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Dis/value in co-production, co-design and co-innovation for individuals, groups and society

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IMPACT

The traditional public service ethos needs to be challenged by including citizens/users in developing and improving public services. However, the often one-sided positive accounts of co-production, co-design and co-innovation risk public managers and policy-makers involving citizens/users when it may be inappropriate and/or cause more harm than good. This article explains these ‘co-concepts’ and suggests how managers and policy-makers should balance the positive with potential negative (disvalue) aspects to enable a more useful practice of citizen/user involvement.

ABSTRACT

Citizens may seek to co-create value during interactions with the provider (co-production), by contributing with improvements of existing services (co-design), or by inventing new services impacting the overall service system (co-innovation). Three empirical cases from Sweden and the UK suggest that disvalue is as likely an outcome as value creation, and that both outcomes need to be recognized at three levels: for the individual citizens themselves, their peer groups, and the broader society. The article contributes to the literature by questioning the assumption that value is inevitably created by theorizing and providing empirical cases that recognize disvalue to be an equally likely outcome in attempts to create value.

KEYWORDS

Co-design; co-innovation; co-production; disvalue; public value creation

Introduction

Among many other concepts (not least an abundance of governance concepts), two streams of literature have addressed some of the alleged shortcomings of New Public Management (NPM): public service logic (Osborne, 2020) and public value management (O’Flynn, 2007). Value is a central concept in both streams. In public service logic, the user is regarded as an active co-creator of value through their actions in co-production, co-design and co-innovation (Osborne et al., 2016): concepts that are gaining in popularity (Bovaird et al., 2019). In public value management, emphasis is on creating value that addresses collective values, rather than value of the individual user (Meynhardt, 2009). Like previous research (Alford, 2016; Eriksson & Nordgren, 2018), we argue that the concept of public value needs to be taken into the account in developing a public service logic, not least to emphasize the risk of value being disvalued at different levels across the public service system.

As recognized by previous scholars (Dudau et al., 2019), the number of ‘co-concepts’ seems to be increasing but with limited clarity—particularly when referring to co-production and co-creation, which are often confused (Voorberg et al., 2015). Co-production, however, has had a long tradition in the public administration literature (for example Ostrom, 1972; Percy, 1978), whereas co-creation has gained increased attention during the last decade; it began in the private sector (Brandsen & Honingh, 2018; Strokosch & Osborne, 2020) and is seen as ‘the new kid on the block’ in public administration and management (Ansell & Torfing,

2021, p. 211). Co-creation is generally conceptualized as broader than co-production, which has traditionally focused on service delivery, whereas co-creation includes planning and design phases (Brandsen & Honingh, 2018). Hardyman et al. (2015) understand co-production as one of the many activities within co-creation. However, a broader definition of co-production includes all phases in the policy cycle (see, for example, Nabatchi et al., 2017). Co-production may be understood to focus more on the public employee–user interface, whereas co-creation focuses on complex public service ecosystems that include various actors (Eriksson & Hellström, 2021). However, some literature elaborates on co-production in the context of interorganizational arrangements (Sancino & Jacklin-Jarvis, 2016). Within public service logic it is commonly argued that co-production entails a linear goods manufacturing logic, whereas co-creation entails an interactive and dynamic logic in which relationships are central (Osborne, 2020).

Different theoretical strands (for example public value management, collaborative governance, strategic management) need to be brought together and synthesized to support co-creation of public value in theory and practice (Torfing et al., 2021), not least collaborations through digitalization (Meijer & Boon, 2021; Rösler et al., 2021). Ongaro et al. (2021) emphasize the importance of connecting strategic management (for instance public value management) to value co-creation. Specifically, governments across all levels need to take on a strategic intermediation role by facilitating and orchestrating interactions and collaborations among actors.

The purpose of this article is to contribute to a more balanced understanding of the value concept more generally in the public management literature and specifically in public service logic. We agree that the overly positive concepts of value creation need to be ‘disenchanted’ (Dudau et al., 2019) by addressing value destruction (Järvi et al., 2018) and disvalue (Cluley et al., 2021). Moreover, we seek to show how value may be both created and destroyed in three specific co-concepts. We draw from three cases in a healthcare context in the UK and Sweden. By doing so, we address the need for empirical research on public value, as well as focusing on disvalue (O’Flynn, 2021). We propose a model of vertical and horizontal value creation/disvalue (see Figure 1) in which the vertical level addresses the value that may be created or destroyed/disvalued at the individual (for example patient), the group (for example minority group), or the societal level. The horizontal level addresses three types of co-creation that may contribute to the creation or destruction/disvalue in different ways: co-production that occurs during the service meeting, co-design of the service, and co-innovating the service system. Because the positive aspects of value are often taken for granted (Cluley et al., 2021; Dudau et al., 2019), the focus of this article is on disvalue in relation to these vertical and horizontal dimensions.

Literature review

Disvalue

The literature on (public) value creation largely focuses on the positives, assuming value to be created (Cluley et al., 2021; Dudau et al., 2019; Ongaro et al., 2021). There is little evidence, especially in a public sector context (Engen et al., 2021), that beneficial outcomes should be assumed (Brix et al., 2020; Fox et al., 2021; Steen et al., 2018; Voorberg et al., 2015). Even if benefits, such as efficiency, are not reached, co-creation and co-production are often argued to be important ends in themselves—not least for democratic purposes (Voorberg et al., 2015). Steen et al. (2018) propose seven ‘evils’ that require further research: the deliberate rejection of accountability and responsibility of governments; failing accountability and unclear roles between public, private and third sector actors; rising transaction costs of involving citizens; loss of democracy by challenging representative democracy and professional expertise; reinforced inequalities by attracting those citizens already better off; implicit demands on citizens to ‘pay back’ to providers by participating in co-production; and co-destruction of public value—this last point is central to this article.

To balance this overly positive narrative, the literature recognizing and addressing the negative aspects is growing. Several terms have been used for this, including the ‘destruction of value’ (Robertson et al., 2014) or ‘disvalue’ (Cluley et al., 2021). Similarly, to Hartley et al. (2019, p. 276) public value ‘can be lost and displaced as well as created’. The explanation of each of these terms may differ slightly. For example, disvalue may be caused by one actor alone (the prefix ‘co-’ is not needed) or jointly (the prefix ‘co-’ is needed) during provider–user interactions (Echeverri & Skålén, 2011) in which both parties contribute

equally to the value destruction process (Prior & Marcos-Cuevas, 2016).

Destruction may occur when an actor misuses their own and/or other actors’ resources by acting unexpectedly or inappropriately from the other actors’ perspective (Plé & Chumpitaz Cáceres, 2010). Staff in public service organizations may misuse their intangible resources, such as skills, knowledge and expertise, for example by performing a surgery unsuccessfully (Olsson, 2016). Even though misuse may often be accidental, it may nevertheless lead to destruction of well-being for the user (Plé & Chumpitaz Cáceres, 2010). For instance Engen et al. (2021) identified four causes of value co-destruction in the public sector stemming from accidental misuse of resources conducted by one or both actors involved in resource-integration processes: inability to serve; mistakes; lack of transparency; and lack of bureaucratic competence. Value may also be destroyed through intentional misuse of resources (Plé & Chumpitaz Cáceres, 2010). For example, increasing stress levels of employees by enforcing shorter hospital visits, which may be at the expense of patients’ well-being (Loodin & Nordgren, 2014), resulting in value destruction for the users, but value creation for the provider as they are more efficient and productive.

Destruction of value may also result in resource loss (Smith, 2013), in which lost esteem and self-efficacy and disempowerment may be due to an unsatisfying interaction, insufficient or contradictory information from different providers or staff. This type of not knowing may hinder users from using their resources and from gaining further knowledge, which, in turn, obstructs the possibilities for users to become involved in activities associated with value co-creation, including co-production/co-design/co-innovation, sorting information, or self-care and so forth (Olsson, 2016). Relationship benefits to staff may also be lost because misuse of resources by providers, for example by changing staff for each appointment, that complicates the relationship-building process with the provider. Value destruction may occur both in terms of process (unsatisfying interaction), as well as outcome (inadequate outcomes, such as health or well-being) (Robertson et al., 2014).

It is also important to clarify levels of analysis concerning co-destruction (Kinder et al., 2022). Much attention is typically on the provider–user interface as Osborne et al. (2018, p. 24) notes: ‘co-production is not a normative good—it has the potential to lead to the co-destruction of value as much as to its co-creation’. This is of course true from other perspectives or interfaces. From the staff perspective, Järvi et al. (2018) identified eight antecedents to value destruction: absence of information, insufficient levels of trust, mistakes, inability to serve, inability to change, absence of clear expectations, customer misbehaviour, and blaming. Focusing on business-to-business, but applicable also in a provider–user sphere, Chowdhury et al. (2016) identified tensions associated with value destruction caused role conflicts, role ambiguity and misunderstandings between firms, opportunism (that to certain extent is expected by involved actors) and power plays to mobilize resources and influence network actors to adhere to objectives related to value co-creation.

Engen et al. (2021) note that value may be created and destroyed at three different spheres of the resource

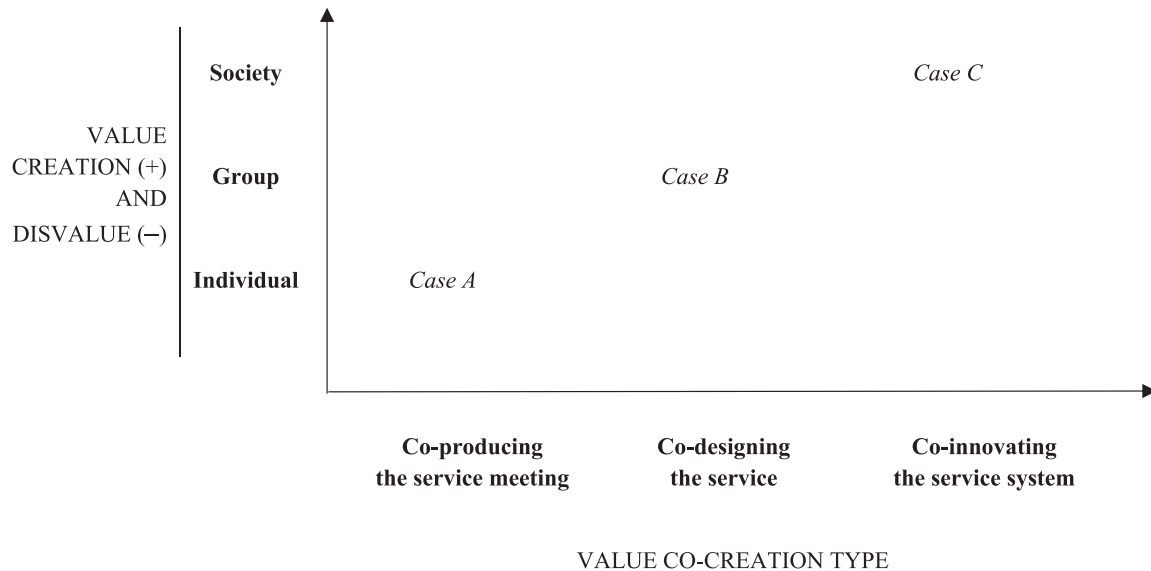


Figure 1. Model of horizontal and vertical value creation and disvalue.

integration process: the provider sphere, where the value proposition is produced; the joint sphere, where the provider and user interact directly; and the user sphere, where the user is realizing value by combining resources from themselves and others. However, both co-creation and co-destruction of value are embedded in service ecosystems and, consequently, a multiplicity of actors—not only provider and user—may contribute to the creation and destruction of value (Engen et al., 2021). In service systems, given their level of complexity and unequal distribution of power, outcomes are not automatically positive but, instead, value can be created for some and, at the same time, destroyed for others (Rossi & Tuurnas, 2021). Value co-destruction also occurs in gaps between parts (for example public organizations) or phases in the service system (Echeverri, 2021). However, this type of value destruction often refers 'to closed systems, in which a negative response by service users do[es] not stimulate change by other system agents. In an open system, individual system faults or generalized system failures will result in actions by other system agents to improve' (Kinder et al., 2022, p. 24).

Public service logic: three co-concepts

A central feature in public service logic is the emphasis on relational and interactional aspects between the customer and the provider in value co-creation (Hardyman et al., 2015), which is often referred to as 'moments of truth' (Normann, 2001). Indeed, because a service (different from goods) is almost always produced and consumed at the same time during a service meeting, the staff–user interactions, the experience and outcomes of a service are inevitably *co-produced* (Normann, 2001). Co-production in this sense differs from the traditional definition in the public administration literature (Brudney & England, 1983; Ostrom, 1996) which has focused on the delivery phase, with co-production viewed as a voluntary practice. Interest in co-production among contemporary public administration and management scholars has increased (Jakobsen et al., 2019), not least due to the claimed benefits

at different levels, ranging from individual to public (Andersen et al., 2020; Sancino, 2016). A focus on service delivery is still favoured by some scholars (for example Brandsen & Honingh, 2018; Voorberg et al., 2015). Most, however, seem to emphasize that co-production may occur at all stages of the policy cycle: planning, improvement/design, delivery, and assessment (for example Jakobsen et al., 2019; Nabatchi et al., 2017). Consequently, co-production is not restricted to interactions between the provider and the user but could potentially include large numbers of employees and citizens (Munno & Nabatchi, 2014).

The elaborations of the public service logic expand the involvement and engagement of the user to 'occur at all phases of a (public) service lifecycle' (Osborne et al., 2013, p. 142). Naturally, this could include various activities. Often mentioned is the importance of sharing information about experiences and expectations of the service (Osborne, 2020). A common example is the user's involvement in improving design and delivery of services. This is referred to as *co-design* in public service logic (Osborne et al., 2016).

In contrast to co-designing existing services, *co-innovation* refers to the user's involvement in developing new services within the service system (Osborne et al., 2016). Indeed, users as drivers of innovation have gained increased attention in public management literature (Simmons & Brennan, 2017). Whereas, co-design and co-innovation are voluntary in that the user/citizen can choose to become involved (or not) in design and innovation, the public service logic's version of co-production is involuntary and unavoidable as it takes place in the service meeting (Osborne et al., 2016).

Public value management: three levels of value

The last decade's elaboration on the value concept (Moore, 1994) within the public management field is largely a reaction to NPM's customer focus, customer satisfaction, and customer orientation (O'Flynn, 2007). The NPM view on value has been criticized to provide a too narrow focus on

the individual user's perception of value, often an insufficient perspective for public services that require also various collectives' perceptions of value (Alford, 2016; Bozeman, 2007).

Value on a common, societal level, often addresses areas such as 'public interest' or 'common good' (Beck Jørgensen & Bozeman, 2007; Bryson et al., 2022). To an extent, these are decided by citizens collectively, often through elected representatives (O'Flynn, 2007). However, public value should not be restricted to democratic procedures, but (re-)created in every social context (Meynhardt, 2009). Therefore public value should not be confused with individual users' aggregated value common in NPM (Alford, 2016).

Public values also include areas such as user involvement and citizen engagement and, in this sense, address the individual level of value (Beck Jørgensen & Bozeman, 2007). In addition, it is suggested there is a middle, intermediate level; that there is value at a group level which is often neglected (Eriksson & Nordgren, 2018). The group level of analysis is highlighted in particular streams of service research (transformative service research and consumer culture theory) that emphasize the importance of understanding experiences and expectations of value at the group level (family, community, patient group as well as based on gender, ethnicity and so forth) and the group's impact on how the individual may perceive value (Anderson & Ostrom, 2015). The focus is how members of specific groups may co-create value together and/or in interaction with authorities and other actors in society (Arnould & Thompson, 2005). Specifically, value at this level often addresses things such as health and well-being for the group, their access to public services, literacy and lack of discrimination and are often used to identify differences between groups and to target those most deprived (Anderson & Ostrom, 2015). Vanleene et al. (2020) highlighted that the different roles that public employees may take on during co-production with citizens may support the focus on communal values or personal value differently. It is often suggested that co-production may lead to co-creation of public value (Bovaird & Loeffler, 2012). However, the different levels and actors involved and concerned by public value causes conflict related to various public value dimensions that co-production cannot easily balance (Jaspers & Steen, 2021).

Public service organizations therefore need to address not only value for individuals or society, but also the group level. Balancing value between these three different levels is a delicate task not least because they may be at conflict (Alford, 2016). According to Hartley et al. (2019, p. 277), leadership in relation to public value needs to be better studied, not least in pluralistic contexts housing 'different publics with different interests, goals and different senses of the public value to be created'. For instance prioritizing access to healthcare services based on need may require some individuals to wait (Loodin & Nordgren, 2014).

It is argued that the original elaborations on public value by Moore (1994) are rather managerial, like NPM, and that a broader society needs to participate in creating public value (for example Bozeman, 2007). Lately, Bryson et al. (2022) suggest that, for social transformation leadership that involves a multiplicity of actors seeking radical innovations, a change in power relationships is required. Brown et al.

(2021) also identified power relations as important in understanding public value.

Method

In this section we explain how data were collected and analysed from three cases. These cases exemplify that value is not only created but also disvalued/destroyed (Cluley et al., 2021; Dudau et al., 2019) at three different levels: individual, group and society (Eriksson & Nordgren, 2018). Moreover, each case exemplifies a co-concept used in public service logic (Osborne et al., 2016): co-production, co-design and co-innovation.

Setting

This case-based research includes three cases—one set in the UK and two in Sweden. The cases were chosen because they represented different forms of user/citizen involvement (co-production, co-design and co-innovation) and focused on different levels of dis/value (individual, group and society). For context, we provide an outline of the healthcare systems in which the cases are embedded.

In the UK, the National Health Service (NHS) is the umbrella term for the four health systems of England, Scotland, Wales, and Northern Ireland. Health has been a primarily devolved matter since 1999 when powers were transferred to the Scottish parliament, Welsh parliament (Senedd) and the Northern Ireland assembly. There are essentially two different models of governance (Bevan et al., 2014). In England, the NHS is described as acting more as a public insurer, funding commissioners to contract with 'any qualified' provider, and with patients empowered to exercise choice in a system in which 'money follows the patient' (Bevan et al., 2014). The health services in Scotland and Wales are more like traditional state monopolies run by organizations funded to deliver care to their local populations (Longley et al., 2012; Steel & Cylus, 2012); arguably, this also applies largely to the healthcare system in Northern Ireland (O'Neill et al., 2012). All nations of the UK have pledged that user involvement will be central to the reform and delivery of healthcare services—for example, as part of the NHS long-term plan, personal health budgets were introduced in England (NHS England, 2019) as one of the ways to personalize care. These personalized budgets were introduced to increase choice and control over how NHS resources are allocated in order to meet the health and wellbeing goals of the individual. In Wales, Prudent Healthcare was adopted by the Welsh Government in response to the challenge of improving healthcare during times of austerity and rising demand (Addis et al., 2018). It has since become a major strategy for the Welsh Government to deliver healthcare which fits the need and circumstance of service users and actively avoids ineffective care that does not benefit the patient (NHS Wales, 2014). One of the four prudent principles is having public and professionals as equal partners through co-production (NHS Wales, 2014).

The Swedish healthcare system is decentralized. The national government and its agencies provide recommendations and guidelines to the 21 regions and 290 municipalities. The regions are responsible for providing specialized care and primary care to citizens and the

municipalities responsible for elderly care in specialized facilities or, increasingly, in their own homes (for example SFS, 2017). All three levels—national, regional and municipal—have their own elected politicians. Services at the regional and municipal levels are largely tax-financed, but there are also out-of-pocket fees and national grants. During the 1990s particularly, Swedish healthcare underwent several reforms. To improve the alleged inefficient and costly healthcare sector, marketization and competition became commonplace (however, this varied between the sovereign regions and municipalities) between public, private and third sector healthcare providers (for example Blomqvist & Palme, 2020). In recent years, the focus has been on equitable healthcare addressing vulnerable groups, on increasing patient-centredness and on disease prevention and promotion of health (Eriksson & Hellström, 2021).

Data collection and analysis

The three cases were selected using purposive sampling (Patton, 2002) with the aim of including information-rich cases to illustrate the phenomenon of interest in a resource-efficient way. The respondents were also purposively sampled, focusing on people with a deep knowledge of values and citizen involvement. In some instances, snowball sampling was used, identifying potential respondents suggested by other respondents (Bell et al., 2017).

The purposive sampling strategy was implemented by the action research approach with researchers getting involved with the healthcare staff, organization representatives, and users/citizens in the research process. This closeness to respondents enabled access to respondents, as well as being able to understand which actors possessed specific knowledge and skills (Coghlan & Brannick, 2014). Another key feature of action research is to change unsatisfying situations for the better (Reason & Bradbury, 2008). In our cases, involvement with healthcare employees, patients and other actors were essential to improve the respective healthcare or welfare services or systems (McIntyre, 2008). When the research was carried out, none of the authors were working directly in healthcare, and were therefore able to occupy the role of the outside action researcher (Coghlan & Brannick, 2014). We were able to bring knowledge and skills of systematic inquiry and analysis, as well as pattern recognition, to the collaborations with practitioners and community members who contributed with their knowledge of the specific setting and situation (Elden & Levin, 1991). Case A involved patients, relatives, patient volunteers and healthcare staff; case B involved representatives of immigrant women and healthcare staff; and case C involved patients, relatives, politicians, healthcare staff and managers, municipalities, and national agencies. Because of the closeness between researcher and practitioners, as well as the efforts to contribute to change, neither objectivity nor impartiality are claimed by action research (Christie & de Graaff, 2017). Instead, reflection is an essential aspect of action research focusing on areas such as how collaborations and interactions work and whether any changes took place (Reason & Bradbury, 2008).

Case A was a pulmonary rehabilitation programme for respiratory patients in one region of the UK. Data were

collected using semi-structured interviews with patients, relatives, patient volunteers and healthcare staff and three patient workshops were held to review and redesign programme information. Case B was a cancer prevention programme among a vulnerable group in a large Swedish city. Data were collected through semi-structured focus group interviews as well as observations, diary notes and statistics collected during a two-year period. Case C was a new patient-led support centre for cancer patients in Sweden. Data were collected through workshops with patients, relatives, politicians, healthcare staff and managers, municipalities and national agencies focusing on needs, being ‘affected by cancer’, and solutions, as well as semi-structured interviews.

The qualitative data were analysed using a similar inductive approach in all three cases with a form of content coding (Hsieh & Shannon, 2005). Codes were derived after listening to recordings and reading transcriptions and were sorted into categories based on similarities and differences that were then clustered into themes (Miles & Huberman, 1994). The results of the analysis of the three cases were discussed and compared by the three authors and then analysed.

Findings

Case A patients had been referred to a pulmonary rehabilitation (PR) programme. First, it was necessary to understand the existing care pathway for respiratory patients, for example a referral from a general practitioner (GP) to a specialist outpatient clinic and support in the community. After interviewing staff and patients, it was possible to map the patient journey and identify key issues, such as the levels of completion and ‘did not attend’ rates for the PR programme. It was evident from the analysis of the early patient interviews that the patient information available for the PR programme did not meet their needs. Over a nine-month period existing PR patients were invited to attend a series of workshops, along with some of the PR team to coproduce new information leaflets. Staff and patients working together were able to produce new information sheets that were made available on the website for patients and healthcare professionals to use. A second intervention of introducing patient volunteers to assist with meeting and greeting patients at the PR programme was also implemented. The volunteers provided social support to patients and assisted staff with organizing refreshments and administration. Three months after both interventions had been introduced, a review of the data showed an increase in completion rates of the PR programme. However, the did not attend rates remained the same. Additional research has commenced where patient volunteers are providing PR information to respiratory inpatients that are referred during their hospital stay to attend PR.

The point of departure for case B was low participation rates in a cancer prevention programme in a community with a large number of immigrants. Almost half the population in this segregated area of one of the largest Swedish cities had been born outside Sweden. To try to increase participation in the cancer prevention programme, existing information had been translated to several languages, but with no improvement. Instead, the residents

involved in a local association for immigrant parents were invited to co-design the prevention service. With their local and cultural competence, the programme was designed to better target the patients' needs and expectations (in particular the many foreign-born inhabitants). For one year, the locals identified barriers to participating in the programme, as well as solutions. The solutions were launched to the public for one year and were continuously changed and updated. Measures included co-designing immigrant women's participation in outreach activities in communicating information, often together with healthcare staff, information on the internet, the radio and other public places. Participation rates in the programme increased by 42% during the intervention year.

Case C focused on people affected by cancer. Swedish cancer care scores relatively well concerning survival rates compared with other Western countries (Eriksson & Hellström, 2021), but cancer patients often face challenges when their hospital treatment finishes. Before this study, there was nowhere for these people to turn to for emotional and social support. To address these unmet needs, a number of innovation workshops with different themes were held with a broad range of participants impacted by cancer. Relevant stakeholders were identified by using a 'life-event perspective': the life-event of getting a cancer diagnosis. Patients and relatives witnessed a fragmented welfare system during their life-event. Relevant resources were identified but they were poorly integrated, which caused unequal welfare and prolonged cancer rehabilitation. One year after the workshop series started, a patient-led nonprofit organization opened a physical meeting-place, where patient needs had been translated into a spatial design. The region (responsible for cancer care), municipality, and local business-owners shared financial responsibilities—an unusual business model in the Swedish welfare sector predominantly financed through taxes. In the two years the centre has been open, there have been various activities taking place and resources have been combined and integrated from not only the financiers, but also other relevant stakeholders in society.

Discussion

By presenting a model of horizontal and vertical value creation/disvalue, we offer three ideal types of disvalue that recognize disvalue as an equally likely outcome as value creation, but also that disvalue and/or value creation may occur at three levels. These ideal types are simplifications, but they bring clarity to the concepts, as well as differences between the levels. In Figure 1, the vertical level addresses the value that may be both created and destroyed/disvalued at three levels. The horizontal level addresses three types of citizen involvement with the provider with the purpose to contribute to value creation but may well equally lead to destruction/disvalue. For instance in case A, co-production that occurs during the service meeting between patient and healthcare staff may not only contribute to the patient's value creation (or for the staff), but may also lead to disvalue if interactions are not satisfactory or patients do not engage in the PR programme. Case B concerns the co-design and improvement of a service to increase value for the group using the service. However, there is a risk that only the

better-off citizens are recruited which may reinforce inequalities to vulnerable groups for whom value may diminish. This was also a risk with case C which addresses co-innovation of new services within the service system. The benefits are many with innovating a new service in the service system, but the new service may fail to address public values that are formally stipulated in laws for public healthcare to follow (for example prioritizing those in greatest need) and may blur the lines of responsibilities in the service system.

As seen in Figure 1, in all of our cases the negative (–) consequences of the various co-concepts coexisted with the positive (+) (Cluley et al., 2021). All three cases had positive outcomes as a consequence of the respective co-concept that will be briefly presented below as an introduction.

Disvalue and co-production

The first ideal type is represented by case A. Here, the focus was on the service approach to *co-production* (Osborne et al., 2016) in which production and consumption of the service takes place at the same time during the crucial service meeting between staff and user (Normann, 2001).

If a service meeting is not a good encounter, this may lead to a diminishing of value for both the user and staff (Engen et al., 2021; Plé & Chumpitaz Cáceres, 2010; Straussman, 2022). In previous studies in healthcare, patients have described service meetings with staff as dissatisfying, particularly concerning communication and unprofessional conduct (Olsson, 2016). Many healthcare professionals lack training in communication (Olsson, 2016), which is why physicians may control the patient–physician meeting focusing on disease (the medical model of care), rather the social elements where the patient is seen as a person. Moreover, disvalue may also occur as a consequence of limited or poorly-designed information making it difficult for the patient to act in a way they want (Engen et al., 2021; Smith, 2013), leading to disempowerment, lost esteem and self-efficacy, as experienced by patients in Olsson's (2016) study of patient complaints in cancer care. Also, time constraints are known to cause a less satisfying meeting for patients, but satisfying managers by increasing 'production' but at the risk of misusing resources (Plé & Chumpitaz Cáceres, 2010). Improvements in the patient information and introduction of patient volunteers enabled the PR team to focus their time on engaging with their patients, but these encounters were limited to the PR programme. Mapping the respiratory pathway highlighted time pressures and other areas for improvement (Williams, 2017). Ineffective service meetings resulted in future non-attendance, which the PR team hoped will be partially addressed by improved information.

Disvalue and co-design

The second ideal type is represented by case B, an example of how users may *co-design* existing services (Osborne et al., 2016).

One reason for disvalue was found to be in the recruitment process. It is possible that the local women recruited to represent the wider female population in the local area were women who were economically, professionally and socially better off, despite having a minority background.

Indeed, the risk of including users who are better off and better educated is well-documented both in the co-production (Brudney & England, 1983; Eriksson, 2022) and citizen participation (Hendriks, 2012) literature. It may also be a consequence of the fact that public employees tend to (unconsciously) recruit people with the same background as themselves (Ricucci et al., 2016). The risk here is that services can be co-designed to miss more deprived citizens. Moreover, there is a risk that stereotypes will be reinforced, for instance by regarding a group as a 'problem', that foreign-born women refrain from seeking healthcare, and that they require extra resources to participate. Previous research mentions that a one-sided focus on one group may risk neglecting or disadvantaging another (Anderson & Ostrom, 2015). Recruiting those really in most need may be an ideal, but also has its known difficulties as they may suffer from poor communicative skills and lack of authority if not representing an organization (Hendriks, 2012). Not to mirror the broader population in a society or community is not wrong but giving an appearance of doing so is wrong (Carson, 2001). There is also a risk of unclear roles between citizens and public employees in co-design where citizens are implicitly expected to 'pay back' to providers, which may influence power relations (Steen et al., 2018). Overall, the potential pitfalls must be taken into account when recruiting the better off, experts and so forth. Otherwise, through the co-concepts it may appear as if vulnerable groups are targeted, but, in fact, the less well off will continue to be denied access to public services.

Disvalue and co-innovation

The third ideal is represented by case C: an example of how users may participate in the *co-innovation* process of new services (Osborne et al., 2016) within the service system and focus on complementing the welfare system.

The third ideal type shares many of the recruitment and representativity challenges with the second ideal type (Steen et al., 2018). In addition, to interfere too much with the service system is not unproblematic. For instance the social norm (Cluley et al., 2021) in Sweden is that public services are financed by public money. Charity is rare and may therefore be seen upon with suspicion, or as a competitor to established public services. There is also a general high level of trust for public organizations among Swedes (Pierre & Rothstein, 2011), supposed to guarantee impartiality, equal access and so forth. These values may be difficult to address for a new player in the system, leading to exclusion to the new service for certain groups in society. It may also be argued that, through co-innovation (as well as in co-design in the second ideal), public organizations disclaim responsibility for healthcare services that are instead passed onto friends and family, associations and others (Bovaird et al., 2019; Steen et al., 2018). Moreover, by gathering various actors there are not only more players that may contribute with value creation, but also destruction as well (Engen et al., 2021), and it is possible that value is created for some actors in the system while being destroyed for others (Rossi & Tuurnas, 2021). Moreover, dominating voices are known to remain dominant (Ricucci et al., 2016): therefore both external and internal inclusion has to be considered (Young, 2000). The sometimes enchanting notion of disruptive innovation and

similar management fads should take the negative aspects into consideration as they always coexist with the positive aspects (Cluley et al., 2021).

Conclusion

This article contributes to the value concept in the public sector by recognizing that value may be both created and destroyed. This may occur during interactions in service meetings with a provider (co-production), by contributing to improvements and developments of existing services (co-design), and/or by inventing new services impacting the overall service system (co-innovation). Similarly, value may be both created and destroyed for an individual user, a particular group or at societal level.

Encounters of dis/value from patient, practitioner and other perspectives require further attention to enable a more balanced and prudent practice of citizen/user involvement. As well, in line with an important finding in Sami et al.'s (2018) literature review on public value, more research is needed in developing countries.

Public sector managers and policy-makers should be more reflective and critical of the potentially negative consequences of fashionable management trends such as value creation.

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