of users beyond compliance. Others are much more prepared and willing to take on the expectations of a modern healthcare system concerning their co-producing role.

As we have shown, this is resulting in a threefold challenge for user organizations. First of all, they have to serve the needs of users and citizens who are basically trying to take up the challenge and make the best possible informed choices. Second, they also have to give special support and protection to the large group of those that have little chance of becoming co-producers with perfect expertise and smart consumers. However, even if user organizations do a perfect job in both of these tasks, there is the danger that they will function solely as ordinary customer services that help to make modern healthcare schemes more usable but have little say in their design and implementation. Third, user organizations are challenged to defend their status as potential change agents within the healthcare system.

At this point of the conclusions we want to turn from a summary to some suggestions concerning the future role of user organizations in a co-productive system that entails a perspective on change toward more user centeredness and democracy.

– First of all, we think that this would mean questioning the widespread ideal of users being enabled to live up to the expectation of becoming perfect experts and consumers. Professionals may see expert–patients in the light of SDM as

knowledgeable partners, willing and able to discuss diagnosis details with them face to face. However, patients themselves often define their expertise in terms of "how it feels" (Sennet 2003). Consequently, they expect a different kind of co-production where their "emotional knowledge" (being a patient that is affected by a certain disease) is taken into account in the treatment process. Beyond the task of building up the skills of users in various healthcare contexts, user organizations could also play a key role by challenging concepts of the user and co-production that, in the name of the utopia of the perfect expert patient and smart health consumer, overlook the need for frameworks and practices that offer solid social protection and a professional ethos of a similarly protective patient-support, thereby helping to re-create trust in public services and professionals.

– Secondly, given the broad range of undertaken by user organizations, from the provision of consultancy to advocacy for neglected needs and concepts for change, the user organizations have to find ways of coping better with the dilemma of "being a jack of all trades but master of none." In this respect, it seems useful that some organizations have tried to split into different organizational units responsible for different tasks. Such a process may, in addition to the creation of units, be responsible for launching campaigns with high visibility and media impact. It may also include the marketization of organizational skills and expertise that are in great demand in the competitive healthcare markets, such as providing e-health portals and telephone hotlines or assisting the invention of managed care schemes. Metaphorically speaking, user organizations may co-produce like a "Swiss Army knife" by providing a toolkit to make healthcare services user-friendly and bring transparency into emerging healthcare markets but also pushing for political change in the long term.

Healthcare users and user organizations are forced to get used to a situation where uncertainty and ambiguity are the norm and the basis for co-production rather than the exception. As we have shown, co-production takes place in a field of tension where users and organizations are urged to cope with contradictory role expectations but similarly adopt, re-interpret and subvert given role models against a backdrop of individual identities and self-construction. Here (the generation of) mutual trust is the currency that turns co-production relationships into a success, such as by tailoring healthcare services to individual needs. Conversely, lack of trust can hardly be substituted by formal arrangements and procedures. If co-production is rooted in and initiated by civil society actors, promotes community-based knowledge on health and healthcare practices and gives co-producers sufficient entrepreneurial space, the much praised term may be something more substantial than simply being another buzzword in the realm of welfare production.

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