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Organisational conditions for co-creation: a health care context

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Partial fulfilment statement

This thesis submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, the University of Adelaide, South Australia, Australia

Abstract

Within health care practice and academe there is recognition that customers co-create service experiences, such as health care service provision and treatment programs, and are no longer passive recipients of service offerings. This perspective is consistent with the recognised shift in extant literature from a goods-dominant to a service-dominant logic (Vargo and Lusch 2004, 2008) that has occurred over the past decade. This literature conceptualises the notion of co-creation as the resource integration that occurs between a customer and an organisation. There is a recognition that organisations should modify their business practices to facilitate co-creation, with research advising organisations to adopt co-creative behaviours such as a service-dominant orientation (Karpen et al. 2015), collaborative practices (Skålén, Pace and Cova 2015), and co-creation practice styles (McColl-Kennedy et al. 2012). However, there is little guidance to explicate the organisational conditions that would support and facilitate co-creation. Organisations seek guidance on the capabilities, culture, activities, and initiatives that will support a focus on customer resource integration and co-creation. Current theoretical frameworks of organisational culture and capabilities do not account for the co-creation role that a customer adopts in conjunction with the organisation and new frameworks should be considered. In addition, although extant literature is beginning to recognise the importance of the customers' role in improving their own service experiences, such as health care management (McColl-Kennedy et al. 2012; Sweeney, Danaher and McColl-Kennedy 2015), there is scant understanding of the effect that undertaking different types of co-creation roles has on the hedonic and eudaimonic well-being of customers. This thesis addresses the current situation by identifying and defining the conditions for customers' co-creation for well-being in a health care context.

The study was conducted in three phases- the first phase identified organisational capabilities

that support customer participation in health care service innovations. A qualitative approach using convergent interviews with health care CEOs and senior managers was undertaken. As a result, four categories of organisational capabilities were identified: customer activation, organisational activation, interaction capabilities, and learning agility.

The second phase of the study utilised three case studies of health care organisations and identified behaviours and values indicative of a co-creation culture. Contemporary organisational culture models are restrictive in their ability to understand and examine a co-creation culture, as they delineate between an internal and external focus and do not recognise the interconnectedness of all actors across traditional organisational boundaries. Findings from this phase of the research showed that a co-creation culture consists of five core co-creation behaviours; co-production, co-development, co-advocacy, co-learning, and co-governance. Additionally, a series of supportive co-creation behaviours enable the interactive nature of co-creation; dialogue, Shared market intelligence, mutual capability development, and Shared decision-making. These behaviours are underpinned by organisational values of mutual respect, trust, empowerment, and acceptance.

In the third phase of the research, well-being outcomes generated by the different co-creative roles of customers were investigated. The findings support extant literature, in that a customer is undertaking co-creation activities identified a resultant sense of hedonic well-being. However, it was also noted that the activity of co-creation, whether in managing their own health care, or providing value for the organisation, a collective group, or society, provided customers with a general sense of purpose, or eudaimonic well-being. Specifically, self-determination theory was utilised to explore the nature of eudaimonic well-being, or a sense of purpose and accomplishment, that arose when customer co-created value for them or a

collective group. This thesis hence provides insight into the capabilities, culture and resources managers should develop to facilitate co-creation of health care management and enhance the well-being of customers.

Declaration of Plagiarism

I certify that this works contains no material which has been accepted for award of any other degree or diploma in my name, in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text. In addition, I certify that no part of this work will, in the future, be used in a submission in my name, for any other degree or diploma in any university or other tertiary institution without the prior approval of the University of Adelaide and where application, any partner institution responsible for the joint-award of this degree.

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Shikha Sharma

31st October 2016

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CHAPTER 1 : INTRODUCTION TO THE THESIS

This exploratory research aims to understand the conditions for enabling co-creation in health care organisations through both the investigation of organisational capabilities and a culture that supports value co-creation and an examination of the influence of co-creation activities on the well-being outcomes for customers. In this introductory chapter, the researcher sets the context, research aims and objectives, philosophical consideration, and provide an overview of the findings from this study.

1.1.Research Context

Health care organisations are facing numerous challenges due to rising health care costs, an ageing population and the increasing demands of customers (Akenroye 2012; Thakur, Hsu and Fontenot 2012). Health care costs are continuously rising, a greater proportion of the population is getting older and the customer is demanding better care (Rethmeier 2010). There are important differences between health services and other contexts, which make it more challenging to involve customers (Kahn et al., 1997). Health services are not particularly desired by the customers (Berry & Bendapudi, 2007). Health ccustomers' are vulnerable, stressful and are sometimes reluctant to play the role of coproducer (Bendapudi and Leone 2003). Traditionally, health care systems have given little consideration to customer involvement as customers were merely considered passive recipients of services (Berry and Bendapudi 2007; Holman and Lorig 2000; McColl-Kennedy et al. 2012).With the shift towards service-dominant logic in other fields health

care practice and academia/ researchers have started to recognise that customers co-create health care service experiences (Gill, White and Cameron 2011; McColl-Kennedy et al. 2012). The role of customers is changing from one where they are passive recipients of health services, as they are taking a more active role in the provision and development of those services. There is a growing recognition that customer participation in managing their health condition has a positive impact on their health outcomes (Holman and Lorig 2000; McColl Kennedy et al. 2012). Several collaborative care models are increasingly being adopted by health care organisations (Sweeney et al 2015). Authors in the public service domain have also started to recognise that the current public management theory is somewhat limited as it focuses on intraorganisational rather than interorganisational processes (Osborne 2010; Osborne, Radnor and Nasi 2013) and that service-dominant logic (SDL) has the potential to create new theoretical insights (Osborne et al. 2013).

To respond to this increased participation of customers, it is suggested that organisations adopt co-creative behaviours (Karpen et al. 2015), collaborative practices (Skålén et al. 2015) and co-creation practice styles (McColl-Kennedy et al. 2012). Health care services are complex systems with interactions between patients, providers, suppliers and financers (Thakur et al. 2012). Due to the complexity of the system it is often the organisation that chooses the means by which it will engage customers (Prahalad and Ramaswamy 2004). While individual customers' participation in health services has gained attention in service research, less effort has been invested in examining how organisational level factors support and facilitate co-creation. This research addresses that

gap by identifying the organisational capabilities and culture required for effective value co-creation as well as investigating the outcome of co-creation practices.

1.2.Theoretical underpinnings of the research

This thesis aims to identify conditions for enabling co-creation by applying co-creation lens to explore the underlying organisational capabilities and culture required for co-creation and the outcome of co-creation practices.

Although customers have often participated in traditional 'firm activities', such as providing ideas for improving services (Bettencourt 1997), what is new is the extent to which the customers are involved in the co-creation of value through their resource integration (McColl-Kennedy et al. 2012). The understanding of value co-creation has been transformative in the marketing field (Prahalad and Ramaswamy 2000; Vargo and Lusch 2004, 2008). During the past decade, most of the co-creation studies are focused on providing insight into its conceptualisation (Prahalad and Ramaswamy 2004), understanding the customers' role and relative importance (Vargo and Lusch 2004, 2008), examining the process of co-creation (Payne, Storbacka and Frow 2008), and identifying activities that customers undertake during co-creation (McColl-Kennedy et al. 2012). Primarily co-creation studies have focused on dyadic customer and organisation perspective (Prahalad and Ramaswamy 2004) which is now shifting to recognise that multiple actors contribute in value co-creation (Tether and Tajar 2008; Vargo and Lusch 2011, 2016).

Organisation boundaries are becoming increasingly porous where organisation and customers are embedded with networks of other organisations, customers etc. (Edvardsson, Tronvoll and Gruber 2011; Vargo and Lusch 2011). This has extended the perspective of value co-creation from unidirectional dyadic customer organisation approach to social contexts in which value is derived (Chandler and Vargo 2011). Organisation cannot simply create value in internal boundaries and pass that to customers rather value is co-created with the customers. This change of value co-creation from dyadic approach to value network challenges traditional mechanism of hierarchical control. Organisation's role is to facilitate and support this resource integration and enhance customer learning (Arnould and Thompson 2005; Hibbert, Winklhofer and Temerak 2012; Karpen, Bove and Lukas 2012; Payne et al. 2008). To achieve this, the organisation requires the requisite condition to enable co-creation (Chandy, Prabhu and Antia 2003; Madhavaram and Hunt 2008). The organisation's operant resources such as culture and capability can create that requisite condition (Barney 1986; Day 1994; De Brentani, Kleinschmidt and Salomo 2010) for co-creation. Despite considerable studies on value co-creation, limited attention has been paid to the underlying conditions for co-creation and the outcome of co-creation practices. Value co-creation requires redefining the way organisations engage with its customers, employees, partners and other stakeholders.

Consistent with the above arguments, this study began by exploring organisational capabilities required for customer participation. Customer participation is the extent to which customer engage in co-creating a service (Chan, Yim and Lam 2010; Sweeney et

al. 2015). Customer can participate in their self management and in the redesign of services at an organisation or system level. Organisations seek to develop capabilities to enhance customer participation. Specifically, the capabilities required to bring the customer and organisation together to facilitate interactions were considered in the initial phase of the research.

Customers are not only interacting with the focal firm but they are interacting with other providers, customers as well. This change of value co-creation from dyadic approach to value network is challenging (Yngfalk,2013). The shift towards value co-creation is not reflected in studies related to organisational culture (Büschgens, Bausch and Balkin 2013; Lukas, Whitwell and Heide 2013; Storey and Hughes 2013). Several studies recently have also recognised that there is a need to study the organisational culture, which will facilitate value co-creation. For instance for instigating service dominant orientation (Karpen et al. 2015), for applying customer value co-creation practice styles (McColl-Kennedy et al. 2012), for service science (Ostrom et al. 2010) and for adopting SDL (Lusch, Vargo and O'Brien 2007; Michel, Brown and Gallan 2008). Contemporary organisational culture models are restrictive in their ability to facilitate co-creation, as they are based on the competing values framework (CVF), which clearly delineates between an internal and external focus for the organisation. Therefore, the purpose of the second stage was to identify and explicate the characteristics of an organisational culture that supports and facilitates value co-creation.

Customer participation in co-creation reflects customer effort in value co-creation (Sweeney et al. 2015). Customers are better off in some ways by interaction, collaboration and active participation in value co-creation process (Gronroos 2011; Grönroos 2008; Vargo, Maglio and Akaka 2008). Value co-creation encourages customer's active participation by creating options for them for meaningful experience. They bring their resources, effort, skills and knowledge and are more willing to participate in service provision which improves their well-being (Vargo et al. 2008). When the customers are actively co-creating with the service providers it not only improves their well-being but other current and future customers can also be benefitted. To date, there are studies that have shown increased productivity, profits, customer loyalty etc. as organisational benefits of customer co-creation while little attention has been paid on the implication of customer well-being by participating in value co-creation. Therefore, the purpose of the third study was to address the influence of value co-creation in improving the well-being of customers and service entities.

1.3.Research aims and objectives

The overarching objective of this research is to understand the conditions for enabling co-creation in health care organisations. The value of this work lies in understanding the capabilities and culture required by organisations to embrace co-creation practices; and in understanding, how these practices can contribute to customer well-being. The following research questions addressed in this thesis:

Research Question 1: *What are the organisational capabilities required to support customer participation in health care service innovation*?

Research Question 2: *What are the characteristics of an organisational culture that supports co-creation?*

Research Question 3*: How do the various roles that customers take in the co-creation of health care provision influence their well-being outcomes*?

In order to realise this objective three studies were conducted during this thesis. The first study addresses the concept of organisational capabilities, which refers to those capabilities that are required to support customer participation. The second study is devoted to identifying and explicating the characteristics of an organisational culture that supports co-creation, i.e. a co-creation culture. The last study explores well-being outcomes that can be generated for customers when they are accessing services through co-creative organisations.

1.4.Overview of the Research Methodology

The way a researcher looks at the world is called a research paradigm and this guides the study's design (Guba and Lincoln 1994). The research paradigm involves ontological and epistemological assumptions that guide the methodological choices of the study.

In this study, ontology of relativism was chosen which is socially constructed by the interaction of several people in a given context and is dynamic in nature (Strauss and Corbin 1998). Therefore, to make these data meaningful it is important to have in-depth

interactions with respondents who have been involved in a service system. In this study, epistemology of realism was chosen by which the researcher builds confidence in the respondents to encourage them to share their views of reality with minimal external influence (Guba and Lincoln 1994). Based on both ontology of relativism and epistemology of realism the methodology for data collection and analysis was developed. An exploratory qualitative approach was employed which included preliminary convergent interviews and multiple case studies. Purposeful sampling was used in selecting respondents for preliminary convergent interviews and for selecting organisations in case studies. Purposeful sampling was used to carefully select the respondents that are knowledgeable and information rich cases (Patton 1990).

In the first study, ten senior executives and two academics were interviewed based on their expertise and rich experience in the field of customer participation in health care settings. In-depth convergent interviews were subsequently conducted until data saturation was achieved and the content was refined based on the findings in previous interviews (e.g., (Gebhardt, Carpenter and Sherry 2006) and each lasted for 50-60 minutes. Follow-up interviews and email exchanges with various key informants were conducted to validate and clarify the data. These insights were accompanied by an analysis of internal documents and archival records. This study identified and structured a portfolio of organisational capabilities to support customer participation in health service innovation.

Results from the first study guided the objectives of the second study by predominantly raising the need to explore the organisational culture that best facilitates co-creation. These results assisted in the selection of case studies and in preparing the interview guide for the second study. As little is known about co-creation culture, in the second study, case studies of three health care organisations in Australia (code-named as RED, YELLOW and GREEN for reasons of confidentiality) were conducted. These are community based health organisations that had provided health care services for more than 10 years. Case studies were selected based on the findings of the first study due to the fact that the RED and YELLOW CEO's were in the cohort of first study interviewees and GREEN was identified for its customer-focussed approach by one of the respondents from the first study who had previously worked there. RED CEO gave several examples of involving customers in their service while YELLOW CEO stressed inter organisational coordination and functioning as a means to deliver customer focussed services. Respondents were selected through purposive sampling to ensure that the study included knowledgeable and informed participants from all segments of the organisations. Gioia, Corley and Hamilton (2013) methodology was adopted to conduct fifteen in depth interviews and seven focus groups in this research, as it provides a systematic inductive approach to concept development. Collaborating evidence was found from other sources through field observation, document analysis, archival records and observations for each of the identified concepts. This study showed that a co-creation culture consists of core co-creation behaviours, a series of supportive co-creation behaviours and that these behaviours are subsequently underpinned by organisational values that enable the interactive nature of co-creation.

In the third study, the case studies of RED and GREEN were revisited as customers specifically commented in their interviews on the influence of participation on their overall well-being. They felt a sense of accomplishment and a sense of competence when they were provided with the opportunity to participate in their own care-plan as well as in the broader service provision of the organisation. Data from the second study was utilised for analysing the influence of co-creation on the well-being outcomes for customers. As RED and GREEN encouraged customer participation in their organisation, they were selected to take part in the third study in order to explore well-being outcomes of co-creation practices. In addition to ten in depth interviews and four focus groups from the RED and GREEN in the last study four more focus groups within RED were conducted and the content from documents and noted observations of both organisations were used. The researcher conducted thematic analysis using Gioia methodology, identified three categories of co-creation roles for customers, and examined how these roles are influencing eudaimonic and hedonic well-being outcomes for customers.

Great care was taken to maintain the reliability and validity of the research design through construct validity, internal validity, external validity and reliability (Yin 1989, 1994). In this research, to maintain the construct validity, multiple sources for data collection such as interviews, focus groups, internal documents, archival records and documented observations were used for the development of the theoretical framework. To maintain the internal and external validity of the research, respondents were selected through purposeful sampling of knowledgeable and informed participants and more participants were added to the sample until the saturation level was achieved. An

interview protocol was developed for the data collection and interviews were conducted and interpreted in a structured manner. The generalizability of the findings beyond the health care sector may be limited (Berry and Bendapudi 2007). While the potential exists for application in other public services, further research is needed to extend the understanding of the co-creation across a variety of services.

In the next section a summary of all three studies is provided, which includes aim of the study, what was done and what was achieved.

1.5.Study One: Organisational capabilities for customer participation in health care service innovation

Despite the growing importance of customer participation in innovation (Matthing, Sandén and Edvardsson 2004; Ordanini and Parasuraman 2011) active customer participation in the improvement of services at an organisational level has not been previously investigated. In particular, few studies have examined the capabilities required by an organisation to facilitate customer participation and those studies focused on product providers or a business-to-business context (Coviello and Joseph 2012; Lin and Huang 2013) little is known about the capabilities required to enable customer participation in services. Therefore, the aim of the first study was to identify and categorise the organisational capabilities that are required to facilitate customer participation in health care service innovation.

Twelve convergent interviews of health care managers were conducted to better understand those organisation capabilities that are critical for the participation of customers in service innovation. By applying dynamic capability theory in a co-creation context, several organisational capabilities were identified and these were grouped in four categories: customer activation, organisational activation, interactive capabilities and learning agility. The first two categories of capabilities, customer activation and organisational activation are dynamic capabilities that harness customer and organisation skills that will facilitate the customer value co-creation process and prepare customers and organisation to integrate their resources in the joint sphere. The third category, interactive capabilities built on the interaction dimensions proposed by (Karpen et al. 2012), are important to encourage dialogue between the organisation and the customers. The last category, learning agility, reflects the organisation's ability to sense changes in the environment and respond to them (Den Hertog, Van der Aa and De Jong 2010; Wilden et al. 2013). In this study it was found that although participants recognised the importance of these capabilities they wish to get further guidance on the application of these capabilities.

This study contributed to dynamic capability theory by applying it in the co-creation context and through knowledge of organisational capabilities building on the work of Coviello and Joseph (2012) and (Karpen et al. 2012). It addresses one of the key priorities of service science research viz. to understand customer participation in service innovation in a complex environment like health care (Ostrom et al. 2010). It advances conceptual understanding of the role of the health care organisation in supporting

customer participation, especially as health care organisations perceive they lack the capabilities required to facilitate customer participation.

1.6. Study Two: Co-creation culture in health care organisation

In the modern, complex and interconnected market, customers are better informed and more willing to participate in service provision. To respond to this increased participation by customers and to manifest co-creative organisational capabilities a supportive culture that shares control, and encourages customers to learn and participate in value co-creation is required (Karpen et al. 2015; McColl-Kennedy et al. 2012; Sharma, Conduit and Hill 2014). The S-D paradigm advocates ~~the~~ interconnectedness between multiple actors (Vargo and Lusch 2008) while, the traditional dyadic organisational culture models do not recognises such an interconnectedness among the actors. Contemporary organisational culture models are restrictive in their ability to facilitate co-creation, as they are based on the competing values framework (CVF), which clearly delineates between an internal and external focus for the organisation. Although a market orientation recognises the customer as a source of information for creating value (Deshpandé and Farley 2004; Urde, Baumgarth and Merrilees 2013), it is not a substitute for SDL. This is because seeking feedback to meet the needs of customers is different from involving customers in the creation of offerings (Michel et al. 2008). There is clearly a need to explore and understand an organisational culture that facilitates collaboration, two-way communication, customers' learning and active participation in value co-creation activities (Karpen et al. 2015; McColl-Kennedy et al. 2012). Therefore,

the purpose of the second study was to identify and explicate the characteristics of an organisational culture that supports and facilitates value co-creation that is a co-creation culture.

This study utilises three case studies of health care organisations and reveals the behaviours and values indicative of a co-creation culture. The findings show that a co-creation culture consists of five core co-creation behaviours; co-production, co-development, co-advocacy, co-learning, and co-governance. Additionally, a series of supportive co-creation behaviours enable the interactive nature of co-creation; dialogue, Shared market intelligence, mutual capability development, and Shared decision-making. These behaviours are underpinned by organisational values of mutual respect, mutual trust, empowerment, and acceptance. These co-creation behaviours and values are built on previous research in investigating the values and behaviours of market-oriented organisations (Gebhardt et al. 2006; Homburg and Pflesser 2000). The co-creative culture values and behaviours identified are different from market oriented culture because they go beyond traditional internal activities and demonstrate resource integration by all actors.

This research contributes to the co-creation and organisational culture literature by exploring organisational culture from a service-dominant perspective and provides a framework for the establishment of a co-creation culture. It provides health care practitioners with a greater understanding of the behaviours and values that foster co-creation and enhance the customers' role within organisations.

1.7. Study three: What is good for the group is good for the individual: Co-creation for collective well-being

When organisations support co-creation through their co-creative capabilities and culture customers are able to achieve value outcomes not only for themselves but also at a collective and societal level. Customers can play various roles in service co-creation to enhance their well-being (McColl-Kennedy et al. 2012). They can participate in their own health care management or participate for the benefit of an organisation, community group or society. Previous research has suggested various noteworthy outcomes of value co-creation with customers, such as improved consumption experiences (Payne et al. 2008), innovation (Bitner, Ostrom and Morgan 2008; Mary Jo Bitner, Amy L. Ostrom and Morgan 2008; Sawhney, Verona and Prandelli 2005), impact on employees' performance (Yi, Nataraajan and Gong 2011) and reducing the cost of new service development (Kristensson, Matthing and Johansson 2008). However, with some exceptions (Guo et al. 2013; Mende and Van Doorn 2015; Sweeney et al. 2015) the influence of value co-creation in improving the well-being of customers is an under researched area. In these value co-creation studies, customer well-being outcomes are generated by co-creating with providers for their own care (Guo et al. 2013; McColl-Kennedy et al. 2012; Sweeney et al. 2015), as they do not address well-being outcomes of an individual by co-creating services at an organisational or system level. In addition, these studies have mostly examined the hedonic dimension of well-being, which is based on the concept of sensory pleasure (Carruthers and Hood 2004; Kahnemann, Diener and Schwarz 1999) and have not considered eudaimonic well-being that occurs when people

fulfil their life purpose (Ryan et al. 2008; Ryff and Singer 1998, 2000; Ryff and Singer 2008). Well-being is a multidimensional construct in which eudaimonic and hedonic well-being are likely to be linked. This paper explores the hedonic and eudaimonic well-being outcomes that arise from the various roles that customers may take in co-creating health care services for themselves and others.

Two case studies of mental health organisations were conducted to examine the different role customers can play in value co-creation and the resultant well-being outcomes that can be generated. Ten in depth interviews and eight focus groups were conducted and for triangulation purposes other techniques such as document analysis, archival records and observations. Data were analysed using Gioia methodology (Gioia 1998; Gioia et al. 2013). Three categories of co-creation roles of customers were identified in our study namely co-producer, strategic partner and citizen and it was demonstrated how these roles influenced well-being outcomes. The researcher analysed the well-being outcomes from the perspective of self-determination theory (SDT), which advocates that fulfilment of three basic psychological needs - competence, autonomy, and relatedness - is essential for individual well-being. The results show that the co-creative role of customers provided all three elements of SDT for the customers, which provided them with a meaning and purpose and in turn improved their well-being. This study extends the work of Guo et al. (2013) and Mende and Van Doorn (2015) by using self-determination theory as a theoretical lens with which to establish the relationship between value co-creation and transformative services. Through this research, theoretical contributions were made to the co-creation and TSR literature and how it responds to recent calls to

explore ways of improving well-being through transformative health care services (Ostrom et al. 2015; Ostrom et al. 2010). This study has demonstrated that value co-creation not only impacts individual well-being but that individual co-creation activities have the potential to impact collective and societal outcomes as well.

1.8. Organisation of the thesis

The thesis is organised into three key areas, which are presented in the next section. In the first one organisational capabilities are identified, through the second co-creation culture is depicted and the third outlines the well-being outcomes that are generated due to value co-creation activities. These three topics are followed by the concluding chapter, which acknowledges the contributions made, discusses the opportunities for future research, and identifies limitations of the thesis.

Statement of Authorship

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Principal Author

Name of Principal Author (Candidate)	Shikha Sharma		
Contribution to the Paper	Collected data, performed analysis on all samples, interpreted data, wrote manuscript		
Overall percentage (%)	70%		
Certification:	This paper reports on original research I conducted during the period of my Higher Degree by Research candidature and is not subject to any obligations or contractual agreements with a third party that would constrain its inclusion in this thesis. I am the primary author of this paper.		
Signature		Date	12/5/2016

Co-Author Contributions

By signing the Statement of Authorship, each author certifies that:

i. the candidate's stated contribution to the publication is accurate (as detailed above);

ii. permission is granted for the candidate in include the publication in the thesis; and

iii. the sum of all co-author contributions is equal to 100% less the candidate's stated contribution.

Name of Co-Author	Dr Jodie Conduit		
Contribution to the Paper	Supervised development of work, helped in data interpretation, manuscript evaluation and revised manuscript		
Signature		Date	18/10/15

Name of Co-Author	Dr Sally Rao Hill		
Contribution to the Paper	Helped to evaluate and edit the manuscript.		
Signature		Date	12/05/16

Please cut and paste additional co-author panels here as required.

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CHAPTER 2 : ORGANISATIONAL CAPABILITIES FOR CUSTOMER PARTICIPATION IN HEALTH CARE SERVICE INNOVATION

2.1 Introduction

The health care industry in the Western world faces rising costs, an ageing population, and customers demanding better care (Berry and Bendapudi 2007; Rethmeier 2010). For instance, in Australia total expenditure on health services in 2011–12 was estimated at $140.2 billion, around 1.7 times higher than in 2001–02 (Australian Institute of Health and Welfare 2013). Health care policy makers face several challenges as a result of the extensive growth of costs and customers' lack of access to health care (Akenroye 2012; Thakur et al. 2012) care is needed to balance cost and access to health care (Omachonu and Einspruch 2010).

Traditionally, health care systems were designed with a focus on the role of the health care provider, with little consideration given to customer involvement (Berry and Bendapudi 2007; McColl-Kennedy et al. 2012). However, within health care practice and academe there is now recognition that customers co-create health care service experiences, and are no longer passive recipients of their treatment (Gill et al. 2011; McColl-Kennedy et al. 2012). Thus, health care organisations are realising the importance of a customer-oriented business approach (Thakur et al. 2012).

This perspective reflects a shift in thought aligned with service-dominant logic that customers are co-creator of value (Vargo and Lusch 2004). Several scholars have documented that customer involvement is important for service innovation (Alam 2011; Ordanini and Parasuraman 2011). It has been shown that co-creation with users is a source of competitive advantage in innovation (Salunke, Weerawardena and McColl-Kennedy 2011). There is also evidence that customer participation reduces the cost of innovation, increases service quality (Ramaswamy and Gouillart 2010; Tanev et al. 2011), and organisations develop more innovative solutions and gain superior knowledge (Matthing et al. 2004). The management of customer participation in co-creating the innovation requires the organisation to learn more about the customer and his or her individual and collective context(Voima et al. 2011). Customers can derive health care innovation both by co-creating with clinicians for their own health care management and by contributing to the improvement of health care services at an organisational or system level. The customers' role in improving their own health care management is recognised in the literature (McColl-Kennedy et al. 2012), however, the processes and structures to actively embrace customer participation in the improvement of health care services at an organisational or system level have not been previously investigated. As health care organisations have not traditionally been customer-focussed (McColl-Kennedy et al. 2012), they often lack an understanding of how to best coordinate their resources and harness their capabilities to address this challenge.

The purpose of this paper is to provide an understanding of the organisational capabilities that support customer participation in health care service innovation. This reflects one of

the key priorities of service science research - to further understand the course to involve customers in service innovation - and addresses the call to conduct service innovation studies in complex environments like health care (Ostrom et al. 2010). Drawing from dynamic capability theory, we identify various capabilities an organisation requires to support customer participation in health service innovation. Specifically, we consider the capabilities required to bring the customer and organisation together to facilitate innovation outcomes.

Extant literature agrees that customer participation affects service innovation (Matthing et al. 2004; Ordanini and Parasuraman 2011; Prahalad and Ramaswamy 2004), however, there are several gaps in the field's knowledge. First, the current understanding of the role of customers in service innovations remains underdeveloped (Alam 2011; Ostrom et al. 2010) . Although several studies have focused on the role of customers (Alam and Perry 2002; Carbonell, Rodriguez-Escudero and Pujari 2012), few studies have examined the capabilities required by an organisation to facilitate customer participation in innovation. Further, studies that investigate organisational capabilities to facilitate co-created innovation predominantly focus on product providers (Coviello and Joseph 2012; Lin and Huang 2013) or a business-to-business context (Coviello and Joseph 2012). Despite the growing importance of customer participation in innovation, little is known about the capabilities required to enable customer participation in health care service innovation.

This paper will advance the literature in this area by identifying, and providing a categorisation of, organisational capabilities that support customer participation in health

care service innovation. Dynamic capability theory will be applied in a co-creation context, to understand the capabilities required in the provider sphere, customer sphere and joint sphere (Grönroos and Voima 2013) to bring together customers and organisations to innovate health care services. The capabilities reflect the activities undertaken by organisations to identify and mobilise customers, and their operant resources, to participate in the co-creation of innovation. In understanding these customer activation capabilities, we build on the work of Coviello and Joseph (2012). Also reflected, are the organisations efforts to identify and coordinate their resources towards the co-created innovation experience. We have termed these capabilities organisational activation. We then consider the nature of the interaction between the customer and organisation as they undertake a dialogue to facilitate the innovation, building on the interaction dimensions proposed by (Karpen et al. 2012) in their conceptualisation of a service-dominant orientation. Finally, while the above capabilities may drive value co-creation in any context, we are specifically concerned with the ability of the organisation and the customer to facilitate innovation outcomes (Coviello and Joseph 2012). Hence, our final category of organisational capabilities reflects an organisation's learning agility to sense changes in the environment and respond to them (Den Hertog et al. 2010; Wilden et al. 2013).

The remainder of this paper is structured as follows. First, we draw on existing literature to discuss the changing nature of the role of customers in health care service innovation. Then we put forth a categorisation of organisational capabilities that provides a structure for examining the capabilities required for health care service innovation. We outline the

qualitative research design employed as part of this research. The organisational capabilities to support customer participation in health care service innovation are identified and the extant literature that provides a theoretical underpinning for these capabilities is explored. The article concludes with a discussion of practical implications, limitations, and future research directions.

2.2 The role of customers in co-creating health care service innovation

The understanding of value co-creation has been transformative in the marketing field (Prahalad and Ramaswamy 2000; Vargo and Lusch 2008). Businesses are reinventing themselves to address the challenges inherent in customers being more active, having open access to information, and generally desiring more interactive experiences with organisations (Brodie et al. 2011). It is widely recognised that customers are co-creators of value and resource integrators, with operant resources the fundamental source of competitive advantage (O'Cass and Ngo 2012; Vargo and Lusch 2008). While some researchers argue that customers create value for customers (Heinonen et al. 2010; Hibbert et al. 2012), customers' operant resources can be utilised to create value for the organisation. Vargo and Lusch (2004) stated that, in modern marketing, co-creation with customers for innovation will be essential, and they termed this "Shared inventiveness."

Customers have often participated in traditional firm activities, such as providing ideas to improve services (Bettencourt 1997), however, a service-dominant perspective recognises the extent to which the customers are involved in the co-creation of value through their resource integration (McColl-Kennedy et al. 2012). Customers' ideas are not just inputs

into the innovation process (Elg et al. 2012), but rather they are involved in the co-creation of value in the form of the final output - the service innovation. From this perceptive, we define customer participation in health care service innovation as the active role customers take in the Redesign of health care services at an organisation or system level. Customers are likely to be involved in activities such as strategy or policy development, providing ideas for improving services (Bettencourt 1997), and co-designing the service (McColl-Kennedy et al. 2012). Organisations need to provide resources that customers can deploy to co-create this value, and often need to facilitate the development of skills and knowledge that lead to more effective resource integration and co-creation (Hibbert et al. 2012). However, there is little guidance in the extant literature to explicate the capabilities and resources health care organisations should develop to facilitate co-creation of innovation.

Health care organisations face several challenges in enabling customer participation for health service innovation. First, health care customers, or patients, often have little knowledge of the nature of their illness and therefore feel stressed, emotional, and not in control of the situation as they may be in other co-creation situations (Berry and Bendapudi 2007). Second, customers often choose the extent to which they wish to co-create their own health management experience (McColl-Kennedy et al. 2012) and therefore, it would follow, they can choose the extent to which they are involved in a co-creative innovation experience. Recently, McColl-Kennedy et al. (2012) elaborated on the conceptualization of co-creation and demonstrated that customers co-create their own health care experience by integrating resources not only from the health organisation but

also through self-generated activities or resources drawn from third parties (McColl-Kennedy et al. 2012). Co-creating their personal health care management is one avenue for customer participation in health service innovation; however, customers experience and interact with the health care system and often have a unique perspective of how it can be improved.

Despite improvement in the delivery of health care services, they are complex systems with interactions between patients, providers, suppliers and financers (Thakur et al. 2012). Managers make decisions in dynamic environments (Thakur et al. 2012), and the challenges in the health care system demand a diverse mix of skills, knowledge and competencies. Although, a customer can be conceived as a co-creator of value, due to the complexity of the industry it is most often the organisation that chooses the means by which it will engage customers (Prahalad and Ramaswamy 2004). Therefore, we investigate the role of organisational capabilities and introduce a categorisation that allows for the exploration of capabilities to support customer participation in health care innovation.

2.3 Organisational capabilities for health care service innovation

Organisational capabilities have been defined as “complex bundles of skills and accumulated knowledge … that enable firms to coordinate activities and make use of their assets" (Day 1994). To stay competitive in a dynamic environment, organisations develop capabilities that enable them to gain a competitive advantage (Bakhru 2004). Dynamic capabilities theory explains how organisations acquire and deploy resources

according to the market environment to achieve superior organisational functioning and success (Teece, Pisano and Shuen 1997). Dynamic capabilities reflect an organisation's capability to develop innovative services or products, responding to changing market conditions. (Teece 2007) identified three elements of dynamic capabilities: sensing, seizing and transforming capabilities. As customer needs shift continuously, organisations must sense and respond quickly to changing customer preferences to create competitive advantage (Roberts and Grover 2012).

Organisations use their resources effectively or acquire new resources to survive in increasingly competitive markets. Organisations' performance differences are argued to be due to the differences in their capability to deploy resources within the organisation (Day 1994, 2011). Teece and Pisano (1994) defined dynamic capabilities as a "subset of the competences which allow the firm to create new products and processes and respond to changing market circumstances." Innovation is also about new products, process, and service development; therefore, dynamic capability theory is central to this research (Lawson and Samson 2001). To identify relevant organisational capabilities for customer participation in health care service innovations, we consider the theoretical underpinning of value co-creation. The shift to a service-dominant paradigm has seen recent research focussed on determining the co-creation capabilities of an organisation (Coviello and Joseph 2012; Hibbert et al. 2012), which was previously absent in the literature. Inherent in the co-creation of innovation is the integration of resources through interaction and activities among collaborators (Grönroos and Voima 2013; McColl-Kennedy et al. 2012). The organisation and the customer are both resource integrators (Vargo and Lusch 2008).

Customers require knowledge and skill (operant resources) to act on the operand resources provided by the organisation during resource integration (Kleinaltenkamp et al. 2012). From an organisational perspective, it needs to develop the capability to support resource integration and customer learning (Arnould and Thompson 2005; Hibbert et al. 2012). Some researchers have argued that customers control value co-creation (Heinonen et al. 2010; Hibbert et al. 2012). However, we adopt the paradigm that argues organisations are able to influence customer value co-creation through interactions (Grönroos 2008; Prahalad and Ramaswamy 2004). To achieve this, the organisation should understand the capabilities required to facilitate these interactions and the resultant co-creation of innovation.

To enable the categorisation of organisational capabilities in this context, we utilise the concept of "value creation spheres" proposed by Grönroos and Voima (2013). They provide a conceptualisation of value co-creation that has a distinct provider sphere, customer sphere and a joint sphere. In the provider sphere processes and activities are performed by the organisation to create an engagement platform for the co-creation of value (Brodie et al. 2013). In the customer sphere, the customer creates value-in-use independent of the provider and may also integrate with resources from other sources (McColl-Kennedy et al. 2012). In the joint sphere, the organisation can influence customer value creation efforts and act as a co-creator; therefore co-creation innovation takes place in the joint sphere.

Organisations seek to develop capabilities to support the dyadic interaction that takes place in this joint sphere, as it is through these interactions that co-creation of innovation occurs (Grönroos and Voima 2013). Firstly, organisations must look to develop the capability to encourage customers to interact as a co-creator of value. It is important for the organisations to utilise customers as a source of competence because customers possess the knowledge and skills, and are willing to learn, experiment and engage with the organisations for the purpose of co-creation (Hibbert et al. 2012; Prahalad and Ramaswamy 2000). To harness customer skills, organisations require the capability to identify and respond to customer needs (Kindström, Kowalkowski and Sandberg 2013). This is achieved through sensing (Teece 2007), mobilising customers, and utilising customer-initiated efforts (Coviello and Joseph 2012); we termed this customer activation.

Secondly, organisations must identify and develop internally the capabilities, or appropriate organisational resources, that will facilitate the customer value co-creation process; we have termed this organisational activation. This reflects a dynamic capabilities logic, and proposes how organisations adapt and create a portfolio of resource capabilities to impact on their organisational functioning and success (Leiblein 2011; Teece 2007)

Thirdly, customer participation in co-creation is influenced through direct interaction (Gronroos 2011) and hence organisations need to develop interaction capabilities. Interaction capabilities are important to encourage dialogue with customers (Prahalad and

Ramaswamy 2000) and for sensing new opportunities for innovation (Kindström et al. 2013). The main focus of an organisation's two-way interaction with customers in the innovation process has traditionally been to gain customer's feedback or to gather information, which only leads to minor variations in existing services (Ojasalo 2009). However, co-creative innovation provides customers the opportunity to design their own experience by using their operant skills and resources (Ramaswamy 2010).

Finally, the joint sphere provides a platform for co-creation but the outcome can be co-creative or co-destructive (Echeverri and Skalen 2011). Therefore, the organisation needs to embrace capabilities to learn about customers, their individual and collective context to optimise the outcome (Voima et al. 2011). This learning agility of organisations is a fourth capability reflective of a firm's ability to utilise the knowledge (seizing) it gained through sensing and, importantly, to reconfigure its resources to respond to this information (Coviello and Joseph 2012; Kozlenkova, Samaha and Palmatier 2014; Wilden et al. 2013).

2.4 Research Methodology

The main objective of this study was to identify the capabilities an organisation requires to support customer participation in health care service innovations. An exploratory, qualitative approach was adopted to obtain rich insights and understand the complexities and nuances of this domain. As such, convergent interviews were used to collect qualitative data from chief executive officers and senior managers in the Australian health care industry. These senior executives have rich experience in the field of

customer participation in health care service innovation. Successive, in-depth convergent interviews were conducted in which data was collected, analysed, and on the basis of findings the content was refined for subsequent interviews (Gebhardt et al. 2006). There were three reasons convergent interviews were used in this research study. Firstly, exploratory research was needed due to limited research on organisational capabilities that are critical for participation of customer in service innovation. Second, compared to other exploratory research technique such as in depth interviews, the convergent interviews are more flexible so the researcher could change the direction of questions depending on the data gathered (Carson D. et al. 2000; Nair and Reige 1995). As little is known about this subject matter, flexibility was essential to generate new ideas that could be explored in subsequent interviews. Furthermore, convergent interviews helped in understanding the research context and refining the questions to be asked in each subsequent interview. Along with the convergent interviews, follow up email, archival records and internal documents were collected for triangulation.

2.4.1 Sample

Senior executives in health care organisations were selected as participants in this study rather than medical practitioners, as they had greater visibility of the role of customers in service innovation at an organisational or system level. The focus of this study was on the organisational capabilities to facilitate a systematic approach to customer participation in health care innovation, rather than the personal management of a patient's medical condition. Senior executives facilitate customer participation in health care innovation by deploying resources and creating structures that encourage participation at

the level of strategy development. Therefore, senior executives were expected to provide greater insights into the organisational capabilities to facilitate customer participation in innovation.

The participants were carefully selected to include programme managers, health policy makers, CEOs, members of executive boards, and advisors working in health care organisations, as well as academics who had conducted research in this area. These informants were chosen based on their expertise in the subject of health service innovation. The participants selected for this study had directly managed and executed a number of reform projects in the primary health care sector across a wide range of health care services. Purposeful sampling was used to ensure that sample was of knowledgeable and informed participants(Dick 1990). In particular, the first participant was carefully selected (Dick 1990) who was not only knowledgeable but also directed to others who were familiar with the research topic (Carson D. et al. 2000; Nair and Reige 1995).

Table 2-1: Profile of Interview Participants

Participant	Title	Type of organisation
Participant A	Lead Partner, Health and Human Services.	Consulting (Healthcare Division)
Participant B	Academician (Engagement and Interactivity)	Research Organisation
Participant C	Academician (Co-creation in Healthcare)	Research Organisation
Participant D	Director	Community-Based Healthcare
Participant E	Consultant	Consulting (Healthcare)
Participant F	Executive Director	Health Consumer Peak Body
Participant G	Community Engagement Manager	Primary Healthcare (National)
Participant H	Chief Executive Officer	Primary Healthcare (National)
Participant I	Chief Executive Officer	Community-Based Healthcare
Participant J	Chief Executive Officer	Primary Healthcare (National)
Participant K	General Manager, Programs	Community-Based Healthcare
Participant L	Leader, Population Health and Community Engagement	Primary Healthcare (National)

The sample size for this research was data driven (Dick 1990), that is, more participants were added to the sample till the saturation was achieved and no new information was added (Nair and Reige 1995). Twelve convergent interviews were conducted to understand the organisational capabilities critical for effective participation of customer in service innovation. Each interview lasted for 50-60 minutes.

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2.5 Analysis

In this study, content analysis of convergent interviews transcripts was conducted and themes were developed. First, each interview was individually analysed and thereafter compared with the others so that patterns could be traced. These themes were labelled to reveal the relationships between customers and their organisation. In order to make refinements to the findings, an iterative process was used (Eisenhardt 1989). Follow-up interviews, email exchange with key informants were conducted to validate the data and the conclusion.

There are four tests of validity and reliability of the study (Yin 1989). To maintain construct validity multiple sources for data collection were used: that is convergent interviews, internal documents and archival records and literature sources. Internal validity was maintained through purposeful sampling to ensure that the sample was of knowledgeable and informed participants. As the research was data driven, more participants were added to the sample until the saturation was achieved to maintain external validity. To maintain the reliability, a convergent interview protocol was developed for the collection of data and convergent interviews were conducted and interpreted in a structured manner.

2.6 Findings

We begin the discussion of the findings with an overview of how respondents perceived the changing nature of the role of customers in health care service innovation. In recent years, customer participation has changed from passive recipient to co-creating value by integrating resources from service providers and other self-activities (McColl-Kennedy et al. 2012). The findings from this study provide additional confirmation of this phenomenon. When participants were asked about the attitude of customers to participate in health service innovation, they unanimously agreed that customers are more active, have more information, and want to be more involved in the health care process. However, the participants observed that although customers are more willing to participate in co-creating service innovation, the health care organisations are slow to respond and resistant to involve customers, as described by Participant L:

> "… the attitude towards the customer has changed in last 20 years in the commercial land and it is gradually changing in the health care sector. However, when you start talking to service providers in the health industry they individually are far more resistant in involving the customers."

Participants also commonly agreed that health care organisations do not have the necessary skills and resources to effectively engage customers in innovating health services, as mentioned by Participant E:

> "There are gaps. I mean it's a particular skill engaging with the consumer, engaging with the community and I think a lot of

> organisations think that it's easy to do - just ask them some questions, get them to fill out a survey, hold a focus group set up an advisory group, tick, done - a lot of it is not being done very well."

Organisations are moving toward involving customers to increase their success in innovating services. However, to enable customer participation organisations require continuous collaboration with customers (Matthing et al. 2004). They need the capability to recruit, engage and manage customer participation. Thus, this requires organisations to develop unique capabilities to enhance the active role of customers.

2.6.1 Customer activation

The nature of customers that participate in health care innovation is diverse and often context dependent with respect to the health care issue and the service innovation. Respondents spoke of individual participation in service innovation (patients, families, carers), as well as organised health care groups (e.g. Diabetes support groups). They recognised that individuals may be seeking to manage their own health care condition or seeking preventative health care. Participating customers would have differing levels of motivation, knowledge or acuity of an illness, knowledge of the health care system, and individual capabilities. It was a widely held belief that a singular health care customer was not the ideal participant for all health care service innovations. The following statement by Participant J further illustrates this:

> "I think that every situation and community is different but there will be some principles that will shape how an organisation will go about [engaging customers]. It will depend on how an organisation identifies

> customers who are encouraged to express their views. It will also depend on the health issues; say, for example diabetes, the impact of diabetes will be very different if you are a new arrival or if you are wealthy middle class Australian and that it would be entirely understandable and accepted that people with different cohort will have different expectations."

Customers can be activated or engaged with health care service innovation at both an individual and a group level. At the point of care with clinicians, customers participate in co-creating the experience of their own health care management (McColl-Kennedy et al. 2012). Customers can also participate at a strategic level for development of a new health care service in the community. Participant G illustrates this:

> "Engaging a voice on an ongoing manner needs to be embedded in the way we do business and not bolted on once a quarter or twice year. … We cannot exclude customer engagement from the process to improve health and wellbeing. You can involve customers in a group at a system development level or involve them at the co-creation of their own health."

Utilisation of customer experiences at a system level requires participation of the customers as a group. However, the organisation first needs to identify and motivate individuals with appropriate skills and resources before engaging with them on a group level. This is evident from the statement by Participant H:

> "I think we need to be really very careful that we don't go about it in tokenistic way …... Ensuring that it is the right person, that the person is supported, that the person has direct access to wider range of consumer groups. I think there is no doubt that engaging with the customer in a group is important through forums, focus groups but often consumers are put into these places with no support and they are obviously bringing often their own experience or of their family and friends to that space so whilst it's beneficial to hear that but it is important to make meaning out of the stories otherwise this is a pointless exercise."

The next section will further discuss the capabilities of customer mobilisation, customer identification, and customer agility that are required to engage the relevant customers in the service innovation process and respond to their input.

2.6.1.1 Customer mobilisation

The immediate identification and involvement of customers is a necessary organisational capability to engage customers in health care innovation (Coviello and Joseph 2012; Prahalad and Ramaswamy 2000). Not all customers are willing or have the appropriate skills and resources to participate in the innovation experience. Therefore, it is essential that organisations build capability to identify motivated customers whose profiles are appropriate to participate in service innovation. Participant C provides further illustration of this:

> "We are finding groups of patients with very low level of co-creation and groups of patient that have very high level of co-creation. Unfortunately it will be at an individual level and the difficulty is that people don't walk around with a label on them "I am willing to co-create". How do you identify the people are willing to co-create and how do you then facilitate the people who do want to and don't bug the people who don't want to?"

Customer mobilisation is an important capability for health care organisation because customer participation in co-creating health services has a great potential to improve health service delivery, customer experience and health outcomes (Crawford et al. 2003). Customer mobilisation is more than just interacting with customers, it is encouraging customers to utilise their own resources and skills (Coviello and Joseph 2012). In order to get this type of customer participation in service innovation, organisations require capabilities to attract, motivate and manage customers to use their operant resources (Hibbert et al. 2012). Although Coviello and Joseph (2012) identified the need for customer mobilisation in the new product development process, our findings demonstrate its relevance to a health care setting and a service innovation context.

2.6.1.2 Customer identification

The nature of service innovation in the health care context varies considerably (for e.g. clinical services, non-clinical services, delivery services, etc.). Organisations need the capability to identify customers with appropriate skills and resources for the necessary service innovation. Many health care organisations, mandated to involve customers in the

innovation process, will engage a customer panel or a small number of individuals and expect them to contribute to all health care service improvements. The description of Participant A, describes the need to for organisations to be able to identify customers with appropriate operant resources to suit the service innovation context.

> "In the case of cardiovascular disease you are much better to engage customers who have these diseases as compared to general consumers. [However] When you want to develop a consumer participation strategy in this case you do not want people with specific disease but you want people who can articulate across a range of different consumers."

Organisations require the capability to engage a relevant mix of customers and be open to their efforts (Coviello and Joseph 2012). Coviello and Joseph (2012) described engaging customers with close connections and some customers with weak connections with the organisation in a business-to-business context. However, in a health care context, the potential customer market is often much more diverse and the organisations do not have established ties to individual customers to draw upon. This makes the organisational capability to identify relevant customers a unique and difficult challenge.

2.6.1.3 Customer agility

Dynamic capabilities relate to managerial processes that sense, seize opportunities and reconfigure organisational resources to improve performance (Teece et al. 1997; Wilden et al. 2013). Customer agility is the capability to "capture the extent to which a firm is able to sense and respond quickly to customer-based opportunities for innovation" (Roberts and Grover 2012). Organisations need to be able to sense the changing needs of

customers and undertake actions to respond with ease, speed and dexterity (Roberts and Grover 2012). The need for cognitive, structural and relational flexibility, and lack of rigidity of process, is also recognised (Coviello and Joseph 2012). Findings from our interviews suggested that organisation's require the ability to obtain feedback on the customer experience (sensing) and respond swiftly to the needs identified. Thus, sensing and responding are identified as key aspects of customer agility, that enable organisations to activate customers to co-create health care service innovations.

The notion of sensing stems from the dynamic capability literature, and is an element required to identify and respond to customer needs (Teece 2007). Sensing can emerge from explicit customer information provided to the organisation in the form feedback, dialogue with front line staff or online, prototyping, and joint experimentation, or from implicit feedback such as that determined through observation. Customer agility should also reflect the organisational capability to identify latent and unmet needs of the customer and find options to meet those needs (Den Hertog et al. 2010). Moreover, customer agility is about aligning sensing and responding capabilities, which means the organisation needs to respond to the identified needs in a timely and appropriate manner. This is evident in this example from Participant I:

> "In the [name] activity program we noticed by looking at our demographic stats and from customers' feedback that we had a lot of men and women at the range of 35-60 but we didn't have many young people, we were not connecting with the young people. Rather than saying that we have to find young people, we know what they want, we

> will invite them, put on some pizza's then we will be up selling, instead of that what we did was that we found some young people as ambassadors help us build a program. They actually developed the program from the ground up so that is an example of innovation where we co-designed the program with customers."

Health care customers are often emotional and unknowledgeable about the service context and therefore appear reluctant to fully engage with providers (Berry and Bendapudi 2007). In addition, customers co-create value uniquely and differently and integrate resources in different ways through interactions with the organisation and other collaborators (McColl-Kennedy et al. 2012; Vargo and Lusch 2008). Therefore, it is imperative that the organisation has the capability to understand both the explicit and implicit customer needs and respond appropriately.

2.6.**2 Organisational activation**

2.6.2.1 Leadership

Health care organisations face critical challenges due to constant health care reform, global economic fluctuations, and employee resistance, which make it hard to drive innovation in the organisation (Rethmeier 2010). Due to these organisational challenges, there is a need for strong leadership (McAlearney 2006). This study confirms the importance of leadership for health care organisations and specifically for their ability to drive customer participation in service innovation, as stated by Participant D:

> "They have commitment to [enable customer participation] but it depends on the leadership in the organisation about how well they do it so you always need a check and balance. There is a commitment to encourage customer participation in the organisation but how far it is translated in good practices is variable."

Although many factors are important for enabling customer participation for successful innovation, the single most important factor is the competence of the leader (Speechley 2005). Active and powerful leadership at the top promotes and drives innovation (Jung, Wu and Chow 2008). Despite this, there have been few studies examining the role of leadership as a capability for effective co-created innovation (Kozlenkova et al. 2014).

Our respondents recognised that leadership must be apparent at all levels within the organisation. Because customers are interacting and co-creating with employees at multiple touch-points, innovation can be generated from any level within the organisation

(Skarzynski and Gibson 2008). Therefore leadership cannot reside centrally, nor be controlled by a few individuals at the top of the organisational chart. Employees at all levels must accept accountability and leadership responsibility in their areas of expertise (Currie and Lockett 2011). This perspective of leadership can be seen in the Participant J statement.

> "Leadership throughout the organisation is important. The CEO needs to model the behaviour expected of staff, and leaders at every level need to model what customer participation is, and expect it of their staff. Leaders should be able to articulate why customer participation is important, and show their staff how to do it. …. Customer participation needs to be part of the way of being."

This perspective on leadership significantly differs from the more traditional central leadership. In many health care organisations, the budget is decentralised, services are delivered from multiple departments, and several people have the responsibility to make decisions (VanVactor 2012). Therefore, leadership cannot reside centrally and be controlled by an individual; rather it has to be interdependent leadership operating at all levels.

2.6.2.2 Collaborative integration of resources

In health care organisations, there are multiple discrete functional areas present in a single organisation, making it more difficult to implement service innovation. In addition, various external stakeholders often need to be involved in the development of service innovation as they form part of the service provision. Therefore, collaborative integration is required to drive collaboration across cross-functional teams, customers and other stakeholders. This enables the organisation to access resources beyond its boundaries (Day 2011). The importance of collaborative integration can be well illustrated by the Participant L's statement:

> "It is very critical to use skilled personnel. An organisation needs to recognise that if they have skills and resources internally or not… if an organisation does not have appropriate resources it should source that from outside. It is critical to discuss and get clarity within the organisation on what are we trying to achieve and this is the hardest part."

Globally, there is more specialization of skills and knowledge and this has increased the interdependency among various actors in the economy (VanVactor 2012). This interdependence has also increased collaboration opportunities, which can result in more innovation (Lusch et al. 2007). Collaboration is often considered an important competitive strategy for innovation (Lusch et al. 2007). It has been recognised that for co-creating innovation in a public sector setting, such as health care, there is often the additional challenge of dealing with multiple stakeholders (Bessant and Maher 2009).

2.6.3 Interactional capabilities

Karpen et al. (2012) developed a service-dominant orientation construct, which recognises organisations need interaction capabilities to facilitate and enhance value co-creation. In this section, participants' statements are provided to illustrate the relevance of each of these interaction capabilities in the health care service innovation context.

Individuated interaction capability is the organisational capability to understand individual customers (Karpen et al. 2012). The customer is the primary resource integrator in co-creating their own health care (McColl-Kennedy et al. 2012) and every customer co-creates differently even when they are provided with a similar value proposition (McColl-Kennedy et al. 2012). Therefore, understanding individual customers' unique contexts, their expectations and preferences is essential in enabling customer participation in health care service innovation. Participant C explains individual customer unique preferences in enabling customer participation.

> "Some people will just be compliant, and they will take the information leaflet and read it. That is the extent of their co-creation. Others would have enrolled themselves in actual short courses offered so that they are more active in co-creation. I think it is about organisations just providing avenues for customers to co-create."

Relational interaction capability is the organisational capability to improve social and emotional connections with customers (Karpen et al. 2012). Customers in health care settings often feel extreme emotions and that they have no control over their treatment (Berry and Bendapudi 2007). A health care organisation's capability to improve social

and emotional connections with customers improves the customer experience beyond medical outcomes and encourages them to participate in health care service innovations. Participant C explains the importance of emotional and social connections when engaging customers for this purpose.

> "For those people who are interested, it is a matter of showing them what the value proposition is, for those engaging not let them have to work it out. Tell them what's going to happen as a result of them [customer] engaging and being involved in improving the system. You can go back to a whole heap of relationship marketing variables. They must feel like they have a relationship with the organisation, trust the organisation etc."

Ethical interaction capability is the organisational capability to act in fair way towards its customers (Karpen et al. 2012). Ethics is the basic professional obligation of health care organisations. In engaging the customers for health service innovation it is essential to act in a fair way and engage customers from different domains of life, especially the marginalised groups. Consider the statement of Participant E as an illustration of this:

> "You will always have certain numbers of consumers you want to be involved but then at the same time you need to encourage new people. So, I would like to meet with some people that have just started or been in the program for 6 months, some who have been in the program for 12 months so that I can get a different perspective but because a lot of people I consult with are fairly vulnerable, older people, people with

mental illness then you really have to make sure that you have good processes in place."

Empowered interaction capability is the organisational capability to empower customers to utilise their skills to shape the nature of service (Karpen et al. 2012). Customers possess knowledge and skills that can contribute to the service process (Grönroos 2008). Organisations require capabilities to engage customers so that they are willing to contribute their ideas, knowledge and skills. A health care organisation's capability to empower the customers plays a critical role in improving their own health (Anshari and Almunawar 2011) and enabling customer participation in health service innovation. Participant I provided an example of young people being empowered:

> "We found some young people as ambassadors help us build a program so they actually developed the flyers, they used their network to say hey let's have a meeting to talk about a program [organisation]… They picked the community centre they brought the young people in and then they actually developed the program from the ground up so that is an example of innovation where we co-design all our programs."

Developmental interaction capability is the organisational capability to develop customer knowledge and competence (Karpen et al. 2012). Customers must acquire the necessary skills and knowledge to be effective resource integrators and organisation should have the capabilities to facilitate the customer learning process (Edvardsson et al. 2011; Hibbert et al. 2012). Participant E provided an example of this:

> "I did A3 laminated pages of graphs and charts showing them [customers] the health of their community. … This is your population, this is the ageing part of your population, this is your health and they were absolutely fascinated by it… what services do you need, where are those gaps. So you actually give information to receive information."

Concerted interaction capability is the ability to facilitate coordinate and integrate service processes that include customers (Karpen et al. 2012). Coordinating the services is an important capability in health care organisations because even if the organisation tries to innovate the way a particular service is delivered it has to coordinate and integrate the participation of various departments, customers and their carers. Consider the statement of Participant H to demonstrate this:

> "I think it's really important that we actually are very inclusive … if we are able to connect up the dots … and feed them up to the strategy … and if we are providing a complete and holistic service to a client … So you know that's a complex scenario but if each of the players are in the loop that can be managed very well and patient can only benefit from that."

2.6.4 Learning agility

2.6.4.1Responding to customer needs

Learning agility is an organisations' capability to improve on its processes for viable business existence (Den Hertog et al. 2010). Our interviews found that learning agility is

important for organisations to innovate health services. Participant A explains that organisation learn from customer participation:

> "Chronic disease there is a lot of innovation that you could [develop] with … these people [customers of chronic diseases] has lot of admission; lot of hand overs so there is real opportunity to improve pathways of care, great opportunity to improve home care, great opportunity to self-management."

New organisations usually generate and share knowledge within the organisation and across the partners and are willing to learn from others and import knowledge from their customers, as well into service innovation (Coviello and Joseph 2012). In contrast, an existing organisation has layers of standard procedures and processes that hamper innovation (Teece 2007). Resources related to responding to changes in the environment (e.g. technical execution, organisational resources) have been frequently examined for their impact on marketing innovation (Kozlenkova et al. 2014). Wilden et al. (2013)Wilden et al., (2013) argued that an organisation's dynamic capabilities could be disaggregated into its capacity to sense and shape opportunities, seize opportunities (through knowledge utilisation) and reconfigure its resource base to take advantage of these opportunities. This capability would positively influence firm performance in multiple ways (Teece et al. 1997).

2.6.4.2 Organisational flexibility

Organisation flexibility enables new organisations to generate and share knowledge within the organisation and across the partners, and it enables ongoing organisations to redevelop their processes and acquire new knowledge. This was well identified by our participant J:

> "Organisations need to be adaptable and flexible to ensure that services provided are those that people actually need. Organisations need to operate in a way that encourages responsive approaches that are based on needs, not what suits the organisation."

Organisational flexibility can have a positive influence on acquiring new knowledge and redeveloping the existing mechanism (Wang et al. 2013). However, old processes and practices often hinder the absorption of new knowledge. Organisations must have the flexibility of unlearning previous processes if they hinder the adoption of innovation. Thus, flexibility within learning agility is an important capability for health care organisations in the current political and social climate.

2.6.4.3 Evaluation tools

Participants were asked about evaluating the impact of activities undertaken by organisations to enable customer participation in health service innovation. Unanimously participants agreed that evaluation would assist the organisations to understand the improvement areas as stated by Participant E:

> "That [Evaluation] is the next step while people are agreeing to undertake stakeholder and consumer engagement what are they doing, how useful is it or are they just having a cup of morning tea and tick the box that they have done some engagement. It has to be real."

Overall, the findings show that the active role of customers is causing challenges for health care organisation as they lack the skills and capabilities to manage increased customer participation. To facilitate customer participation in health care service innovation several organisational capabilities were identified in the study and categorised into four categories these include customer activation, organisation activation, interaction capabilities and learning agility. The next sections will discuss the findings in more detail followed by the limitation of the research.

2.7 Discussion and conclusion

This research addresses a key priority area in service science research, furthering our understanding of customer participation in service innovation (Berry and Bendapudi 2007; Ostrom et al. 2010). Specifically, it advances dynamic capability theory by applying it in a co-creation context, and enhances our conceptual understanding of the role of the organisational capabilities to support customer participation in health care service innovation. Although some previous authors consider customers to be self-directed in their resource integration activities and subsequent learning (Hibbert et al. 2012), our findings articulate that managers endeavour to take an active role in managing customers within this interaction.

Our findings provide support for previous research that has found that the role of the customer in health care management has significantly changed in recent years (McColl-Kennedy et al. 2012), with the customer being an active co-creator of their experience and demanding more meaningful interactions with the health care organisations. We reveal that, as a result of this changing role, health care organisations perceive they lack the capabilities required to effectively manage the increased customer participation.

The primary objective of this study was to provide insight into the organisational capabilities required to facilitate customer participation in service innovation. By applying dynamic capability theory through the lens of co-creation, we revealed several organisational capabilities and ordered them into four main categories around the customer and provider spheres of co-creation (Grönroos and Voima 2013). The first two categories, customer activation and organisational activation, reflect the organisations capability to motivate and prepare both parties to come together, in the joint sphere, and integrate their resources to co-create innovation. This ensures both parties have the relevant operand and operant resources to contribute and draw from in this interaction. Organisations need to identify and mobilise customers, recognise their explicit and implicit needs, and develop skills within customers to ensure that they are able to integrate resources. Concurrently, an organisation needs to provide a supportive leadership team and relevant and integrated resources. The third category, interactive capabilities, encourages an effective dialogue between the organisation and the customers. Organisations require the capability to engage customers in this dialogue, continue development of their skills, and provide them with the support and opportunity

to create value and learning through the interaction. The final category, learning agility, reflects the organisations capability to continually respond to the opportunities identified and implement emerging innovative solutions. This will require the continual adaption and flexibility of process to meet the changing needs of customers. Our findings show that although health care organisations recognise the importance of these capabilities to support customer participation in health care service innovations, most health care organisations seek further guidance on their implementation.

Previous research studies have mostly focused on customer participation in innovation as an input in the process (Alam and Perry 2002; Carbonell et al. 2012). Therefore, organisational capabilities to enable customer participation throughout the full spectrum of the innovation development have not been explored adequately. In addition, most of the literature on organisational capabilities had focused on product providers (Coviello and Joseph 2012; Lin and Huang 2013) and capabilities related to customer participation in service innovation remain underexplored. Thus, this study has addressed a gap in the literature by applying dynamic capability theory in a co-creation context and identifying and demonstrating capabilities required for customer participation in service innovation.

This study has contributed to dynamic capability theory and the knowledge of organisational capabilities, and builds on the work of Coviello and Joseph (2012) and Karpen et al. (2012). Coviello and Joseph (2012) identified customer mobilisation and learning agility as marketing capabilities for co-creative innovation. However, their study was set in a business-to-business context and therefore customer mobilisation was

depicted as involving a small group of customers with whom they already have a close relationship, or operate within close proximity in a network. We found that health care organisations are often at a psychological distance from their customers and therefore customer activation and mobilisation is more challenging. We therefore extend the notion of customer mobilisation as proposed by Coviello and Joseph (2012), to have a greater focus on customer identification.

Karpen et al. (2012) identified six strategic interaction capabilities that constitute a service-dominant orientation. Our findings extend their work by highlighting the importance of these capabilities for a health care organisation. A health care organisation needs the capability to interact with the individual customer while taking into consideration equity, access, knowledge sharing and ethics. This is imperative in the health care sector, as organisations often find it difficult to engage customers due to either lack of access, poor health literacy, or lack of skills and resources. Coviello and Joseph (2012) identified learning agility was important factor to ensure that organisation had cognitive, structural and relational flexibility to provide services that customers need. However, they examined new and emerging technological firms. Our findings corroborate their findings and extend them to both new and existing firms in a health care setting.

From a managerial perspective, our findings will assist managers of health care service organisations in several ways. First, our findings show that customers want to participate further in the improvement of health services for themselves as well as for the

community. However, senior executives raised concerns about their ability to deal with this increased participation from customers. Therefore, the organisational capabilities identified can guide managers in successfully encouraging and supporting customer participation in health care service innovation.

Second, our findings suggest that to harness the valuable skills and resources of customers to contribute to service innovation, organisations require the capability to identify and respond to customer needs that are constantly changing. Managers need to mobilise a mix of relevant customers, as not all the customers will be willing to participate or have the necessary skills and resources to contribute to the service innovation process. Therefore, managers need to build customer activation capability to identify customers with appropriate skills and resources to participate in a successful service innovation experience. Strategies such as workshops or discussion forums to identify willing and competent customers to leverage into innovation initiatives would be effective.

Third, we recognise the importance of the internal capabilities of an organisation being predisposed to support customers' participation in innovation. Given the complexity of many health care organisations, managers face a challenge to collaborate with cross-functional teams, customers and other stakeholders. Therefore, there is a potential advantage for managers to stimulate collaborative integration and leadership to take place throughout the organisation.

Fourth, our respondents articulated that their organisations had not had a history of being customer-focussed. Therefore, it was recognised that managers would need to develop organisational capability to effectively interact with customers. These interaction capabilities would need to recognise customers as individuals, build relationships, empower and develop them, act ethically, and be a coordinated and integrated effort. Much of this effort would be directed through formal and informal communication channels.

Finally, for innovative outcomes to be achieved, managers need to build organisational capability to learn from evaluation, and have the flexibility of unlearning the previous processes if they are hindering the adoption and diffusion of innovation. Customer surveys, discussion forums, and other feedback mechanisms would initiate this process, but more important is the organisation's responsiveness to the evaluation.

2.8 Limitations and Future Research Directions

Despite the contributions outlined above, there are several limitations arising from the study, which deserve attention. First, while the respondents in our sample were selected for their ability to provide rich and valuable insight, the study could be further expanded among a broader range of health care professionals, including from other countries with different health care systems, to enhance the generalisability and further refine the insights generated. Second, as there has been little research conducted to date to understand customer participation in health care service innovation, undertaking a qualitative research design was necessary to understand the complexity of the experience. Further research could look to empirically test the influence of the capabilities on resource integration behaviours of customers and the organisation, and the ultimate effectiveness of the innovation design. Third, to respond to this increased participation of customers in service innovation organisations require a supportive culture towards customer participation. Further research could explore what this type of organisational culture looks like, what are its components and how it manifests. Fourth, several of the capabilities identified warrant further investigation and understanding to enhance their managerial relevance. For example, although the capability of customer activation recognises the need to identify customers with appropriate skills and resources to facilitate the innovation process, further investigation could be undertaken to understand the customer profiles that are best suited to participate in innovation. Finally, this study has focussed on the health care context, as it is rich in complexity and unique challenges for customer participation. Further research is required in other complex service

environments (e.g. banking and finance) to collaborate and investigate further the organisational capabilities required to support customer participation in innovation.

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Name of Principal Author (Candidate)	Shikha Sharma		
Contribution to the Paper	Developed conceptual framework, collected data, performed analysis on all samples, interpreted data, wrote manuscript		
Overall percentage (%)	65%		
Certification:	This paper reports on original research I conducted during the period of my Higher Degree by Research candidature and is not subject to any obligations or contractual agreements with a third party that would constrain its inclusion in this thesis. I am the primary author of this paper.		
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Co-Author Contributions

By signing the Statement of Authorship, each author certifies that:

i. the candidate's stated contribution to the publication is accurate (as detailed above);

ii. permission is granted for the candidate in include the publication in the thesis; and

iii. the sum of all co-author contributions is equal to 100% less the candidate's stated contribution.

Name of Co-Author	Dr Jodie Conduit		
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Name of Co-Author			
Contribution to the Paper			
Signature		Date	

CHAPTER 3 : CO-CREATION CULTURE IN HEALTH CARE ORGANISATIONS

(Previous version of published paper)

3.1 Introduction

The recognised shift from a goods-dominant to a service-dominant logic (Vargo and Lusch 2004, 2008) has called for organisations to modify their business practices, with research advising organisations to adopt co-creative behaviours such as a service-dominant orientation (Karpen et al. 2015), collaborative practices (Skålén et al. 2015), and co-creation practice styles (McColl-Kennedy et al. 2012). These activities require organisations to recognise the customer as an operant resource (Vargo and Lusch 2008) and an active participant in value co-creation, which is in contrast to the traditional view of customers as passive receivers of marketing strategies (McColl-Kennedy et al. 2012). To achieve this shift and provide support for the implementation of these practices, organisations require an organisational culture that is open, shares control, and encourages customers to learn and participate in value co-creation (Karpen et al. 2015; McColl-Kennedy et al. 2012). Although a market orientation embodies a customer focus, it is an incomplete substitute for the service-dominant logic approach (Michel et al. 2008). While a market orientation acknowledges the importance of understanding customer needs, genuine co-creation can occur only when the organisational culture includes the customer in the life of the organisation (Ostrom et al. 2010). Organisations therefore need to establish a culture that recognises and treats customers and employees

as operant resources (Lusch et al. 2007) and seeks to co-create core business practices with and among them. This research explores the characteristics of an organisational culture that comprehends the customer's active role in value co-creation and facilitates active participation and resource integration among multiple actors.

Many current organisational culture models are constrained from embracing and supporting co-creation practices because they are based on the competing values framework (CVF), which clearly discriminates between an internal and external focus for the organisation (Deshpande and Webster 1989; Lukas et al. 2013). In contrast, the service-dominant paradigm asserts that the boundaries between the organisation and the customer are blurred and argues that all actors co-create value within a service ecosystem (Payne et al. 2008; Vargo and Lusch 2008). Although the organisational culture literature recognises the importance of the customer (Deshpandé and Farley 2004), it views customers as a source of information for creating value (Urde et al. 2013) and largely does not specifically discuss the customer's role within the organisational culture (Lukas et al. 2013). In addition, while a traditional dyadic customer–organisation view of organisational culture takes the perspective that value is co-created by the organisation, its customers, and their network, it does not acknowledge interconnectedness among the actors. This neglect results in a need to explore and understand an organisational culture that facilitates collaboration, reciprocal communication, Shared understanding, and customers' active participation in value co-creation activities (Karpen et al. 2015; McColl-Kennedy et al. 2012).

The purpose of this paper is to identify and explicate the characteristics of an organisational culture that supports co-creation. We build on the definition of value co-creation of McColl-Kennedy et al. (2012) and define a co-creation culture as the behaviours and values that support all actors in actively participating in resource integration to mutually create value in a complex interconnected system. To examine the concept of a co-creation culture in the health care sector, we take a qualitative, interpretive research approach and use three case studies of community-based health care organisations to explore the socially constructed phenomenon of a co-creation culture. More specifically, our investigation entails an examination of the complex interactions and interrelationships among customers, care-givers, providers, and suppliers (Thakur et al. 2012). Relying on fifteen interviews, seven focus groups, and two hundred ninety two pages of content from documents and noted observations, we conduct a thematic analysis to provide rich descriptions of the concepts and construct a conceptual framework that depicts a co-creation culture (Gioia et al. 2013). Our findings show that a co-creation culture is built around a series of core and supportive co-creation behaviours. Core co-creation behaviours reflect resource integration to achieve outcomes such as co-production, co-development, co-advocacy, co-learning, and co-governance, while supportive co-creation behaviours enable interaction and include dialogue, Shared market intelligence, mutual capability development, and Shared decision-making. Underpinning these behaviours is a set of values that are central to the co-creation process and are Shared across the organisation and its customers. We explore the values of mutual respect, mutual trust, empowerment, and acceptance and examine the role of each in a co-creation culture.

The remainder of this paper is structured as follows. In the next section, we review the literature on value co-creation and organisational culture to demonstrate the need for a deeper understanding of a co-creation culture. We then outline the methodology of this research. We subsequently identify the behaviour and values that underpin co-creation culture and discuss the theoretical and practical implications of our findings. We conclude with an acknowledgement of limitations and suggestions for future research.

3.2 Co-creation culture: conceptual development

3.2.1 Value Co-creation

During the past decade, several scholars have studied value co-creation to provide insight into its conceptualization (Prahalad and Ramaswamy 2004), understand the customer's role and relative importance in co-creation (Vargo and Lusch 2004, 2008), examine the process of co-creation (Payne et al. 2008), and identify activities that customers engage in during co-creation (McColl-Kennedy et al. 2012). Initially, co-creation focused on the dyadic interaction between the customer and the organisation (Grönroos and Ravald 2011; Prahalad and Ramaswamy 2004). However, this perspective has broadened to recognise that multiple actors contribute in value co-creation (Tether and Tajar 2008; Vargo and Lusch 2011). For example, the concept of value co-creation now extends beyond the customer–firm dyad to include self-generated activities or resources drawn from third parties (McColl-Kennedy et al. 2012). Service-dominant logic also emphasizes resource integration by all actors (Vargo and Lusch 2008). Actors exist within service ecosystems with increasingly permeable boundaries, where organisations and customers

are embedded within networks of other organisations, customers, and partners (Edvardsson et al. 2011; Vargo and Lusch 2011). The practice of value co-creation expands the unidirectional dyadic customer–organisation approach to a broader social context in which value is derived (Chandler and Vargo 2011).

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Viewing value co-creation from a network perspective rather than from a dyadic viewpoint challenges the traditional management mechanism of hierarchical control and requires specific organisational elements for support. The organisation's role is to facilitate and buttress resource integration and to enhance the broad range of customer experiences (Arnould and Thompson 2005; Hibbert et al. 2012; Karpen et al. 2012; Payne et al. 2008). To perform this role, the organisation requires a culture that supports actors in communicating and making decisions that contribute to the creation of value (Karpen et al. 2015; McColl-Kennedy et al. 2012). An organisation is unlikely to have rigid processes and procedures for dictating co-creation activities, and the organisational culture therefore provides a general framework to guide the necessary interactions. We thus explore the specific behaviours and values that facilitate and promote value co-creation by multiple actors.

3.2.2 Organisational Culture

An organisation's culture reflects its Shared assumptions and values and distinguishes it from other organisations (Schein 1984, 1990). Organisational culture is "the pattern of Shared values and beliefs that help individuals understand organisational functioning and thus provides them with norms for behaviour in the firm" (Deshpande and Webster

1989). Values are social principles or philosophies that inspire desired behaviour within an organisation (Schein 1990), and the behaviours of the employees in the organisation are influenced by the mutual values evident (Homburg and Pflesser 2000).

Values are fundamental in understanding an organisation's culture (Ott 1989) and researchers often employ the competing values framework (CVF) to examine organisational culture (Quinn and Rohrbaugh 1983). According to the first value dimension of the CVF, an organisation's positioning can take either an internal focus, where the emphasis is on integration, or an external focus, where the emphasis is on competitive positioning through differentiation (Cameron and Quinn 2006). However, from a service-dominant logic perspective this dichotomy of an external or internal focus is counter-intuitive. Rather than regarding organisational culture as a closed system with boundaries, a service-dominant logic perspective recognises that organisations work together with customers, partners, and other actors across boundaries (Edvardsson et al. 2011; Vargo and Lusch 2011). Similarly, the second CVF value dimension assumes that an organisation's processes are either flexible or mechanistic (Cameron and Quinn 2006). However, the customer is not a passive recipient of these processes but is instead a co-creator of value (Bijmolt et al. 2010), with the organisation acting as a facilitator to provide customers with the necessary support for deriving value. To align their processes with the customer's processes, organisations need flexibility rather than a mechanistic approach—implying that the popular two-dimensional CVF is limited in its ability to describe the contemporary organisational culture.

Past research has given little consideration to the customer's role within organisational culture (Lukas et al. 2013), although the CVF was adapted to include a market orientation (Deshpandé, Farley and Webster 1993), which is a fundamental aspect of an organisation's competitive strategy (Narver and Slater 1990) and organisational performance (Deshpandé et al. 1993; Homburg and Pflesser 2000). A market orientation regards the customer as a source of information (Deshpandé and Farley 2004) and emphasizes acquiring, disseminating, and responding to market intelligence (Kohli and Jaworski 1990). This perspective contrasts with the service-dominant logic perspective of customers and organisations working together to integrate resources and co-create value (Vargo and Lusch 2008). This difference suggests that a market-oriented culture is inadequate to support the role customers are assuming within the organisation. As the foundations of marketing are changing to reflect a service-dominant perspective, the theories and practices in marketing need re-analysis (Fisher and Smith 2011), and particularly important is an understanding of the organisational culture that facilitates value co-creation by customers, employees, and other actors for themselves and others (Karpen et al. 2015).

Our research directly answers the call to explore an organisational culture that is open, allows Shared control, and facilitates customer participation and learning (McColl-Kennedy et al. 2012). We examine the characteristics of a co-creation culture in a health care organisation.

3.3 Methodology

Customer participation in health care is receiving increased attention in both the health care literature (Nambisan and Nambisan 2009) and the marketing literature (McColl-Kennedy et al. 2012; Sweeney et al. 2015). Presently, customers in health care are demanding participation. However, their poor health literacy, a power differential, a fragmented health care delivery system, management's lack of willingness, and organisations' lack of skills create a challenging context (Sharma et al. 2014). Nevertheless, the recognition that pursuance of a co-creation culture is important, in conjunction with the complexity of the industry, make health care organisations a rich context for our research.

3.3.1 Research Approach

Our methodology was informed by an ontology of relativism and an epistemology of realism. The ontology of relativism is dynamic in nature and socially constructed by the interaction of several people in a given context (Strauss and Corbin 1998). In an epistemology of realism, the researcher builds participants' confidence to share their views of reality with minimal influence (Guba and Lincoln 1994). These perspectives are consistent with the Gioia methodology adopted in this research (Gioia et al. 2013) which is built on a grounded assumption that the organisational domain is socially constructed and organisational employees are knowledgeable agents creating their own realities. Therefore, close interaction with multiple employees from the organisation helps construct reality by understanding their perspectives on a Shared culture. The Gioia methodology provides a systematic inductive approach to concept development in that

prior constructs or theories are not imposed on informants as an a priori explanation for their experience. The approach therefore captures concepts relevant to the human organisational experience in terms that are meaningful for the participants in that experience and fosters a level of scientific theorizing about that experience (Gioia et al. 2013). For these reasons, we took this approach to examine the phenomenon of a co-creation culture.

3.3.2 Data Collection

Our exploratory qualitative approach comprised two phases: preliminary convergent interviews and multiple case studies. In the first phase, we interviewed ten senior executives in health care organisations, as they facilitate customer participation at the level of strategy development in their organisations. In addition, we interviewed two academics who had conducted research in the area of co-creation in health care and customer engagement. These convergent interviews guided the objectives of the research by consistently revealing the need to explore the organisational culture that facilitates co-creation. The interviewees' discussion of business practices helped with preparation of the interview guide for the second phase and provided information that assisted with the recruitment of case studies.

The second phase consisted of three case studies of health care organisations in Australia (referred to for confidentiality reasons as RED, YELLOW, and GREEN). This phase employed multiple sources, including field observation, document analysis, and media documentation as well as in-depth interviews and focus groups (see Table 3-1). A

multisource approach to data collection allows for conceptual development and the induction of a conceptual model (Siggelkow 2007). Consistent with the recommendations of (Gioia et al. 2013), we emphasized the semi-structured interviews and focus groups to gain the perspective of the lived human experiences, especially in light of the socially constructed context of organisational culture. However, for each of the identified concepts, the data analysis revealed corroborating evidence from other sources. All observational and interview data were collected by the lead author.

Table 3-1: Data Sources

Data source	Type of data	Description
Documents and archival records	Annual reports Samples of job descriptions Meeting agendas and minutes Blogs (written by CEO and a client)(RED only) Organisational charts Orientation packs Survey analyses of customer advisory group review and service improvement review (GREEN only) Consumer participation policy and frameworks Terms of reference of advisory committees Website content	240 pages of content
Observations	Field notes from participation in: 2 strategic planning meetings (attended by customers, care-givers, volunteers, and employees) 2 advisory committee meetings (attended by care-givers, employees ,and CEO) 2 customer meetings (attended by customers and employees) Senior management meetings (attended by employees and CEO).	44 pages of field notes
	Informal conversations with reception staff, customers, support staff, families of customers	8 pages of field notes
Interviews and focus groups	12 convergent interviews with senior executives in health care organisations	165 pages of transcripts
	15 in-depth interviews from case study participants	298 pages of transcripts
	7 focus group interviews from case study participants	103 pages of transcripts

3.3.2.1. Identification of respondents

The CEOs of RED and YELLOW were interviewed in the cohort of first-phase interviewees and their customer participation approach was evident. RED's CEO emphasized the firm's strategy of involving customers in all its programs, while YELLOW's CEO placed more importance on intra-organisational coordination and functioning to deliver customer-focused services. We therefore selected RED as a best practice example of a co-creation culture and selected YELLOW as a counter case. GREEN was selected later in the research on the recommendation of a respondent from the first phase, who highlighted that firm's customer participation approach to service provision.

Table 3-2 summarises the profile of respondents from all three cases. Cases and respondents were selected through purposive sampling to ensure that the study included knowledgeable and informed participants. We took steps to ensure that the sample represented all segments of the organisations, including both service-facing roles (e.g., support workers) and non-service-facing roles (e.g., finance managers). We identified key personnel from organisational charts and through recommendations from senior management. We conducted in-depth interviews with respondents in leadership and management roles and held focus groups with the middle managers, front line staff, and customers. We interviewed the CEOs of RED and YELLOW again at this phase of the research, consistent with Gioia's suggestion to backtrack to prior informants to ask questions that arise from subsequent interviews. In total, we conducted fifteen in-depth

interviews and held seven focus groups across the three organisations (see Table 2). The in-depth interviews and focus groups lasted 50 to 60 minutes and each focus group had 3 to 6 participants. Respondents were between 25 and 50 years of age and had been associated with the organisation for at least 12 months. Finally, 74% of respondents were female, reflecting the employee base of the organisations.

Table 3-2: Profile of Interview and Focus Group Participants

	RED	YELLOW	GREEN
	Interview Respondents		
Respondent 1	CEO	CEO	National Services Manager
Respondent 2	General Manager	General Manager	Service Development Manager
Respondent 3	Finance Manager	Clinical Supervisor	Consumer Participation Manager
Respondent 4	Program Manager	Finance Manager	Corporate Services Manager
Respondent 5	Program Manager	Marketing Manager	State Manager
	Focus Group Participants		
Focus Group 1	Team leaders (3 participants)	Service Managers (4 participants)	Team leaders, support workers and customers (6 participants)
Focus Group 2	Support workers (3 participants)	Support workers (3 participants)	
Focus Group 3	Customers and volunteers (4 participants)	Family advisory committee (6 participants)	

3.2.2.2 Interview protocols

For the collection of data, we developed a protocol for the interviews and conducted and interpreted the interviews and focus groups in a structured manner. While in-depth individual interviews reflected each respondent's perceptions of the organisational culture, focus groups allowed us to explore group dynamics and Shared culture (Jaskyte and Dressler 2004). All respondents were asked about the role of customers within the organisation, the nature of interaction between customers and staff, communication and engagement with customers, resources and systems in place to engage customers, and strengths and challenges in encouraging customer participation. Specific questions also addressed the characteristics of the culture and the behaviour and values underlying the organisation's customer participation strategy. Owing to the interpretive nature of the research, we made minor modifications to the interview protocol as the research progressed (Gioia et al. 2013). However, the main topics of investigation remained unchanged. An iterative process of simultaneously collecting and analysing data helped in refining the understanding of emerging themes (Glasser and Strauss 1967).

3.3.3 Data Analysis

The data collected were analysed using thematic analysis to identify and examine the themes emerging from the data. Interview transcriptions, focus group transcriptions, observations, and documents were managed electronically with NVivo software. We reviewed the interview transcripts and focus group transcripts along with other relevant documents to become familiar with the data and determine distinct and shared patterns among various respondents. Each interview was coded separately on the basis of phrases

used by respondents (Miles and Huberman 1984) and read several times to compare across respondents (Glasser and Strauss 1967). We coded observations and documentations collected from the organisations in a way similar to that of the interview data, which supported and refined the emerging categories. Concurrently, similar codes were collated into first-order categories. Throughout the data analysis, a codebook was developed and refined on the basis of iterative comparisons between the newly analysed transcript and the previously coded data (Strauss and Corbin 1998). After coding all of the interviews and focus groups from RED, 95% of the first-order categories in the codebook had been identified. Coding from GREEN identified a further 5% of the categories and saturation was deemed to have been achieved (Guest, Bunce and Johnson 2006). YELLOW served as a counter case and was examined for the absence of these concepts.

We systematically examined the first-order categories to uncover relationships between and among categories, which facilitated organizing them into second-order themes. While the first-order categories emerge from informant observations, the second-order themes arise from the researchers' expert knowledge of existing theory to determine whether the emerging themes suggest concepts that describe and explain the observed phenomenon. This process is similar to axial coding (Strauss and Corbin 1998) and provides a qualitatively rigorous demonstration of the links between the data and the induction of the identified concepts (Gioia et al. 2013).

We measured the prevalence of each identified concept on the basis of the number of

different respondents who articulated the theme across the entire data set (Guest et al. 2006). We assumed that the number of individuals expressing the same idea is a better indicator of thematic importance than the absolute number of times a theme is expressed and coded (Guest et al. 2006). We chose this approach because previous researchers have expressed concern that in calculating each individual occurrence of the theme, the frequent occurrence of a word or coding category might be due simply to a respondent's talking at length about the topic (Shields and Twycross 2008), and therefore the calculation would not accurately capture the enthusiasm or importance expressed by the respondents (Guest et al. 2006). In our study, as YELLOW is a counter case owing to its market-oriented culture, the absence of a category provides further support that the category represents a co-creation culture.

3.3.3.1 Credibility of the Data

The lead author initially developed the codebook in consultation with other researchers on the project. When interpretations of informant terms differed, we revisited the data, engaged in discussions, and attempted to arrive at a consensus. A qualitative researcher from a separate school was engaged for peer debriefing to gain an outsider's perspective (Lincoln and Guba 1985). Once the codebook was finalized, it was shared with an independent coder who coded the data to assess inter-coder reliability. To ensure that the comprehension of the codes remained consistent throughout the coding process, we conducted several calibration checks (Kurasaki 2000). We calculated inter-coder agreement for each of the thematic categories as well as an overall average agreement across all themes. Inter-coder agreement on the themes ranged from .81 to .94, for an

average of .89 across all themes. Table 3-3 summarises the results.

Table 3-3: Intercoder Agreement for Each Theme

Themes	Agreement between coders
Co-production	.86
Co-development	.90
Co-learning	.89
Co-advocacy	.92
Co-governance	.94
Dialogue	.92
Shared market intelligence	.92
Mutual capability development	.81
Shared decision making	.90
Mutual respect	.89
Mutual trust	.89
Empowerment	.81
Acceptance	.94

We took several steps to ensure trustworthiness of the data (Lincoln and Guba 1985). First, we conducted the study over a period of 12 months and engaged the CEOs of RED and YELLOW with the research during the preliminary phase. The prolonged engagement with the respondents helped the field researcher to understand the social setting by observing various aspects of the organisation, building trust with the respondents, gaining access to various archival records, and speaking with a range of people. Second, prolonged engagement helped with consistent observations and triangulation of the interview data with the archival records and observations. Finally, to test our reconstruction of what we observed and assess whether the conclusions reached were plausible, we provided a case report to the senior management of all three

organisations.

3.4 Findings

The data revealed that all three organisations acknowledge the role of the customers in value co-creation. RED has a commitment of "sharing the journey" with its customers, suppliers, and partners and demonstrates a high degree of commitment to co-creation. RED endeavours to involve customers in every aspect of the business, including new initiatives, service delivery, business development, and governance (evaluation). GREEN also recognises the importance of customers and involves its customers, suppliers, and other stakeholders in a wide range of initiatives. However, this involvement is on ad hoc basis and the organisation is working toward improving its co-creation approach. YELLOW has experienced a recent change in management and is planning to shape its organisational culture to ensure greater participation from customers. Although the firm currently has a customer focus, customers and other stakeholders are not intrinsically involved. The differences in the culture of the three organisations are evident from the statements of the CEOs and senior executive managers:

> "One thing that is very strong and very important in our organisation is the fact that we co-design our programs. It's the participants who work with staff to not only connect with the programs but often to design, develop and even deliver the programs" (RED Respondent 1)
>
> "Our culture is very much built around…a collaborative model…that is about working with people on what is important to them, what's their

values and what direction do they want…how we can help them action plan that". (GREEN Respondent 1)

"I have asked one of the staff to ring 8 families a month with 4 or 5 questions about if they are happy with our service if not why not…. I have introduced a newsletter for staff…. I have set up some information sessions for families and customers on topics that I understand would be of interest to them". (YELLOW Respondent 1)

While complementary behaviours were identified across all three health care organisations, the manner in which these behaviours manifest was fundamentally different. YELLOW had a predominant customer focus, or market orientation, but did not seek to actively co-create with customers or involve them in the daily life or culture of the organisation. In this regard its activities differed from RED and GREEN and provided a comparison of the distinction between a market-oriented culture and a co-creation culture. Table 3-4 provides an explanation of the co-creation behaviours and values identified in our findings and the comparative market-oriented behaviour exhibited by YELLOW and identified in previous research (Gebhardt et al. 2006; Homburg and Pflesser 2000).

Table 3-4: Organisational Behaviours and Values

	Co-creation Culture		Market-oriented Culture	
	Co-creation Culture	Exemplars	Market Orientation	Exemplars
Co-creation behaviour	Co-creation behaviour involves a mutually beneficial relationship among multiple actors with a Shared goal of integrating resources for the purpose of value co-creation.	Programs continue to evolve and shape with innovative and creative co- designing which is a Shared experience for staff , volunteers, students and participants…to build consistency, mutual planning, sharing expertise and resources. [RED Documents, Annual Report]	Collaboration in market orientation is related to inter-functional cooperation and team work. (Narver and Slater 1990)	"Each department has their own meetings and we also have joint staff meetings between service managers and staff. We go through the functions of services, functions of the organisation and how those interact". [YELLOW Focus Group 1]
Dialogue	Multiple actors are engaged, informed and connected through two-way communication with the organisation and among other customers and stakeholders.	"Sitting down with participants and working out what needs to be done. What you like about this program, how we can do it better, do you like to be involved….Now we have participants bringing in other participants and giving them orientations. Having the conversation, providing the opportunity to be involved in those conversations." [RED Focus Group 2]	Open and proactive communication is valued between departments. However, the customer is not involved in a dialogue with the organisation, but rather information is sought and shared. (Kohli and Jaworski 1990)	"So we always have been client focussed as far as services are concerned. We have a communication working group in place that works on how we communicate throughout the organisation…. how we are getting and giving the information to the parents [customers and carers]". [YELLOW Focus Group 1]
Shared market intelligence	Market intelligence is generated in conjunction with customers and other actors and often simultaneously adopted into the organisations strategies.	GREEN consumers are actively involved in shaping its activities, program planning and policies. [GREEN Documents, Consumer Advisory Group Review Report]	Organisations gather information regarding customers and disseminate this market intelligence throughout the organisation for future strategy implementation. (Kohli and Jaworski 1990).	"It wasn't our idea, it came from management team and our feedback was sought". [YELLOW Focus Group 3]

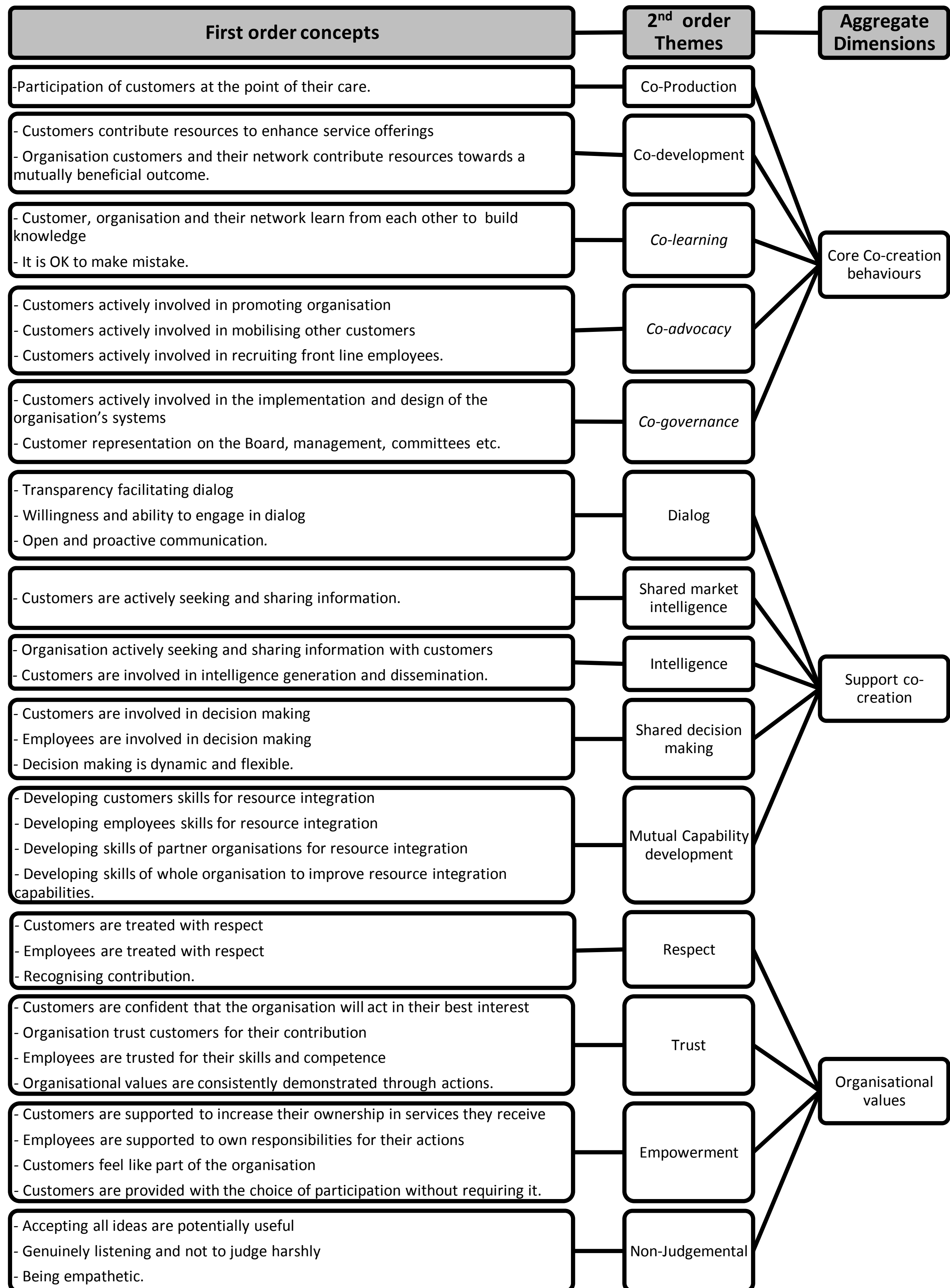
Mutual capability development	Organisation capability development has a focus on developing the resources and capabilities of customers, partners and other organisations as they are resource integrators in the value co-creation.	GREEN trains their customers and encourage them to participate so that they are able to articulate their needs and their perspective can incorporate into the policies and programs of the sector. [GREEN Documents, Consumer Participation Framework]	Organisation capability development has an internal focus, with employees trained to work in cooperation with different departments.	"We are actively talking about our developmental approach to our staff. What skills you need, what support we can provide you which can make you feel more confident about what you do…." [YELLOW Respondent 1]
Shared decision making	Decision making involves not only the internal departments but also collaboration with customers and other actors.	"We had manager sitting next to participants, sitting next to program workers, next to volunteers… developing our strategic plan side by side they sit together to talk about what [RED] is doing well, what can we do more of, what can we do less, what else can we do". [RED Respondent 1]	Strategic decisions are made cross functionally by sharing ideas and discussion among various departments; however, customers are not actively involved.	"It [strategic plan] was done very quickly, it was more of the employees that contributed. It did go out with the newsletter for people [customers] to comment on so there was a chance for commenting perhaps not active participation". [YELLOW Respondent 2]
Mutual respect	Mutual respect is the feeling that the all actors in the co-creation process are important and have resources to contribute and should be treated in an appropriate way.	"We understand our values it goes back to respect. In this organisationone of the ways of working is that we deal with people in a way we liked to be dealt with. It covers all that. People see it on a regular basis" [RED Respondent 3]	Respect for the ability of every member of the organisation to contribute.(Gebhardt et al. 2006).	"This CEO came in by herself, has taken the time, listened to everyone's opinion, respected us, as well brought in people to support not only management but other members of the organisation as well." [YELLOW Focus Group 2]
Mutual trust	Trust is having a sense of confidence in the reliability and integrity of the other actors in the co-creation process and a belief that in creating value for	"Here it is that you show interest and they allow you to try different things giving you a lot of trust, they encourage people to participate." [RED Focus Group 3].	Trust that fellow employees are telling the truth and will follow through on commitments. (Gebhardt et al. 2006)	"I would trust them to share or vent and they say that we will take that on board. It is such an open table now that we can say what we actually need from them as a mentor or as a manager and they have taken that on

	themselves, they will not negatively impact on the well-being of other individuals.			board and have accommodated what we need for the services. [YELLOW Focus Group 1]
Empowerment	Empowerment is sharing control among all actors in the co-creation process such that they can choose to assume responsibility for the outcome of value co-creation.	"Empowerment is the single most important element of being involved in GREEN's operations" [GREEN Focus Group 1]	Employees should feel empowered to work harder for the benefit of the organisation. (Gebhardt et al. 2006)	Empowerment was not discussed by YELLOW.
Acceptance	Acceptance reflects a tolerance for the different experiences, capabilities and resources of all actors involved in the co-creation process and demonstrating this through genuine listening and empathy.	"We really engage people at the level they are prepared to be engaged at in a non-judgemental and very inclusive way" [RED Respondent 4]	This concept is not broadly recognised in the market orientation literature.	Acceptance was not discussed by YELLOW.

Concepts Identified from Thematic Analysis

Our analysis shows that a co-creation culture orientation is evidenced by five core and four supportive co-creation behaviours along with four organisational values pertaining specifically to co-creation. Figure 1 presents the final data structure, including the first-order concepts (those meaningful to the informants) and the second-order concepts (induced by the researchers) that led to the aggregate dimensions.

Figures 3-1: Coding process (adapted from Gioia et al. (2013)



The five core co-creation behaviours depict the integration of actor resources to achieve a value outcome. The difference among the five behaviours is determined by the value outcome that the actors seek to achieve (e.g., fulfilling the service production, enhancing the service offering, advocacy of the service). The supportive co-creation behaviours are resource integration activities of the actors that facilitate and enhance co-creation, and the core and supportive co-creation behaviours rest fundamentally on four key co-creation values that the actors within the co-creation culture share. As these values are the implicit or explicit concepts that influence the selection of actions (Homburg and Pflesser 2000), they provide guidance for all actors seeking to behave in a co-creative manner.

3.4.1 Core Co-creation Behaviours

Each actor integrates resources to achieve value outcomes that enhance that actor's well-being (Karpen et al. 2012). Therefore, the value outcomes derived from resource integration are diverse and often multifaceted (Fyrberg Yngfalk 2013). Our thematic coding showed that although the individual value realized may differ, the actors engaged in five core co-creation behaviours, each with a generally agreed upon mutual goal that is represented in our proposed core co-creation behaviours of co-production, co-development, co-learning, co-advocacy, and co-governance.

Co-production: Co-production refers to customers' participation in direct service provision, effectively integrating their resources to achieve a desired outcome (Lusch et al. 2007; McColl-Kennedy et al. 2012). The organisational cultures of RED and GREEN provided many opportunities, strong encouragement, and meaningful support for these

behaviours. There was widespread acknowledgment throughout both RED and GREEN staff and customers of their participatory approach to the programs implemented for customer health care management.

> “There isn’t any program out of 10 programs where we don’t share the journey with the participants, where we always find ways to work with people to say what is that you need this is not ours program but it is your program and how can we work together to make this program the best that it can be”. (RED Respondent 3)

As counselling sessions between customers and their counsellors were confidential, the researchers could not attend these sessions. However, in its annual report RED discussed one of its treatment projects, in which customers mutually develop a treatment plan with their counsellors’ and work toward achieving the plan by actively managing their symptoms and addictions.

> RED engaged their customers in the National Tobacco and Mental Illness Project in which customers developed their strategies to quit smoking with their counsellors. In the 12 months of follow-ups customers have continued to work on addressing their goals around tobacco use at their own pace. (RED Annual Report, p. 18).

Our identification of co-production as a co-creation behaviour is consistent with previous findings (McColl-Kennedy et al. 2012). As co-production is the integration of resources into direct service provision (e.g., customers managing and administering their own

treatment), co-production and co-creation are not distinct phases of the production process, as depicted in some previous research (Greer and Lei 2012). While prior literature widely recognises the role of co-production (McColl-Kennedy et al. 2012), few studies have examined its role in the development of an organisational co-creation culture. The organisations in this study consistently provided resources and a culture supportive of direct customer integration into service provision.

Co-development: Co-development is co-creation behaviour that enhances the service offering. In this regard, all actors contribute their resources toward a mutually beneficial outcome that may not directly affect the individual. Our observations showed that employees, customers, care-givers, volunteers, students, suppliers, and partners contribute knowledge, time, labour, and ideas with a common goal of enhancing the offering of the organisation and hence improving the well-being of the broader community.

As an example of this enhancement, RED engaged an indigenous community in designing a health program. Firm representatives visited community members in their homes and together designed services, planned the budget, and later employed community members to deliver the program. When community members argued for a more collective definition of "family", the health program was modified and the relevant government policy altered. The involvement of customers in this process was a deliberate and valued strategy of RED, and several options for customer involvement in the co-development process were created.

> "So you can see its all the way through from working with participants, working with community…, also balancing it with what the government wants…with a co-design aspect or a consumer engaging process it needs to come from both sides very carefully and clearly" (RED Respondent 2).

Similarly, GREEN collaborated with customers in developing and evaluating programs such as the Sustainable Living Program. Customers were involved in designing future sustainable living opportunities and determining possibilities for improving the program. Reflecting this, GREEN states on its website that they give voice to the people who use their services as it reflects the need of the community and helps to guide and develop the organisation (GREEN website, 11/2015).

Identification of co-development as a co-creation behaviour extends prior work that identified how customers and private citizens get involved in giving new ideas and testing new products (Jaakkola and Alexander 2014). Our findings demonstrate that this activity can manifest as core behaviour within an organisation that builds a culture of co-creation. It provides mutual benefit to the organisation and its customers.

Co-learning. Co-learning occurs when customers actively share information with other customers and the organisation with the intent to build knowledge about the service offering or its associated context. To develop and improve service offerings, the health care organisations we examined worked closely with marginal groups (e.g., the Lesbian,

Gay, Bisexual, and Transgender (LGBT) community) to understand their needs and challenges. In one example, RED worked closely with the LGBT community to apply for funding for a mental health program. Both entities actively sought information from and about each other to develop their knowledge and foster greater co-creation.

> "It is also about looking at ourselves….at the moment we are going through the process of what do we need to learn so that we are friendly and accessible and engaging with this community" (RED Respondent 1).

> "I see RED as a platform where people from different groups of life come together and they mix and they try to basically learn from each other. It is a great platform where we try to deal with it together" (RED Focus Group 3).

In her blog, the CEO of RED described several opportunities for staff to learn while working with customers. In one instance, a customer attended a program at RED and learned various strategies to manage her role as a care-giver to her son with a mental health issue, and her input helped to improve the care-giver program.

> "I know many of us share a sense of privilege in supporting people living with mental illness and their carers. Equally there are all of those great opportunities for us to continue to learn from each other" (CEO blog posted 4 Aug 2014)

In identifying co-learning as a core behaviour in a co-creation culture, we pay respect to

earlier work showing that customers actively seek and share information with the organisation in their co-creation activities (McColl-Kennedy et al. 2012; Yi and Gong 2013). We build on this finding and demonstrate that the organisation also engages in co-learning behaviours by actively seeking information and sharing knowledge with customers.

Co-advocacy. In the context of value co-creation, advocacy represents an individual's voluntary promotion of the firm's interests beyond the individual's own interests (Yi and Gong 2013). Therefore, co-advocacy entails customers working with the organisation to actively promote the organisation and its service offerings. An example of this involvement occurred when the researcher attended a RED customer meeting (comprising five customers and one staff member) to plan strategies to build awareness of a new mental health program. Several customers had previously developed flyers for RED's services, distributed them at hospitals, and aged care facilities. Discussion ensued as to other potential avenues for distribution of the brochures, which were to be delivered by customers. Several customers volunteered to attend an industry event with RED staff and be present at RED's kiosk to discuss the program with potential new clients. In addition, one customer described his efforts to promote the activity through his social network and noted that he had actively recruited other customers to assist in the promotion. This same individual had worked with RED on creating a social media presence. In a subsequent focus group, he explained how he initially came forward to help RED create content about the new mental health program.

He [the Marketing Officer] said would you like to write a blog, we are

> always looking for content. I said ok, it took a while to get it together but now I have a couple of blogs on the website [RED Focus Group 3]

Similarly, GREEN also actively used its customers as advocates for the organisation. In a recently published report on service improvement initiatives, GREEN outlined various customer advocacy roles, including co-presenting at conferences and participating in industry forums on the firm's behalf.

Our findings endorse both advocacy and influencing or mobilization behaviour identified by other researchers (Jaakkola and Alexander 2014; Yi and Gong 2013). Through both of these behaviours, customers use their skills to influence other customers for the benefit of the organisation. Customer initiation of this behaviour, as in our findings, suggests an organisational culture that values and supports this behaviour.

Co-governance: Co-governance recognises the shift in locus of control toward customers in a service-dominant orientation (Fisher and Smith 2011), and our case studies provided evidence of customers' active involvement in the design and activation of the organisation's strategies and systems. Both RED and GREEN had customer representatives on the Board, active customer participation in strategic planning, and customer attendance at regular management meetings.

> "The Governance committee will have staff participation as well as consumer participation and then everything else will report into them in terms of continuous improvement, working groups, things for short

> term and long term go up to them. We are developing a more sophisticated structure that actually facilitates the environment to have consumer participation both from top down and bottom up" (GREEN Respondent 1)

In a RED strategic planning meeting attended by one of the researchers, customers, volunteers, caregivers, and employees sat at tables around the room without their roles being identifiable. They discussed avenues for improvement, the efficiency of the current structures and systems, and future strategies. Each individual took a turn in leading the discussion and reporting back on the outcomes of the group discussion, with a customer initially taking the lead on the researcher's table.

When customers, employees, and other actors participate in strategic planning, committees, meetings, and programs, they develop a Shared understanding that is used in developing or improving governance, service provision, or policy development. Whereas a resource-based view of the firm attributes competitive advantage to the resources of the organisation (Barney 2001), co-governance recognises that the resources customers contribute are equally important and influential in the process.

3.4.2 Supportive Behaviours

Dialogue: Dialogue is defined as "interactivity, engagement and propensity to act on both sides" (Prahalad and Ramaswamy 2004). Two-way communication, or dialogue, is fundamental to pursuing a service-dominant approach, as multiple actors come together

and integrate resources to achieve their mutual goal (Vargo and Lusch 2008). Our case studies illustrated that an organisation with a co-creation culture has the ability to develop and manage effective dialogue among multiple actors, so that customers actively engage in ongoing discussions with the organisation and other actors to seek information or communicate their needs. RED and GREEN facilitated complex dialogue among actors that formed the basis of resource integration. This is achieved through round table discussions, forums, open blogs from the CEO and in-house discussions between staff and customers. We identified key elements that enhance dialogue among actors, such as transparency, willingness and ability to communicate, openness, and proactive communication.

> "Informally too, it is a constant conversation on what people want to do, where you want us to go, do you want to try something new, it is just engaging everybody" (RED Focus Group 3).

In contrast, communication between customers and the organisation at YELLOW, a market-oriented organisation, was predominantly one-way and limited to information gathering or information sharing. The organisation routinely distributed newsletters and sought customer feedback through surveys and feedback forms, but made little effort to engage in interactive communication.

Shared market intelligence: A shift to a service-dominant orientation affects the organisational mindset with respect to the generation of market intelligence. Whereas a traditional market-oriented company employs specialists to gather market information

and disseminate it across the firm, organisations with a co-creation culture develop a market schema in conjunction with their customers. This development occurs through activities such as workshops and through ongoing participation at all levels of the organisation. In the following example, the market intelligence provided by a customer of RED is simultaneously integrated into the strategic planning of the organisation.

> "We have got strategic planning going on right now…it was open to anyone to come… we had managers sitting next to participants, sitting next to program workers, next to volunteers, to work on developing our strategic plan side by side. They sit together to talk about what [RED] is doing well, what can we do more off, what can we do less, what could we do differently" (RED Respondent 1)

While the co-creation literature recognises the process of information seeking and information sharing (Yi and Gong 2013), it generally does not acknowledge that organisations can create a market schema in partnership with actors. As a consequence, the fundamental market-oriented behaviours (Kohli and Jaworski 1990) may need to be revisited, as disseminating market information to passive actors who underutilise it, is ineffective.

Mutual capability development: Whereas a resource-based view of the firm holds that an organisation's competitive strength is embedded in its internal resources and skills (Hunt and Morgan 1995), co-creation recognises that customers' skills and resources can be leveraged. Importantly, however, increased participation requires customers to have

appropriate skills and knowledge to be effective resource integrators—and organisations need to be prepared to facilitate this development (Hibbert et al. 2012). We found support for this notion in our study, with RED and GREEN actively developing the skill and capacity of their customers, as well as other organisations in the sector, so that these actors can effectively contribute their resources in value co-creation.

GREEN's customers often experienced mental health concerns and felt anxious if they did not have the skills required to participate. In this situation, an appropriate organisational response is to develop customers' ability to understand medical terminology and foster their understanding of how to be involved in their personal health care management so they can participate within the organisation.

> "We offered a training launching pad for consumers, so that it was providing the opportunity to develop their capacity to participate in working group not only internally but in sector consultation forums, steering committees" (GREEN Respondent 5).

RED recognised its role as a lead organisation in the health care sector with respect to customer participation and provided education and training to other professionals to encourage the broader development of these skills across the sector.

> "I worked with [RED] to develop a training package that they delivered about how you participate…. we worked with all those groups all around the country to develop a training package to actually start to support people [customers] to participate and leading the organisation"

(GREEN Respondent 1)

While facilitating capability development of the actors with which it integrates resources, RED also continuously seeks to improve its own organisational capabilities. In particular, participants are often asked how the organisation can enhance the co-creation experience offered.

Shared decision making: In health care organisations, providers usually dominate decision-making (Fine et al. 2010). While Shared decision-making can improve value outcomes for health care customers (Coulter et al. 2011), adoption of this approach is slow (Elwyn et al. 2010). A service-dominant approach shifts the balance of power, as the decision-making responsibility is no longer solely that of the organisation but is shared with customers and their networks (Fisher and Smith 2011).

> "[For] some of the programs that we facilitate it's the participants who make the decision on what they want to do, then we work through budget and stuff like that to see how we can fit what they wanted" (RED Focus Group 1).

When the health care organisations in our study adopted Shared decision-making, this change encouraged a culture that embraced flexibility and dynamism in the decision-making process. Recent studies of marketing culture have supported flexibility and sharing of control with boundary-spanning employees so that they can effectively fulfil customer needs (Morgan et al. 2014). However, this research has not given proper

consideration to the need for flexibility and sharing of control with the customers as revealed in our research study.

> "We share the journey…so we don't have to have the answers… you have got the principles, the aims and you can say to participants, let us see how it works.… Similarly to employees, saying that I am not sure about that and you don't feel like you have to be the boss who has all the answers" (RED Respondent 2)

In contrast, the decision-making within YELLOW was consistent with the characteristics of decision-making in a market-oriented organisation (Shapiro 1988). Information regarding customers' needs is shared between functions and strategic decisions are made by coordination among various departments. This practice demonstrates a strong customer focus and responsiveness to customer needs, but customers are not involved in the decision-making.

3.4.3 Values

Mutual respect: The organisations in our study exhibited integral values that demonstrated their support for a co-creation culture. One of these key values was mutual respect. From an organisation's perspective, mutual respect is an appreciation for the resources and value contributed through customers' co-creative practices. Customers also respect the contribution made by the organisation in the co-creation process. Several respondents within RED demonstrated a firm belief that every actor has something to add and that the organisation is responsible for facilitating and enabling each party to contribute.

> "That sense of people being valued that they have got something to add. It is a respectful culture, and it is the culture supporting people for doing with and alongside, not for people, because we are trying to build people" (RED Respondent 1)

Our identification of mutual respect extends earlier findings that respect is a foundational value of a market-oriented culture (Gebhardt et al. 2006). However, while those findings demonstrated an appreciation for the ability of all employees to contribute to the organisation's strategic objectives, our findings extend to actors outside the organisation who are involved in co-creation.

Mutual trust: Embedded in the notion of mutual trust in a co-creation culture is the idea that in creating value for themselves, other actors will not negatively affect the well-being of an individual. Many examples of mutual trust embedded in the co-creation process emerged from our case studies. Customers trust that the organisation will provide quality service and act in their best interest (Delgado-Ballester and Luis Munuera-Alemán 2001).

> "One more very positive thing about [RED] is I feel safe. All the activities I have done, I am always at least with two staff members so you are always looked after. I wouldn't close my eyes and go to an organisation whom I don't trust" (RED Focus Group 3).

The firms in our study nurtured mutual trust through activities such as engaging customers in service provision. Demonstrating belief in customers' skills and capabilities

and involving them in decision-making can continue to nurture trust.

> "Here it is that you show interest and they allow you to try different things giving you a lot of trust, they encourage people to participate" (RED Focus Group 3).

The market orientation literature has recognised the importance of trust between employees committed to and acting to achieve the same goal (Gebhardt et al. 2006). Establishing mutual trust as a key value for co-creation culture extends this importance, as it acknowledges that although all actors may be pursuing different value outcomes, the ultimate goal is mutual betterment.

Empowerment: In co-creation, control is shared among customers and the organisation (Fisher and Smith 2011), so both have the power to influence the value outcome. Empowerment is manifest in the organisation's ability to engage its customers and other actors in shaping the nature of exchange and in customers' desire to contribute and assume responsibility for the outcome of value co-creation (Karpen et al. 2012). Further, empowering customers to co-create value in a health care setting is critical to improving customers' own heath (Ouschan, Sweeney and Johnson 2006). The organisations in our study created an empowered workplace so that both customers and employees felt safe in initiating a problem solution.

> "Empower people, it's not about us being in the driver's seat it's about people be in the driver seat of their own recovery journey" (RED Focus Group 2)

The organisations further Empowered customers by offering choice in the way the customer could interact with the organisation in providing service. Customers could choose whether they wished to participate in the life of the organisation beyond the basic service provision.

> "Embracing choice is about creating the opportunities for involvement but not requiring it. They give you support but they don't want to force you…there is nothing like you have to do this" (RED Focus Group 3)

Acceptance: Acceptance reflects a tolerance for differing points of view. It suggests an ability to work with people with an attitude of acknowledgment of their experience, genuine listening, and empathy. Especially in the health care sector, customers are often emotional and distressed owing to their underlying medical condition (Berry and Bendapudi 2007). They can differ markedly in their level of motivation, skills, and acuity of illness (Sharma et al. 2014), which causes them to feel disadvantaged. Therefore, all parties need to be accepting and non-judgmental to work through uncertainties and emergent outcomes. As actors jointly create value, the organisation needs to be ready to listen patiently, observe, and offer support in a constructive way. Under these conditions, which routinely occurred at RED, customers are appreciative and are more actively engaged.

> "You need to have openness to understanding the majority and minority and where those prejudices can occur. Organisation should be open to change, open for a new idea or concept. To have a process to modify, shift and adjust to embrace that new idea" (RED Respondent 1)

RED has a philosophy of adopting language that is inclusive. The firm has a welcome sign in 22 languages in the foyer, and the organisation refers to its customers as "participants." This expression is intended to demonstrate customers' equivalence to other actors in the system and encourage them to participate in the co-creation of value for themselves and others.

When the customer perspective is provided through market research reports and other market intelligence documents, it is often interpreted by the managers on the basis of their existing market schema and any views counter to their interpretation are discounted, which can limit the development of new service offerings. The practice of acceptance offers everyone an equal opportunity to contribute and considers all ideas and resources, hence enhancing potential service offering development.

3.4.4 Prevalence of Key Co-creation Behaviours and Values

To gain further insight into the necessary conditions for a co-creation culture, we considered the prevalence of each identified concept by ascertaining its presence or absence in interviews and focus groups (Gioia et al. 2013). When a concept was present in RED and GREEN, we considered it to be characteristic of a co-creation culture, whereas we expected co-creation concepts to be absent within YELLOW, as it was a counter case and indicative of a market-oriented culture. Table 5 summarises the presence of thematic codes.

Table 3-5 Prevalence of Thematic Codes

	R1	R2	R3	R4	R5	RG1	RG2	RG3	Y1	Y2	Y3	Y4	Y5	YG1	YG2	YG3
Co-production	X	X		X	X	X		X	X		X			X		
Co-development	X	X			X	X	X	X								
Co-learning	X	X			X		X	X								
Co-advocacy	X			X	X		X	X								
Co-governance	X		X	X	X		X	X								
Dialogue	X	X	X	X	X	X	X	X	X	X				X		
Shared market intelligence	X	X		X	X			X								
Shared decision making	X	X	X		X	X	X	X								
Mutual capability development	X	X	X	X	X	X	X	X								
Mutual respect	X	X	X	X	X	X	X	X								
Mutual trust				X		X	X	X	X					X		
Empowerment	X	X		X	X	X	X	X								
Acceptance	X		X	X	X	X	X	X								

Central to the concept of co-creation are the behaviours of co-production (McColl-Kennedy et al. 2012) and co-development (Jaakkola and Alexander 2014). Therefore, we expected that co-production and co-development behaviours would be systemic throughout the organisations with a co-creation culture, as was evidenced in the findings. Perhaps more surprising was the prevalence of co-governance, identified by more participants than any other core co-creation behaviour. This finding suggests that for a co-creation culture to prevail, the firm needs to make a structural effort to incorporate customers into the governance and planning of the organisation. At a minimum, co-production, co-development, and co-governance seem to be required to establish a co-creation culture. Co-learning and co-advocacy were less prevalent, reflecting the fact that the organisations provided customers with the option of pursuing these co-creation activities.

At the cornerstone of co-creation is the need for open, reciprocal communication (Karpen et al. 2015; McColl-Kennedy et al. 2012). With only one exception in both RED and GREEN, all respondents identified the presence of dialogue, suggesting that it is a necessary condition for a co-creation culture. Similarly, most respondents identified the mutual development of capabilities as a relevant co-creation behaviour. While prior literature recognises the need for the development of appropriate skills and knowledge among customers (Hibbert et al. 2012), few authors have discussed the mutual development of capabilities. Although Shared market intelligence and Shared decision-making were prevalent behaviours within RED, few respondents at GREEN mentioned them. This finding is somewhat surprising given the prevalence of co-governance and co-

development within that organisation, and suggests that these behaviours are still being developed or may occur in an informal and unrecognised manner.

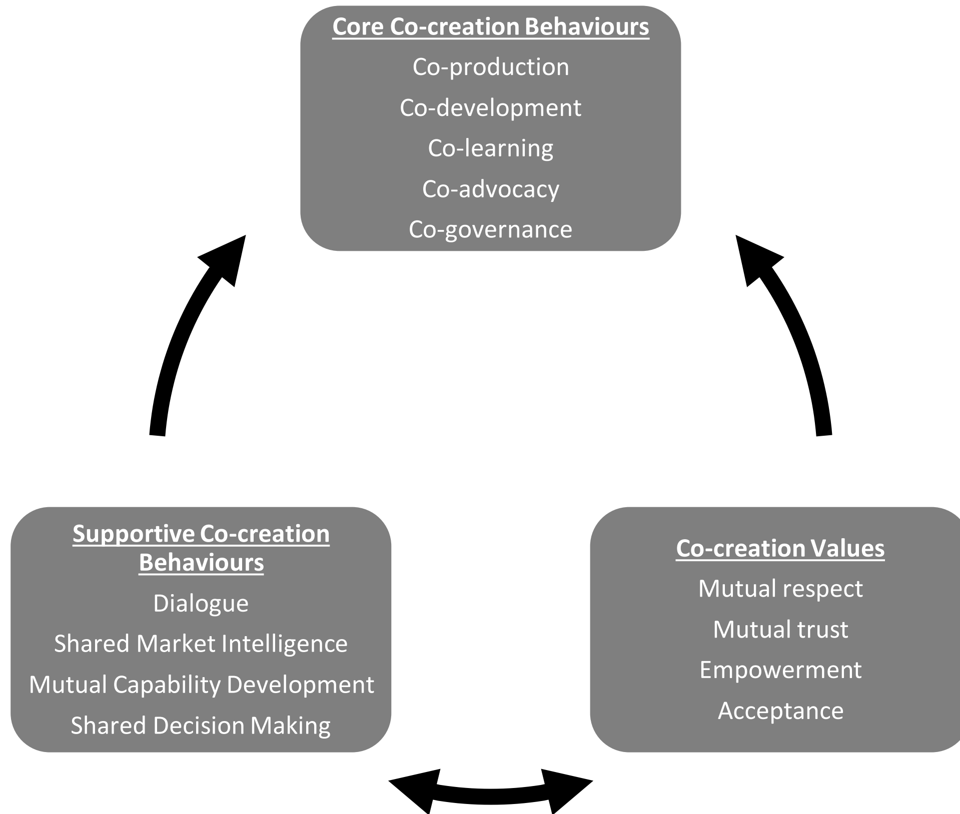
As organisations with a co-creation culture provide customers with the opportunity to actively participate with the organisation, we expected that empowerment would be widely identified by respondents as a value consistent with a co-creation culture. However, as mutual respect and acceptance are not extensively recognised in the co-creation literature, we did not anticipate their prevalence as the most identified values in a co-creation culture. Trust is consistent with a market-oriented culture (Gebhardt et al. 2006), and therefore we expected that mutual trust would be important in a co-creation culture. While mutual trust was pervasive within GREEN, individual respondents (senior managers) within RED seldom identified it as necessary. While this lack of discussion about mutual trust by senior managers could be indicative of its absence, it was widely espoused by customers and as such it could indicate that it was an embedded value which was no longer given overt consideration.

3.4.5 Dynamic nature of a co-creation culture

The initial data structure, presented in Figure 1, offers a static picture of a co-creation culture. After the second-order categories were determined, we examined the data again to identify the inter-relationships among the emergent concepts. This examination provides further understanding of the dynamic nature of organisations' co-creation culture and offers theoretical insights into the interplay of core co-creation behaviours, supportive behaviours, and organisational values. Overall, the emergent conceptual

model depicted in Figure 2 offers a view of how the broad aggregate dimensions of core co-creation behaviours, supportive co-creation behaviours, and organisational values interact to construct a co-creation culture.

Figure 3-2 Co-creation behaviours and Values



The core co-creation behaviours focus on resource integration explicitly for the mutual benefit of the actors involved; each co-creation behaviour has a sense of purpose and associated value outcome (e.g. co-development, co-governance). The manner in which these core co-creation behaviours are revealed is through the supportive behaviours, as the supportive behaviours depict the means by which the interaction takes place (for example, intelligence is Shared or decisions are jointly made). Often multiple supportive

co-creation behaviours will be evident in the interactions required to achieve a core co-creation behaviour. For example, co-learning requires Shared marketing intelligence and an open dialogue between the organisation and its participants. While customers need to be able to share their experiences with employees, the open dialogue surrounding these experiences affords the relevance and meaning that enhances the learning of both parties. An active example of this interplay occurred when RED engaged its customers to develop a program to connect with younger customers with mental health issues in the community. RED provided resources about the incidence of mental health in the younger generation, and engaged in an ongoing dialogue about the issue. In return, the participants described their personal experiences, co-developed flyers to promote the service, and invited their peers to participate in the co-production of a youth mental health service. Further examples of the interaction between core and supportive co-creation behaviours are evident in Table 3-6.

As a result of examining the interplay among the aggregated dimensions of a co-creation culture, we put forth three propositions that reflect the nature of these inter-relationships. The first of these depicts the relationship between core and supportive co-creation behaviours. Hence we propose:

Proposition 1: In a co-creation culture, supportive co-creation behaviours facilitate core co-creation behaviours.

Table 3-6 Examples of Inter-relationships among Core Co-creation Behaviours and Supportive Co-creation Behaviours

	Co-production	Co-development	Co-learning	Co-advocacy	Co-governance
Dialogue	"People have discussions at the point of care as what do you want from your activity program. This is our program here we run it with participant together." (RED Respondent 1)	"They were consumers active in participating with GREEN and we talked to them about what supported them, what wasn't so supportive what could we do better, to get their input and then the framework was developed in consultation with the consumers." (GREEN Respondent 3)	"I see RED as a platform where people from different groups of life come together and they mix and they try to basically learn from each other on how to come up with strategies in how to live their life better and get through their illness. It is great platform where we try to deal it with together". (RED Focus Group 2)	"Now we have participants bringing in other participants and giving them orientations. Having the conversation, providing the opportunity to be involved in those conversations." (RED Respondent 1)	"I think the sense is that it is a very flat organisation. In meetings, anyone comes with an idea participant or whoever. It is like, if you have an idea people ask what do you think you need ... let's keep going with it" (RED Focus Group 3)
Shared market intelligence	"Supporting staff and consumers to understand the co-production approach, even if there is that power difference everybody around the table has the same information. So decisions are made from that information so people are equal in the knowledge that is Shared in that space." (GREEN Respondent 3)	"An organisation which lets us share our ideas and don't just discount us just because we are not paid. Here they want us to be involved" (RED Focus Group 3)	"What I think is really important for me is to keep that close connection with customers so that I don't lose the purpose for work. It informs how I do my work as they are the foundation of what I am doing back here." (RED Respondent 5)	"One of the funding bodies likes a qualitative report, so we always try to put a case study written by a participant. It is a story that they will bring to us that doesn't have any editing and we provide that as a case study." (RED Respondent 5)	"People sit in little groups and brainstorm and put down what their thoughts are, and all that information is fed back to the strategic planning process." (RED Respondent 4)
Shared decision making	"They know what works better for them, so any changes that need to happen needs to involve	"In some of the groups that we facilitate it's the participants who make the decision on what they	"We have a role in coaching and mentoring as well..... If you have struggled with systems and	"We found some young people as ambassadors to help us build a program. They used	"We use our consumers meaningfully on interview panels to help us select really good

	the people whom it will impact. They will have the best information on which way to go" (RED Respondent 2)	want to do. Then we might work through budget and stuff like that to see how we can fit what they wanted." (RED Focus Group 2)	bureaucracy through being involved in a mental health system sometimes you are limited in how you achieve outcomes." (RED Respondent 5)	their network to say hey let's have a meeting to talk about a program RED could start. They brought the young people in and we developed the program from the ground up." (RED respondent 3)	staff. We made a commitment that every position that was a direct service delivery position will have a consumer participant on the interview panel". (GREEN Respondent 1)
Mutual capability development	"Everything is about us providing a framework and coaching the individual to identify their own values, what their own goals are. So we don't work as an expert but we work together with the individual. (GREEN Respondent 5)	"We developed a consumer leadership program called launching pad. That covers reflecting and looking at policies and procedures and how you can have input in that area." (GREEN Respondent 3)	"We are going through the process of what do we need to learn so that we are friendly and accessible and engaging with LGBTIQ community… Therefore, we are working to upskill our staff so that when we share the journey with participants." (RED Respondent 1)		"We are building the capacity with the consumer and building the capacity with the staff that affects all systems and processes of GREEN" (GREEN Respondent 3)

Consistent with the theory of organisational behaviour and the Fishbein model (Ajzen & Fishbein, 1980), basic values underlie and influence the behaviours exhibited within an organisation (Homburg and Pflesser 2000). The core co-creation behaviours are buttressed by organisational values consistent with co-creation: mutual respect, mutual trust, empowerment, and acceptance. If customers participate in activities such as co-development, they need to feel Empowered to voice an opinion and trust that their suggestions will be treated respectfully and considered thoughtfully. Without these values as the foundation for the co-development process, customers will disengage from the process and any activities the organisation initiates for this purpose will be unsuccessful. Similarly, as not all customers will want to be involved in activities such as co-production or co-governance, empowerment of those who do take part is critical. Speaking of her experience with the organisation, a RED customer stated,

> [The] more I got involved I found that there is lot of trust developing. It is very welcoming…. nobody tries to pull you out of your shell if you want to stay in your shell, they give you support but they don't force you. [RED Focus Group 3]

Table 7 provides further examples of the importance of the values underpinning the core co-creation behaviours. Hence, we put forth the following proposition:

Proposition 2: In a co-creation culture, core co-creation behaviours are supported by co-creation values.

Table 3-7 Examples of Inter-relationships among Core Co-creation Behaviours and Co-creation Values

	Co-production	Co-development	Co-learning	Co-advocacy	Co-governance
Mutual respect	"We also show the same respect. If we go in an activity program where there are participants and staff who develop mental health programs together, we will always knock - it is about showing that respect." (RED Respondent 1)	"Be yourself, be authentic, look, listen and learn, don't just run in and try to throw your weight around... create space and consumers can participate and they can do that too because they know they are being respected." (GREEN Respondent 1)	"We train the staff so that when we are sharing the journey with participants we do not want them to feel offended or disrespected." (RED Respondent 2)		"They are welcome to come to the strategic planning, they are on the board, and they are involved in participant meetings……their input is as valued as the involvement of staff." (RED Respondent 1)
Mutual trust	"There is pretty careful negotiation around trust building, in that we don't tell people what to do. We help you as much as you need, with the idea that you can take it on, we can help you identify options and those sorts of things, but we do as much as needed." (RED Focus Group 1)	"Here it is that if you show interest they allow you to try different things; giving you a lot of trust. They encourage people to participate in ways like helping the large program, opportunities to go to forums, emotional well-being groups etc." (RED Focus Group 3)	"They want us to be involved they give us lot of trust as well…they foster learning, it is ok to fail, no one is perfect, it can happen to anybody. I think it is an organisationwhich has really supportive environment for learning." (RED Focus Group 3)	If customers show interest they are allowed to try different things giving a lot of trust, they are encouraged to participate [in co-advocacy projects]." (RED Focus Group 2)	
Empowerment	"Someone coming in at their own pace and sitting in their own time, in their own moment and whatever capacity they are able to be here is welcomed because next time when they come they might do a little bit	"We are participant-led in activity programs for instance. They will have a say in meetings, what their space looks like, what their programs look like. It doesn't mean that the staff will go and do it. It means staff will support them to do	"You know that is something we try to help foster with participants. What things you are good at? What things you would like to be good at? .... It is about finding strength because everyone has got some strength."	"They have choice in the activities that are offeRED. Consumer participation will provide a forum for consumers to advocate on issues of concern." (GREEN Respondent	"*Sharing the journey* which for us means a lot of things. It's not up and down; it's a flat structure where the staff and participants own the organisation". (RED Respondent 1)

	more or we might not see them for a while. There is no expectation of people and I think that takes away pressure.” (RED Respondent 5)	it. That is an integrated approach.” (RED Respondent 2)	.(RED Focus Group 3)	3)
Acceptance	“Everyone has got that opportunity of recovery, and what recovery means and how much that means is different to everybody. I think it is possibly that the culture is about respecting everyone uniqueness.” (RED Respondent 4)	“If you are going to co-design a program and if you are going to engage people you must be ready to listen to them and to face the obstacles as they come.” (RED Respondent 1)	“I think lived experience for me is what comes out the most. That we don’t sit in the seat of the expert, we sit in the seat of the curious and we keep learning from people every day.” (RED Respondent 5)	

Thirdly, we see an interplay of supportive co-creation behaviours and the foundational values in the organisation. For example, sharing sensitive market intelligence can build trust among customers. The willingness to engage in open dialogue with customers demonstrates mutual respect, and providing opportunities for co-advocacy or co-governance empowers them. As an example, to overcome resistance to the development of a mental health program for the Aboriginal community, RED employees went to community members in their homes and engaged in a dialogue about the program. This approach demonstrated respect and fostered trust among the community, which led to the sharing of relevant information and an enhanced mental health program. Therefore, our final proposition reflects the nature of these inter-relationships. Table 8 provides examples of inter-relationships between supportive co-creation behaviours and co-creation values.

Proposition 3: In a co-creation culture, there is relationship between the supportive co-creation behaviours and the co-creation values.

Table 3-8 Examples of Inter-relationships among Supportive Co-creation Behaviours and Co-creation Values

	Dialogue	Shared Decision Making	Shared Market Intelligence	Mutual Capability Development
Mutual respect	"The respect that is given to our participants in really respecting things like confidentiality, the way we go about things. It's really a level playing field that you don't feel as an expert worker and participant, it's very much a two way street the way we work with participants, we do try and put them in the driver's seat as much as we can." (RED Focus Group 2)	"If you try and work with people give them what they want within reasonable limits, then they have a greater respect for the organisation and they want to give back." (RED Focus Group 1)		"A respectful culture is the culture supporting people for doing things alongside people because we are trying to build people capacity." (RED Focus Group 2)
Mutual trust	"If as a participant you are not sure if you can trust someone about your diagnosis you don't have to say that. We can fill in a form and know it is confidential. That sort of trust is there and I think that is very important." (RED Focus Group 3)		"The more trust they build they think they can disclose more information." (RED Respondent 4)	"Here it is that if you show interest they allow you to try different things giving you a lot of trust, encouraging people to participate in new things." (RED Focus Group 3)
Empowerment	"They have choice in the activities that are offered. Consumer participation will provide a forum for consumers to advocate on issues of concern." (GREEN Respondent 3)	Customers at GREEN provided with the opportunities to influence the decision-making not only at individual level but also at group and organisational level. (GREEN Documents, Consumer Advisory Group Review Report)	""RED has commenced a new round of strategic planning with an important early step being the collection of information about how we are performing. We have developed both a questionnaire and a workshop format to give people choice on how we gather information." (RED Documents, Blog from CEO)	

Acceptance	"Ask questions and not to just jump to the conclusion, to be open to hearing about how might other people think about something, not to rush to a solution to have an open kind of process." (GREEN Respondent 1)	"You need to have openness to understanding the majority and minority and where those prejudices can occur. Organisations should be open to change, open for a new idea or concept." (RED Respondent 1)		"We don't want to be tokenistic … we are also aware that we can't expect one person with lived experience to represent everyone ……if we haven't provided them with the tools to do their jobs they will be struggling." (RED Respondent 3)

3.5 Discussion

Our study acknowledges the priority of creating and maintaining a service culture that involves customers in the commercial and psychological life of the organisation (Ostrom et al. 2010). In doing so, it responds to calls to explore the role of organisational culture in facilitating resource integration and value co-creation and hence a service-dominant orientation (Karpen et al. 2015; McColl-Kennedy et al. 2012). Our findings explicate core and supportive co-creation behaviours and values characteristics of an organisational culture that facilitates and promotes value co-creation by multiple actors. Our results provide the micro-foundations of a co-creation culture and extend the literature on value co-creation, organisational culture, and health care management.

We build on recent research in the value co-creation literature that identifies co-creation and engagement behaviours (Jaakkola and Alexander 2014; McColl-Kennedy et al. 2012; Payne et al. 2008; Yi and Gong 2013). In particular, our study takes into account the breadth of actors' collaborative activities to achieve mutual value through resource integration. These activities reflect five broad themes of co-creation behaviour—co-production, co-development, co-learning, co-advocacy, and co-governance—and recognise that co-created value is often complex and multifaceted and that resource integration has many purposes. We also identify several supportive co-creation behaviours that enable and facilitate the interactive nature of these co-creation activities: dialogue, Shared market intelligence, mutual capability development, and shared decision-making. The identification of these behaviours pays respect to earlier work that recognised the need for open, transparent, two-way communication to facilitate co-

creation (Prahalad and Ramaswamy 2004).

The co-creation behaviours are underpinned by organisational values that facilitate interaction: mutual respect, mutual trust, empowerment, and acceptance. These cultural values embrace the equality of all actors and are shared throughout the organisation, influencing the selection of specific co-creation actions, and they create an organisational environment that is supportive of organisation-wide collaboration and co-creation.

Our exploration of the characteristics of a co-creation culture is the first to examine organisational culture from a service-dominant perspective. The identification of co-creation behaviours and values builds on previous research investigating the values and behaviours in market-oriented organisations (Gebhardt et al. 2006; Homburg and Pflesser 2000). The behaviours and values distinguished in our research differ from those of a market-oriented organisation, as they go beyond traditional internal or boundary-spanning activities and demonstrate the integration of all actors within the organisation's service network. Previous research found open internal communication and employee responsibility (Homburg and Pflesser 2000), respect, openness, trust, keeping promises, collaboration, and market as the raison d'être (Gebhardt et al. 2006) to be values of a market-oriented culture. Although some overlap occurs with our identified values, the manner in which the values manifest is distinctly different. Within a co-creation culture, these values are purposely extended to all actors, especially those outside traditional organisational boundaries. Consistently, market-oriented behaviours reflect the need to generate intelligence about external customers and disseminate it broadly throughout the

organisation for action (Kohli and Jaworski 1990). In contrast, co-creation behaviours reflect organisations working directly with customers to integrate resources and co-create value outcomes.

The findings from this research emphasize the limitations of the competing values framework (CVF) in organisational culture research (Deshpande and Webster 1989). The CVF framework clearly distinguishes internal and external boundaries of the organisation, whereas our findings demonstrate that customers are integrated into the activities and culture of the traditional organisational structure. While recent work demonstrates that customer orientation is a distinct culture (Lukas et al. 2013) co-existing with previously identified CVF cultures (Deshpande and Webster 1989), we argue that the CVF framework inhibits the ability to evaluate a co-creation culture. We maintain that this result stems from the constrained view of the firm's boundaries and that, as shown by our research, co-creation requires a distinct organisational culture.

Our exploration of the concept of a co-creation culture in a health care context directly responds to the request for further investigation of value co-creation in highly collaborative and participatory environments (Edvardsson et al. 2014). The public services management literature, especially the health care literature, has acknowledged that current public management theory is somewhat limited owing to its focus on intra-organisational rather than inter-organisational processes (Osborne et al. 2013), and that a "public service-dominant approach" would enhance public service management (Osborne et al. 2013). Our findings provide a conceptual foundation for future research into the

organisational culture supporting a service-dominant approach to health care management.

3.5.1 Managerial Implications

Against a backdrop of an aging population, fragmented health systems, and poor health literacy among customers, health care initiatives include collaboration in chronic care, engaging customers in quality improvement initiatives, and person-centred care (Sharma et al. 2014). Although transformative benefits flow from health care professionals' use of a patient-centred approach to support customers in value co-creation (Sweeney et al. 2015), many organisations lack the infrastructure to support this approach (Sharma et al. 2014). By understanding the behaviours and values that constitute a co-creation culture, health care organisations can actively develop strategies to facilitate and encourage appropriate co-creation behaviours and values within the organisation.

The results of our study hold a number of immediate implications for health care practitioners. Our research demonstrates that customers are actively participating with organisations in developing, producing, advocating, and evaluating services to improve the service delivery of the organisation. Health care organisations benefit by providing opportunities for their customers to participate in activities such as recruitment of service delivery staff, strategic planning, and promotion activities. Managers must recognise the ongoing nature of this collaboration and provide avenues for constant dialogue, capability development, and interaction between customers and employees to facilitate co-creation behaviours.

Our investigation has identified four organisational values that promote commitment to co-creation and work to enhance co-creation behaviours: mutual respect, mutual trust, empowerment, and acceptance. Managers need to be cognizant of these values and reinforce them through strategic initiatives, role-model behaviour, and formulation of the organisation's philosophy. When health care practitioners treat customers with respect, gain their trust, and empower them, customers respond with a sense of ownership and motivation to engage in co-creation activities. Importantly, in providing opportunities for customers to co-create, health care organisations should also allow customers the choice to decide how much and when to co-create. Indeed, if customers feel compelled to participate they can become negative and unwilling to co-create (Bendapudi and Leone 2003).

This research provides preliminary insight into the role of customers in the co-development of service improvements and innovations. In co-developing marketing intelligence and providing a Shared market schema, customers and employees together co-create new service ideas and improvements. By relinquishing some control of the development process, managers can act as an engagement platform for the actors, assisting in the capability development of customers, employees, and other partner organisations so they can meaningfully contribute to value co-creation. As health professionals act as facilitators and empower customers to manage their own health, customer well-being will be enhanced and the burden on the health care system will be reduced.

3.5.2 Limitations and Future Research Directions

Despite its contributions, our research has several limitations. This study examined three case studies across the health care sector to remove any potential bias arising from cross-sector evaluation and allow examination of a co-creation culture in a complex system. As a consequence, the generalizability of the findings beyond the health care sector may be limited (Berry and Bendapudi 2007). While the potential exists for application in other public services, further research is needed to extend the understanding of the co-creation culture across a variety of services.

Many health care organisations have customers who are vulnerable owing to severe mental or physical disabilities and are unable to participate in their health care management. Often caregivers or family members participate in the co-creation behaviours on their behalf. In this research, although caregivers and family members were included wherever possible, their experience was not distinguished from the customer's experience. Future research could explore in more detail the role of third parties in the value co-creation process, especially when the customer is vulnerable (Berry and Bendapudi 2007).

In examining the inter-relationships across the aggregate dimensions of a co-creation culture (i.e., the core co-creation behaviours, supportive co-creation behaviours, and organisational values), we did not explore the potential intra-relationships within each second-order category. For example, when an organisation respects each individual's

contribution, customers will trust that the organisation will act in their best interest and feel further Empowered to participate in co-creation. Further research can examine the relationships among the second-order categories.

Leadership style in an organisation determines future direction, aligns resources, and facilitates the realignment of values and behaviours necessary for co-creation. It has long been recognised as a key determining factor of the resultant organisational culture (Deshpandé et al. 1993). As co-creation is dynamic and uncertainty is inherent in the process and outcome of co-creation, leadership has to evolve and change depending on the situation. Leaders need to learn from the situation as new opportunities and challenges arise and develop according to the situation presented. Future researchers can explore what leadership style is conducive to developing and maintaining a co-creation culture.

Future research might also develop a scale of co-creation culture characteristics identified in this research to allow for the empirical testing of the culture's nomological network and enhance the understanding of a co-creation culture and its customer- and organisation-related value outcomes. Our study has suggested a series of values and behaviours of a co-creation culture and offered three core research propositions that consider the broad interplay between the behaviours and values. Future research could examine and validate which values and behaviours are predominant and whether they change over time and with context. An examination of the relationships between and among the core co-creation behaviours, supportive co-creation behaviours, and co-

creation values in different contexts would significantly advance the knowledge of co-creation culture. This insight would provide managers with an understanding of how to effectively facilitate a co-creation culture and successfully manage within that culture.

Health care organisations face tremendous challenges owing to increased customer demands and rising health care costs. The development of a culture that supports co-creation approaches to health care not only will enhance customer well-being (Sweeney et al. 2015) but should improve the efficiency of organisational practices (Greer and Lei 2012). Anecdotal evidence from our case studies suggests that in one of the organisations examined, a co-creation culture has supported organisational growth. Future research should explore the financial and performance benefits of developing a co-creation culture.

Statement of Authorship

Title of Paper	Hedonic and Eudamonic well-being outcomes from different co-creation roles		
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Principal Author

Name of Principal Author (Candidate)	Shikha Sharma		
Contribution to the Paper	Developed conceptual framework, collected data, performed analysis on all samples, interpreted data, wrote manuscript		
Overall percentage (%)	70 %		
Certification:	This paper reports on original research I conducted during the period of my Higher Degree by Research candidature and is not subject to any obligations or contractual agreements with a third party that would constrain its inclusion in this thesis. I am the primary author of this paper.		
Signature		Date	17/10/16.

Co-Author Contributions

By signing the Statement of Authorship, each author certifies that:

i. the candidate's stated contribution to the publication is accurate (as detailed above);

ii. permission is granted for the candidate in include the publication in the thesis; and

iii. the sum of all co-author contributions is equal to 100% less the candidate's stated contribution.

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CHAPTER 4 : HEDONIC AND EUDAMONIC WELL-BEING OUTCOMES FROM DIFFERENT CO-CREATION ROLES

4.1 Introduction

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With rising health care costs, an ageing population, and more demanding customers posing significant challenges to health services , it is not surprising that academicians and policy makers are encouraging and instigating further research in the field of health care management. In the past decade, there has been a growing academic interest in exploring the customers’ role in health care service provision, particularly focussed on the organisational benefit of customer value co-creation (Bitner et al. 2008; Chan et al. 2010; Gallan et al. 2013; Sawhney et al. 2005). Extant literature recognises that customers participate in their own health care management and/or participate to improve health care services for the benefit of an organisation, community group, or society (McColl-Kennedy et al. 2012). The co-creation of a health care management perspective (McColl-Kennedy et al. 2012), identifies that direct and dialogic interaction between customers and health care professionals has the potential to improve the well-being of customers as it encourages the customer’s active participation by creating options for them to contribute to meaningful experiences. Hence, there are calls for research to understand how to effectively manage these customer and service provider interactions to positively impact both individual and societal well-being (Berry and Bendapudi 2007; McColl-Kennedy et al. 2012; Ostrom et al. 2010).

Few researchers in transformative service research (TSR) have examined the interactions between service providers and customers that lead to customer well-being outcomes (Guo et al. 2013; Mende and Van Doorn 2015; Sweeney et al. 2015). However, these studies focus solely on the outcomes for the individual and do not consider the role the customer plays in co-creating value for the benefit of an organisation, community group, or society. Furthermore, these studies have largely given consideration to the hedonic dimension of well-being (i.e. customers' life satisfaction) (Carruthers and Hood 2004; Diener and Lucas 1999; Kahnemann et al. 1999) and have not considered the effects of co-creation on an individual's sense of meaning or purpose in life – i.e. their eudaimonic well-being (Ryan et al. 2008; Ryff and Singer 1998, 2000). While the notions of eudaimonic and hedonic well-being are interrelated, it is essential to distinguish between the two to understand the path through which each is achieved. Thus, this research will explore hedonic and eudaimonic well-being outcomes that arise from the various roles customers take in co-creating health care services for themselves and others.

As such, the specific research question that guides this research is:

How do the various roles that customers take in the co-creation of the health care provision influence their well-being outcomes?

In this study, we conduct case studies of two mental health organisations and identify that individual customers adopt various roles in their interactions with the service providers resulting in different well-being outcomes. Utilising ten interviews, eight focus groups

as well as content from documents and noted observations, this thesis undertakes a thematic analysis using the Gioia methodology (Gioia et al., 2013). It identifies three categories of co-creation roles for customers, viz.: co-producer, strategic partner and citizen and demonstrates how these roles influence well-being outcomes for customers.

Through this research, this thesis contributes to the co-creation and TSR literature. First, this research addresses the call to explore ways of improving well-being through transformative health care services (Ostrom et al. 2010, 2015). Second, the paper extends the work of Guo et al. (2013) and Mende and Van Doorn (2015) by exploring value co-creation within transformative services using self-determination theory as a theoretical lens and by suggesting that wellbeing is an outcome of co-creation. The paper demonstrates that not only is well-being generated when individuals participate in their own health care service provision (Guo et al. 2013; McColl-Kennedy et al. 2012; Sweeney et al. 2015), but that co-creation at an organisational or system level also impacts individual well-being. Third, it identifies and examines multiple ways by which customers contribute in creating value for the individual, collective and society. Finally, this study also contributes to the health psychology literature by demonstrating that customer participation beyond their individual point of care can impact on well-being. In this way this study extends value co-creation and TSR to the health services literature.

The remainder of the paper is organised as follows. The next section reviews the literature on customer well-being, and specifically the co-creation of well-being. This followed by an explanation of the methodology employed for this study. The findings

follow from that, with an explanation of the co-creation roles played by customers that facilitate customer well-being and the subsequent well-being outcomes generated. The paper concludes with an overview of the theoretical and managerial implication of the research and a discussion of its limitations and future research directions

4.2 Literature Review

4.2.1 Customer Well-being

Recently, there has been an increased focus on well-being in marketing literature (Anderson et al. 2013; Rosenbaum et al. 2011) and there have been calls to measure well-being outcomes associated with service provision (Ostrom et al; 2010; 2015). Well-being is a complex construct that is derived from two perspectives in the literature; the hedonic and eudaimonic perspectives. There is overlap between the hedonic and eudaimonic well-being and this is best conceived as a multidimensional phenomenon (Compton et al. 1996; Ryan and Deci 2001). Hedonic well-being is founded on the concept of sensory pleasure (Ryan and Deci 2001). According to the hedonic concept of well-being, an individual experiences happiness when they have positive emotions and satisfaction with life (Carruthers and Hood 2004; Diener and Lucas 1999; Kahnemann et al. 1999). Eudaimonic well-being is based on the view that people achieve betterment if they experience utilisation of their full potential, which means they experience life purpose and are appropriately challenged (Ryan et al. 2008; Ryff and Singer 1998, 2000). Self-determination theory has embraced the concept of eudemonic well-being as a central

definitional aspect, and this recognises three psychological needs – autonomy, competence, and relatedness – as being essential for well-being (Deci and Ryan 2008; Ryan and Deci 2001).

Well-being can be distinguished from general happiness as some activities or deeds may be pleasure producing, but their outcome may not be good for people and therefore may not lead to wellness. Furthermore, hedonic experiences have the potential to increase the individual's wellbeing only temporarily (Deci and Ryan 2008), or in other words, these experiences are transitory in nature (Myers 1992). We thus view well-being as not just achieving pleasure due to fulfilment of needs but as the realization of one's true potential (Ryff and Singer 1998, 2000), recognising both hedonic and eudaimonic constituents of well-being. The thesis explores the nature of well-being outcomes inclusive of the perspective of self-determination theory (SDT). SDT identifies an individual's competence, autonomy, and relatedness as crucial drivers of goal achievement (Deci and Ryan 2008; Ryan and Deci 2000, 2008; Ryan, Huta and Deci 2008). Competence is the confidence of customers in their ability to participate and interact with others in fulfilling their goals (Deci and Ryan 2000). Autonomy reflects self-regulated actions performed by the customers, which also give them ownership of their goals (Deci and Ryan 2000). Relatedness is the sense of being respected and engaging in behaviours beneficial to significant others (Ryan et al. 2008), not only to pursue individual benefits but also for social cohesion (Ryan & Deci, 2000; Ryan et al., 2008). While studies in TSR literature have considered the components of SDT in relation to well-being (Chou and Yuan 2015; Engström and Elg 2015), these studies used SDT as a motivational theory that drives

customers to participate in co-creation. Consistent with psychology literature (Compton et al. 1996; Ryan and Deci 2001), this study will therefore embrace SDT as a central definitional component of eudaimonic well-being, and examine its prevalence in a health related context

4.2.2 Co-creation of well-being

Value co-creation is known to enhance customers' perceived benefits and thus has the potential to increase their quality of life perception and their mental and physical well-being (McColl-Kennedy et al. 2012; Sweeney et al. 2015). Marketing studies have mostly focussed on well-being measures of an individual through co-creating with providers for their own care (Guo et al. 2013; McColl-Kennedy et al. 2012; Mende and Van Doorn 2015; Sweeney et al. 2015), For instance, Sweeney et al. (2015) found that, as customers make more effort in value co-creation by engaging in more demanding activities for their care, this increases their well-being (Sweeney et al. 2015). Further, when customers choose to comply with the recommendation of the providers and proactively co-create using the knowledge and skills learned, it enhances their financial well-being (Guo et al. 2013). While these studies demonstrate a link between value co-creation and well-being, they only consider activities that an individual is engaged in for their individual benefit. Recent conceptualisations of service highlight the importance of dynamic interactions in co-creation where customers co-create services with the organisation, customers, and other relevant actors to produce value outcomes for others as well as themselves (Tether and Tajar 2008; Vargo and Lusch 2011, 2016). This extends the notion of value co-

creation from a dyadic customer-organisation approach to one that recognises the broader, dynamic nature of resource integration (Vargo and Lusch 2011, 2016).

As customers engage in value co-creation activities they can offer or seek values in diverse ways (Frow et al. 2014), which are influenced by their role (Edvardsson et al. 2011). Two types of customer value co-creation roles are identified in the literature customer in-role behaviour which are necessary for value co-creation and customer extra-role behaviours, such as "customer helping behaviours" or "citizenship behaviours", which are voluntary and are not required for value co-creation (Bove et al., 2008; Groth, 2005; Yi & Gong, 2008; 2013; Yi, Nataraajan, & Gong, 2011). At an individual level, the customers have an active role in co-creating their individual outcomes by demonstrating customer in-role behaviour which are necessary for value co-creation. At a collective level, customers participate with other customers and employees to address service improvement initiatives within the organisation. At a societal level, customers participate with other customers, organisations, and community members to improve access to services for the broader society, reduce vulnerability for marginalised population etc. Customers voluntarily participate at collective and societal level to improve services, which demonstrate their extra role behaviour. Previous studies have argued that through extra-role behaviour, customers can provide extraordinary value to the organisation; however these extra role behaviours (voluntary behaviours) are not requisite for successful value co-creation (Yi and Gong 2013). However in this study it is argued that the dialogical interactions by customers with other customers, organisations, and community members have the potential to influence well-being outcomes for others as

well as for themselves (Rosenbaum et al. 2011; Vargo and Lusch 2009). Well-being outcomes are not only generated for individuals who are co-creating services but also enhance value outcomes at collective and societal levels, because others are benefitted by the improvements (Chou and Yuan 2015). Thus, this study will explore well-being outcomes generated by the different roles customers play when they co-create services at individual, collective and societal levels.

4.3 Methodology

A qualitative approach was taken to identify the various well-being outcomes that can be facilitated as customers adopt different roles in value co-creation. Two case studies of health care organisations in Australia (named as RED and GREEN for reasons of confidentiality) were conducted. The data collection and analysis in this study followed the Gioia methodology (Gioia et al. 2013), which assumes that respondents are 'knowledgeable agents' constructing their own realities. Considerable attention paid to selecting case-study organisations that had a strong customer-centred approach. Two not-for-profit mental health organisations were selected which had provided health services for more than 10 years. Recommendations from industry experts, an initial meeting with senior executives and an examination of each organisation's stated charter, annual plan and organisational goals determined that these organisations had the requisite customer-centred focus. Mental health services were selected for this study as it is a complex service that faces unique challenges to facilitate the co-creation of services between the organisation and customers. Mental health issues are often chronic in nature, customers would prefer not to need the service, and there is often a stigma in the society associated

with mental illness so people do not want to be involved with the service. Treatment also requires high contact and a high involvement by which providers continue to work with the customers over an extended time.

4.3.1 Data Collection

A total of ten in depth interviews and eight focus group interviews were conducted with a total of forty-two respondents. Ten members of the organisations' leadership teams were interviewed and eight group interviews were conducted with seventeen customers and fifteen providers across the two organisations. Table 4-1 elaborates types of respondents and their role descriptions.

Table 4-1 Profile of Interview and Focus Group Participants

	RED	GREEN
	Interview Respondents	
Respondent 1	CEO	National Services Manager
Respondent 2	General Manager	Service Development Manager
Respondent 3	Finance Manager	Consumer Participation Manager
Respondent 4	Program Manager	Corporate Services Manager
Respondent 5	Program Manager	State Manager
	Focus Group Participants	
Focus Group 1	Team leaders (3 participants)	Team leaders, support workers and customers (6 participants
Focus Group 2	Support workers	

	(3 participants)
Focus Group 3	2 Customers and 2 volunteers
Focus Group 4	3 Customers and 1 support worker
Focus Group 5	4 Customers and 1 support worker
Focus Group 6	3 Customers
Focus Group 7	3 Support workers and 1 team leader

The interviews and group sessions lasted between 50 to 90 minutes. In-depth interviews were conducted with the senior executives and the manager to gain insight about value co-creation practices in the organisations. These respondents had extensive experience of engaging customers in various forms of service provision so they added not only their perspective about value co-creation and its well-being outcome but they also had the capability to reflect on the customer perspective. Team leaders and support workers were included in focus group discussions because they interact with customers on a daily basis. As the customers may have cognitive impairment due to their mental health issues it was essential to interview team leaders, support workers and senior executives too to reflect the customers viewpoint. The remaining five group interviews were conducted with customers and where necessary support workers were invited to help facilitate the discussion between researcher and respondents. Each group interview had three to six respondents so that the individual well-being outcome and collective well-being outcomes could be explored. A consistent interview protocol was utilised for all interviews and the interviews and focus groups were conducted and interpreted in a

structured manner. Wherever possible observations were either audio recorded and transcribed or field notes were taken during the observation.

In addition to the interviews, for triangulation purposes the researcher also used other techniques such as document analysis, archival records and observations (Dubois and Gibbert 2010) For example, various documents such as annual reports, job descriptions, meeting minutes, meetings agenda, blogs, organisational charts, orientation packs, survey analyses, terms of reference, websites etc. were analysed. Data collection ended when saturation occurred and no new themes emerged. All interviews, focus groups and other sources of data were managed and analysed electronically by NVivo software.

4.3.2 Data Analysis

To analyse each interview the 'Gioia methodology' (Gioia 1998; Gioia et al. 2013) was followed. Each interview was transcribed immediately and the transcription and other relevant documents were imported into NVivo simultaneously. An iterative process was adopted for data collection and analysis (Thompson, Locander and Pollio 1989) and data were compared for theory development and verification. The themes and subthemes were refined and revised with ongoing data collection and fieldwork (Eisenhardt 1989; Strauss and Corbin 1998). The Gioia methodology provides a systematic inductive approach to concept development in that prior constructs or theories are not imposed on informants as an a priori explanation for their experience. The approach captures concepts in terms that

are meaningful for the participants and fosters a level of scientific theorizing about their experience (Gioia et al. 2013).

The texts in the interview transcripts that appeared relevant were then highlighted and coded on the basis of phrases used by respondents (Miles and Huberman 1984). Observations and documents were coded likewise. Similar codes were assembled for first order categories. A codebook was developed in which codes were documented along with their meaning and parameters(Miles and Huberman 1994). Whenever the codebook could not be applied to new text, a new code was defined and it was added to the codebook. When no new codes could be added to the codebook data collection was stopped as theoretical saturation was achieved (Strauss and Corbin 1998). Field notes and other documents were also used in the interpretative process. First-order category relationships were studied and they were organised into second order themes after several iterations using the researchers' expert knowledge of existing theory to determine whether the emerging themes suggest concepts that described and explained the observed phenomenon, in a process consistent with axial coding (Strauss and Corbin 1998). Interviews were used as the main source of data while observation and documentation were used for triangulation of key issues (Miles and Huberman 1994).

4.4 Findings

The findings of this study recognise that customers' well-being outcomes are influenced by the role individual customers undertake in their value co-creating interactions.

Whereas some value co-creating roles deliver value to an individual, other co-creation roles deliver value to other customers or society in general.

To understand how the various roles customers that take in the co-creation of the health care provision influence their well-being outcomes, this researcher first identified the different roles customers' take. A service-dominant logic perspective views all actors as resource integrators, however, it also acknowledges that different actors use and assess resources in different ways (Vargo and Lusch 2011; 2016). Consistent with this view, the present research identified three categories of co-creation roles for customers in our study based on their nature of interaction: co-producer, strategic partner and citizen. It should be noted that these are the broad categories of roles and within each type the nature of resource integration will differ, depending on the value outcome required and these roles may overlap for some customers. In this sense, we build on the work of McColl-Kennedy et al. (2012) and Jaakkola and Alexander (2014) who identified different types of co-creation and engagement activities undertaken by customers.

4.4.1 Co-creation roles of customers

Co-producer: The notion of co-production captures the participation of the customers in direct service provision (McColl-Kennedy et al. 2012). In this study, the researcher focused on service situations where customers are expected to have an active role in co-creating their individual outcomes. Mental health services require high levels of co-production and value is created when customers engage in activities to achieve their personal goals. RED and GREEN provide many opportunities for their patients to

actively participate in their own treatment plan. They support their customers by reviewing their case histories and identifying strategies for various treatment options and then assisting customers in developing strategies to manage their symptoms. The research found that customers of RED and GREEN participated at the point of care by supporting and redesigning their treatment plans, actively taking responsibility for Reducing their stress, taking medication on time, and by integrating resources from other sources (e.g. advice from families and friends) (McColl-Kennedy et al. 2012) as evidenced by the statement of the RED CEO.

> "Every time someone connects at RED we actually design with them their point of care treatment. For us it's a given... if someone engages in counselling the counsellor doesn't say what you need is 'narrative therapy', let's start. They listen to the person at the point of care. It's the job of the counsellor to think would a narrative approach here or cognitive therapy be required. The counsellor thinks about all their frameworks all their strategies and…then engage at the point of care with the participant, is this what you are looking for, and how do we make this happen" (RED Respondent 1)

When customers acted as a co-producer they became an active partner in their own care, setting personal goals and strategies for managing their health. Customers were involved with resources and groups for seeking additional information or assistance in managing their personal health needs. In undertaking these activities they create value for

themselves and they went beyond the basic compliance and put increased efforts into utilising the services.

Strategic partner: Customers were considered 'strategic partners' when they were actively involved in the design of services and governance within RED and GREEN. Our study found that customers participated at many levels in both organisations through activities such as the design of service provision, in organisational strategic planning, by having representation on the Board, and other activities for improving service provision, policy development, and governance of the organisation.

> "We had a risk assessment working group in which customers were represented nationally throughout the organisation and it ran for about 2 years. We worked together to assess the risk associated with our programs and presented back to the leadership forum, at the annual forum, and the customers came along and presented with us" (GREEN Respondent 1)

In GREEN, customers are first trained in interview skills through a program called Launching Pad and subsequently they participated in the recruitment of staff that work closely with customers in developing treatment plans. Customers in GREEN also participated as advisors or members of the advisory council, and members of operational committees, such as the safety and quality committee.

When customers acted as a strategic partner their focus was to participate in improving the service design and governance of the organisation. They participated with managers,

front line employees and clinicians in planning new services, as well as in the evaluation of present service offerings. Though this type of role may benefit the individual, the primary focus is to improve the organisation's operations. In this sense, customers are creating value for the organisation and for other customers rather than doing so exclusively for themselves as an individual.

Citizen: When the customers adopted the role of a 'citizen' they were volunteering in a manner that provides value within the broader context (i.e. society or industry). For instance, RED customers represented the organisation with the employees by taking part in community-based health events, in conferences, in state level mental health consultation groups, advisory committees etc. As a result of their participation, RED customers have advocated for more funding and better services and have helped the community to understand the misconceptions around mental health. While this provides value beyond the individual, it also provides intrinsic value to the customer as they feel they are able to "give back" to the community. One of the focus group respondents involved in these types of activities said,

> "In some ways I have contributed in improving access to services for mental health clients like they are involving us more and it does help us a lot" (RED Customer Focus group 4)

Similarly, GREEN customers participated in government consultations, in advisory panels and in the work of other organisations and were supported in these roles. One customer of GREEN nominated in an advisory Council commented in the Service

Improvement Review Report:

> "As a member of the Council I have also presented the Consumers Perspective at …various consumers and service provider forums reflecting on service provision to enhance our recovery journeys" (GREEN Service Improvement Report 2014-15, p. 13]

The citizen role explored in this research is different to citizenship behaviours identified in previous studies (Rosenbaum 2015; Yi and Gong 2013). Customer citizenship has been defined as customer contributions to the services of the firm by following their plan of action (Rosenbaum and Massiah 2007) and by providing them with feedback to improve services and by advocating their services to other users (Yi and Gong 2013). These studies have not considered the customer's role as citizens in contributing to the system beyond the organisational boundaries. Besides, previous studies have argued that through citizenship behaviour, customers can provide extraordinary value to the organisation; however these behaviours are extra role behaviours (voluntary behaviours), which are not requisite for successful value co-creation (Yi and Gong 2013). However, in the present study it was found that when customers take the role of a citizen they are more engaged with the service and want to participate, as this has an impact not only for others but also impacts upon their own well-being. When customers played a role as a citizen for RED or GREEN, the focus was to ensure that the broader mental health system is providing opportunities to customers to participate in their care and is therefore more co-creative in its approach.

4.4.2Well-being outcomes generated from co-creation

The primary research objective of this study was to investigate the well-being outcomes that resulted from the different co-creation roles of customers. Previous researchers have acknowledged that the degree of effort needed to participate in a service can influence one's well-being (Guo et al. 2013; McColl-Kennedy et al. 2012; Sweeney et al. 2015). However, in these studies customers' efforts to co-create value for their own benefit have been linked with their personal well-being. In this study, it was found that customers' well-being was not only linked with their participation in co-creating for their own benefit but it was also linked with co-creating for organisational and societal benefit. Furthermore, both hedonic well-being (i.e. sensory pleasure) and eudaimonic well-being (i.e. fulfilment of human potential) outcomes were identified in the case studies.

This research explores the customer well-being outcomes generated by co-creation from the perspective of self-determination theory (SDT) (Ryan and Deci 2001). In the present case studies the researcher found evidence of eudaimonic well-being outcomes linked to competence and autonomy when customers co-created as a co-producer and found evidence of all three components of SDT (viz. Competence, Autonomy and Relatedness) in well-being outcomes when customers co-created as a strategic partner and citizen. Fulfilment of autonomy, competency and relatedness act as principal factors that foster eudaimonic well-being as assisting in self-realisation of one's potential. Table 4-2 illustrates the wellbeing outcomes generated by different co-creation roles of customers and these are discussed in the following section providing examples from our case study.

Table 4-2 Wellbeing outcomes generated by different co-creation roles of customers

Role of Customers	Wellbeing outcomes (Eudaimonic and Hedonic)
Co-producer	• Sense of confidence • Sense of control • Happiness and pleasure
Strategic Partner	• Sense of competency • Sense of freedom • Sense of common purpose • Happiness and pleasure
Citizen	• Sense of mastery • Sense of empowerment • Sense of social contribution • Happiness and pleasure

4.4.2.1 Customer hedonic well-being generated from co-creation

Individuals participate in a task when they find enjoyment and interest in it (Deci and Ryan 1985) It was found in the case studies that when customers are pursing various co-creation activities (as co-producer, strategic partner and citizen) they often enjoy their role. They have a positive experience, which brings a sense of happiness and pleasure Experience of pleasure is vital for the hedonic perspective of well-being (Kahnemann et al. 1999). When customers' at RED and GREEN participated as a co-producer they actively engaged in their treatment plan and were willing to share information with the providers and this gave them a sense of satisfaction. When there is a high involvement of customers with the service providers the customers perceived greater benefits from the service (Kinard and Capella 2006) as narrated by one respondent.

> "When you come here for counselling you get a sense of satisfaction you feel better after coming here" (Customer Focus group 5)

Previous scholars have also found that when customers placed more effort on value co-creation by engaging in more demanding activities, it increases their quality of life perception (Sweeney et al. 2015). In these studies customers participated in co-creating their own health care experience which (according to the data) increased their life satisfaction. In this study it was found that when customers at RED and GREEN participated as strategic partner and citizen they contributed resources for mutually beneficial outcomes and enjoyed being productive and helping others as stated by respondents.

> "We increase awareness about mental health. I just enjoy the process of doing that" (RED Consumer Focus Group 4)
>
> "I think each member of the group whether you are staff, participant, or volunteer gets as much from each other as we do. It is a two way thing, it is a reciprocating thing we enjoy, there is a lot of enjoyment in what we do" (Consumer Focus Group 4)

When customers participate in value co-creating activities they find it interesting and entertaining (Nambisan and Baron 2007) and their' effort in value co-creation influences their well-being (McColl-Kennedy et al. 2012; Sweeney et al. 2015). In this study it was found that participation of customers whether creating value for themselves, the collective, or society improves their hedonic wellbeing because they experience pleasure and happiness through their participation.

While co-creating services improved hedonic well-being, the researcher also found that it has the potential to improve the eudaimonic well-being of individuals. The present paper found various evidence of eudaimonic well-being outcomes for customers, which have categorised below with relevant examples and illustrative quotes.

4.4.2.2 Customer eudaimonic well-being generated as Co-producer

When customers act as a co-producer this helps them to influence the outcome of their care, as they actively participate in co-creating their treatment options in consultation with the providers. Our analysis shows that when a customer takes the role of co-producer two psychological well-being needs reflecting their sense of purpose - competence and autonomy - were achieved. Customers felt that the organisations supported them to have more confidence (competence) in their ability to achieve their potential and this in turn gave them a sense of control (autonomy) over their own destiny, particularly in regards to their health care management but also beyond. The research found evidence of both well-being outcomes for customers, which have been categorised below.

Sense of confidence: is related to the competence of the customers in participating in their own health care. RED and GREEN support their customers to understand instructions, provides them with resources to improve their participation skills, and hence increases their confidence to engage with their counsellors at the point of care. Customers are confident communicating with counsellors and work alongside them in the coordination of their personal health care management. Many customers of RED identified that the

organisation supported their efforts, by offering both training and resources and this motivates the customer to participate in and co-create their care.

> "It gives me a bit of a confidence and I am paid musician and I stopped playing guitar for about 10 years. It is after coming here that I got started and so that gives me so much to go home and catch up with 10 years practice that impacts my entire week coming here for 1 day. Even my friends notice and say you look better now, as you have started playing music. That is RED and RED has done that for me. (Customer Focus Group 4)
>
> "You are supported to be your best which has totally transformed my life" (Customer Focus Group 5)

These examples illustrate that RED provided support to their customers, which in turn provided a sense of confidence in their abilities and encouraged the customers to pursue their passion and purpose even beyond their supported recovery.

Sense of control: is related to the autonomy of the customers in participating for their care-plan. Customers considered that participation in their care provides them with a sense of control over their mental illness and life in general. Customers can find their voice and exercise their choice with regard to their health care management. While engaging in their care they have the choice of just following basic compliance, or collaborating in developing their treatment plan. This gives the customer a sense of control over the situation and allows them to feel their skills are being utilised, which

appears to enhance customers' acceptance of their treatment regime and positively influences their eudaimonic well-being.

> "And just coming here you kind of feel like this is where I need to be. This is the place that will help me be a better person, being able to control different aspect of my mental illness" (RED Customer Focus Group 5).

> "What motivates me is if you come here you can draw pictures and express what you are feeling and you have a control over your feelings. So if you come here and you feeling down and you are really good artist you can draw how you feel". (RED Customer Focus Group 5).

Similarly, GREEN has implemented the collaborative recovery model for the services provided to their customers, which is a coaching framework that emphasises providing support to customers in their recovery. There were several examples in GREEN documents where customers have highlighted that they have a great relationship with their providers due to which they feel comfortable in voicing their opinion. The service providers understand their needs and this has improved customers' confidence in contributing to their treatment program.

4.4.2.3 Customer eudaimonic well-being generated as Strategic partner

The research found that customer participation as a strategic partner has the potential to improve each customer's individual well-being. This type of well-being is eudaimonic in

nature as co-creation for value at a collective level provides opportunities for customers to actualize their potential and this in turn gives them a sense of purpose. We found that when a customer took the role of strategic partner their three psychological needs - competence, autonomy and relatedness - were achieved, providing them with a greater sense of purpose, or eudemonia.

Sense of competence: reflects the feeling an individual achieves from their focus on being productive and it contributes to their perception of self-efficacy (Bandura 1977). Opportunities to participate in service provision increase customers' sense of competence as they feel they have the perseverance to participate in achieving goals that are greater than their own health. This influences their intellectual efforts and strategies to advance their personal goals and achievements because they feel they are more productive. This provides the customer with a greater sense of purpose and eudaimonic well-being as reflected by a customer who participated in the performance committee at GREEN

> "Being involved in any opportunity like this makes me feel just great that I am involved in making decisions about what resources GREEN will have … that my skills and experience matter…… This has a huge impact on my recovery and on my self-esteem" (GREEN Service Improvement Review Report 2014/15 pg 14).

Sense of freedom: The collective aspect of participation is influenced by social interactions within the group (Carù and Cova 2007) Keeping this in mind, RED enables customers to engage freely, interact with others and explore things at their own pace.

They enjoy a sense of freedom in the way they may co-create in the group, which makes people feel more comfortable as they are able to personalise their experience. The sense of freedom gives them a feeling of being autonomous as they consider they are not compelled to behave or co-create in a certain manner, which in turn makes them aware of their responsibility and fosters their involvement (Amabile 1993).

> "It is up to you if you want to get involved and they support you in getting involved. You are supported to be your best which has totally transformed my life from someone who started here as a participant and was quite unwell to someone who is working in the field now" (Consumer Focus Group 5).

Sense of common purpose: RED and GREEN support customers to develop strong social relationships, and these have helped them to increase their willingness to share skills and knowledge with others. They feel that they are collectively connected for a cause or purpose so they are motivated to participate in service provision beyond their own care for that common purpose. They are able to learn from others, interact with people in similar situations and establish social relationships within the group. These mechanisms positively influence their eudaimonic well-being as they feel they are able to contribute for others in the community and they feel associated with others which gives them a sense of *common purpose. They* are proactive in providing suggestions to the organisation about how to improve services, as they value relatedness as the way to improve their own well-being (Deci and Ryan 2000) as evident in the following statement.

> “It’s participant focussed. It’s basically for the participants by the participants really. You have got support workers guiding you but its mainly you coming up with ideas. It just gives you the motivation that you actually succeeded in something. With that it always help in your mental illness because when you are at your low point you think you can’t achieve anything and actually achieving something may be its just an idea or getting involved in something it does it makes you feel better and it comes out to everyone as well” (RED Customer focus group 5)

This finding is in contrast to that of (Guo et al. 2013) who argued that when customers are involved in the development of organisation systems or processes it has no effect on their well-being, as the target of involvement is to improve services of the organisation.

4.4.2.4 Customer eudaimonic well-being generated as a Citizen

When individuals are participating for value outcomes at a societal level it creates greater well-being as customers experience eudaimonic outcomes by strengthening the individual’s experience of self-determination. The ethos of RED is ‘sharing the journey’, which aims to welcome everyone, regardless of whether they are customers, carers, volunteers, community members, students, or researchers. Customers, as citizens, along with the organisations and other relevant actors raise awareness about mental health, trying to REDuce the stigma associated with mental illness, motivating people to access services if there is a need, and thus having a transformative impact on the community. When customers play the role of citizens they are not only concerned about their

individual outcome or outcome for the organisation, but they are co-creating services with other actors to improve the value outcomes at a societal level. When customers take the role of citizen, their three motivational needs - competence, autonomy and relatedness are achieved. The research highlights the impact of these 'psychological needs fulfilment through well-being' outcomes that were generated when customers co-created for societal benefits:

Sense of accomplishment: when the individuals are participating for value outcomes at a societal level it enhances their perception of self-efficacy as they experience competence in achieving shared goals. This creates a greater sense of well-being as customers experience eudaimonic outcomes by helping people to connect with services or by contributing resources for improving access to services. Customers of RED and GREEN shared their experience of gaining the sense of accomplishment by contributing to the societal good, especially when they know they have made a difference in someone's life. Customers were motivated by the benefits the community can receive and this strengthened their sense of accomplishment as illustrated by one RED customer.

> "When we go out in society there are people who have never heard of mental health services and we sometime hear little bit of apprehension for mental illness. We help them to understand the mental health issues and engage with mental health services. I think we have made a positive impact in terms of reducing stigma. This gives me a sense of accomplishment that my skills and experience matter" (RED Customer Focus Group 4)

Sense of empowerment: Being able to participate in accruing value outcomes at the societal level provides a sense of self-efficacy, as individuals see their values and ideas being respected. This enhances the customer's sense of empowerment by strengthening their perception of self-determination (Deci and Ryan 2002) and self-efficacy (Bandura 1977) and in turn enhances customers' determination to participate beyond their own care. Both RED and GREEN encourage customer participation in their outreach programs, in service provision and in utilising them as volunteers to improve the health literacy and reduce the stigma about mental health among the community members. When the customers integrate resources it drives their belief in the knowledge and skills they possess. They share knowledge and related resources and pursue active collaboration towards a common purpose of co-creation. This empowers each individual within these groups and leads to an enhancement of eudaimonic well-being.

> "Being able to participate like participants playing music in the festival' that is making a big effect and it goes beyond this room. Some people just sit and listen while some people are actually performing music, art shows……. I went for art thing I saw more you involve people it changes their lives. This gives that perspective that I can do things, I can get involved; I can help in certain ways. It gives me a sense of purpose" (RED Consumer Focus Group 6).

Sense of social contribution: Social contribution has been defined as the evaluation of social value and it reflects the belief that the things that people do are valued by the society (Keyes 1998). RED and GREEN gave their customers a platform to participate in

outreach programs, exhibitions, conferences and this allowed customers to advocate for better services, increased awareness and also set an example for the public by showcasing what customers have achieved since joining. Customers are able to contribute in unlocking the potential of excluded people, improve the market place literacy and customers' access to services. This influences customers' well-being as they consider their participation helps them to contribute socially. They feel they are a vital member of the society and fulfilling their potential.

> "Obviously me helping to volunteer, helping people, which makes you feel better because when you are ill you felt like going nowhere; it sort of made you achieve something you might not being able to do" (RED Customer Focus Group 5)

Prosocial community involvement behaviours of the individual support their individual well-being as people feel more socially integrated and have socially contributed (Keyes 1998). Community involvement of customer provides a sense of competency, autonomy and relatedness, which influences customers' eudaimonic well-being (Ryan et al. 2008). The customer feels intrinsically motivated to participate at societal level, which has the potential to enhance their psychological growth and well-being (Ryan and Deci 2001).

4.5 Discussion and Implications

This study makes theoretical contributions to TSR, psychology and co-creation research by demonstrating how the differing co-creation roles of customers lead to different customer well-being outcomes. This work responds to recent calls to explore ways of

improving well-being through transformative health care services (Ostrom et al. 2010, 2015) which lies at the heart of TSR (Anderson et al. 2013). This thesis utilises SDT, which advocates that fulfilment of basic psychological needs may foster well-being and suggests its relevance in individual, eudaimonic well-being. This chapter showed that value co-creation activities provide the feeling of autonomy, competence, and relatedness to customers. It was seen in both the RED and GREEN case studies that customers were sharing their resources and skills willingly, they were voluntarily participating for self, collective and societal benefits and that served to strengthen their experience of self-efficacy and self-determination. The results demonstrate that a feeling of self-efficacy and self-determination due to value co-creation fostered customer well-being. These findings contribute to the TSR and co-creation literature by suggesting well-being as another valid outcome of co-creation of value.

In transformative services research the well-being of individuals has been emphasised by co-creating with providers for their own care (Guo et al. 2013; Mende and Van Doorn 2015; Sweeney et al. 2015), but in our study we found that individual actions have the potential to impact on collective and societal outcomes. For instance, the extent that customers' value co-creation in their health management impacts on their personal health but it may also result in improving access to health services for the community. This research also elucidated the relationship between individual well-being and value outcomes for the self and others. It proposes that as individuals aim to contribute in co-creating value at collective and societal level, their individual needs of autonomy, competence and relatedness are met, enhancing their eudaimonic well-being. Therefore,

the research has contributed to the TSR literature by focussing on well-being when customers pursue not just individual but also collective and societal outcomes.

Three types of co-creative roles of customers were identified: co-producer, strategic partner and citizen. All three roles manifest hedonic and eudaimonic well-being outcomes. Firstly, as a co-producer of their health care service, customers participate in their care, which gives them pleasure, as they are more involved in their treatment regime in concert with the providers. When the organisation provides support for improving skills for participation of the customer, and customers have a sense of control over their ailment, it also enhances eudaimonic well-being. Secondly, as a strategic partner, customers participate in groups to provide value for the collective. This leads to a sense of competence, sense of freedom and a sense of common purpose while participating in co-creating services; it also provides a sense of happiness and pleasure. Finally, citizen customers participate in improving access to services in society, hence reducing the stigma associated with mental illness and in improving health literacy. Individual customer well-being is enhanced through this process, as they may feel they have gained mastery in understanding the system, feel Empowered to advocate services to the broader community, and there is a sense of social contribution and connectedness for the society due to value outcomes that are produced by co-creating services at societal level. These present findings suggest not only that the hedonic well-being characteristics of pleasure and happiness are associated with the co-creation of value but also eudaimonic well-being is an outcome that provides a sense of achievement and purpose to customers. The researcher has used the construct of SDT to identify different forms of eudaimonic well-

being. The research explored how the co-creative role of customers provided competency, autonomy and relatedness for customers. Eudaimonic well-being occurs with value co-creation at all levels, but is more pREDominant when the value co-creation is for the collective and society.

Managerial implications

The findings have implications for managers of health related organisations and for policy makers. Since the co-creative role of customers has a positive impact on their well-being, organisations should not only focus on providing customer oriented services but also invest in developing skills and competencies of customers so that they are better prepared and feel ready to act as co-creators. When customers' skills and competence are improved, they are more willing to not only engage in co-creative activities within the organisation, but they also start to integrate resources outside the organisation and this has an impact on their well-being as well. It was apparent in the present study that although, due to mental health concerns, the customers cognitive ability to participate in services is impaired; if the organisation provides them with the opportunity they will choose to participate. Customers chose to participate not only in development of their treatment plan at the point of care but also in organisational systems and processes.

As customers are willing to participate it is imperative that organisations understand the different roles customers can play in value co-creation. The customers can not only act as co-producer and proactively manage their own care but they can also act as strategic

partner and citizen to participate beyond their self-management. Managers can use these roles of customers and the well-being outcomes to train their staff in co-creation practices. This may also help the organisation in recruiting and supporting suitable customers for value co-creation activities.

Additionally, as differing well-being benefits arise from different co-creation activities, it is essential that organisations provide customers with multiple opportunities and avenues for participation, as this increases their sense of autonomy and their overall well-being. It was evident in the study that customer participation in activities that were challenging and in which they were able to utilise their full potential either by participating in their individual care or by participating as a strategic partner and citizen were able to influence their own well-being. Therefore, organisations must also invest in exploring different challenging opportunities for the customers, as they can meet their abilities and emphasize the value they are contributing during their participation. This will increase their sense of competency and relatedness, which therefore impacts on their well-being.

The findings provide implications for health care policy makers suggesting that customers can play varying roles in co-creation and so the strategies employed to engage them should also be different. The organisations should not restrict their policies for engaging with customers at the point of their care but aim to provide different strategies for organisations to engage customers more broadly and widely as this not only has benefits for the organisation but also positively impacts the customer's individual well-being and there are positive outcomes at collective and societal level.

4.6 Limitations and Future Research Directions

Despite the theoretical and practical contributions, there are a number of limitations associated with this study along with opportunities for future research. First, the co-creative roles of customers and resultant well-being outcomes were identified in a health care setting where customers have unique challenges and abilities to be involved in the co-creation of value. So, future research could test the applicability of these findings beyond health care. We believe that the findings from this research are potentially transferable, especially in high contact and high involvement service settings such as financial counselling services.

Sweeney et al. (2015) has done preliminary quantitative work to demonstrate the transformative potential of value co-creation however their work is concentrated on well-being measures of an individual by co-creating with providers for their own care. In this thesis study it was learned that individual actions have the potential to impact collective and societal outcomes as well. The researcher utilised a case study approach to identify co-creative roles of customers and the well-being outcomes generated. This was very effective in explaining the link between co-creation and well-being. The next step for future researchers is to investigate the findings in a quantitative setting and test if the findings hold true and test our conceptual understanding.

Third, respondents in this study were from a mental health organisation so the research was focussed on psychological well-being measures (Oishi et al. 1999) while in other

situations such as in weight loss programs, researchers may focus more on physical well-being or in financial counselling they may focus on the credit score or financial well-being (Mende and Van Doorn 2015) Therefore, future researchers can look for additional well-being outcomes in various other fields.

In this study, individual well-being was aligned with the collective and societal well-being but it should be acknowledged that this may not always be the case. For instance, an individual may want a health policy to be implemented that is detrimental to the public health. Therefore, future research should also investigate instances when there is a conflict between individual and collective or societal value outcomes.

CHAPTER 5 : GENERAL CONCLUSIONS OF THE THESIS

While research on co-creation in the last decade has focussed on its conceptualisation and nomological network, very little has been done to address the organisational conditions for value co-creation. This exploratory study, deployed in three phases, has addressed this gap and contributed to a deeper understanding of the capabilities, culture, activities, and initiatives that will support a focus on customer resource integration and co-creation within an organisation. This concluding chapter acknowledges the theoretical and managerial implications of the research, discusses the limitations and the opportunities for future research.

5.1 Theoretical Implications

The shift towards service dominant logic (SDL) has increased the emphasis on customer integration, however limited research has been conducted to adequately explore the organisational conditions that support co-creative behaviours and recognise the customer as an operant resource (Vargo and Lusch 2008). Scholars, such as (McColl-Kennedy et al. 2012), call for future research to understand the impact of customer co-creation on organisations. Also, Ostrom et al. (2010) while reflecting on the key priorities of service science research have noted the need to further understand the way to involve customers in service innovation and to extend the boundaries of organisational culture to include customers as a contributor. In responding to the calls for further research in value co-creation, this thesis explores the capabilities and culture that firms need to support co-

creation and it extends the knowledge by understanding that people co-create not just for their own benefit but also for the benefit of the collective and society. Similarly, Edvardsson et al. (2014) and Ostrom et al. (2010) call for further investigation of value co-creation in highly collaborative and participatory environments therefore, this thesis has explored the concept of value co-creation in a health care context. The concept of customer participation is slowly being recognised in the field of health care provision; however, until now there is lack of studies which have addressed the conditions for enabling value co-creation in health services and its effects on well-being outcomes for customers (Leone, Walker, Curry, & Agee., 2012; Evers & Ewert, 2012). This thesis takes the footprint of SDL beyond the marketing literature to the health care domain. It illustrates that SDL has the potential to create new theoretical insights for public services such as health care. In doing so, this thesis addresses the call from authors in the public services domain (Osborne 2010; Osborne et al. 2013) for further research into adopting a services-dominant approach for the management of public services.

There is awareness in the literature that both the organisation and the customer are resource integrators but there is a paucity of studies that have examined the capabilities (Coviello and Joseph 2012; Hibbert et al. 2012) and culture (Karpen et al. 2015; McColl-Kennedy et al. 2012) required by an organisation to facilitate customer participation. With the shift to a service-dominant paradigm, the existing capabilities and culture models fall short as they ignore the role of customers as resource integrators. The present findings demonstrate there are additional capabilities (e.g. interaction capabilities) and

different values and behaviours (e.g. co-creation behaviours) that constitute a culture that reflects the inclusion of customers within traditional organisational boundaries.

The extant literature on capabilities has focussed on those assets of a firm that it controls in-house to achieve a competitive advantage (Alam and Perry 2002; Carbonell et al. 2012). With the shift towards a service dominant paradigm it is important to identify the capabilities that an organisation is able to draw on for supporting customer participation. Extant capability studies focus more on product providers (Coviello and Joseph 2012; Lin and Huang 2013) than the role of customers and they provide a narrow(er) perspective of the firm capabilities that are required to efficiently and effectively enable customer participation in service innovation (Hauser, Tellis and Griffin 2006). The capabilities identified through this research specifically advance dynamic capability theory by considering it from a co-creation perspective. Drawing from dynamic capability theory, we identified and categorised organisational capabilities by applying the conceptual framework of the customer, (service) provider and joint spheres of co-creation (Grönroos and Voima 2013). The capabilities that were required to bring together the customer and organisation to facilitate innovation outcomes were also considered. We identified and categorised four sets of organisational capabilities: customer activation, organisational activation, interaction capabilities, and learning agility. In doing so, this research builds on the work of Karpen et al. (2012) and Coviello and Joseph (2012). Coviello and Joseph (2012) identified customer mobilisation and learning agility as capabilities to achieve innovation in a business-to-business context. As health care customers are far more stressed, emotional, and sometimes very reluctant to co-create or participate (Berry and

Bendapudi 2007), customer activation and mobilisation can be seen as challenging in a health care context. Therefore, in this research the notion of customer mobilisation as proposed by Coviello and Joseph (2012) was extended to have a greater focus on customer identification. Our findings also extend Karpen et al. (2012) interaction capabilities, which include six dimensions to facilitate interaction among customers, by highlighting the importance of these capabilities for a health care organisation.

First and foremost co-creation focussed on dyadic customer and organisational relationships (Prahalad and Ramaswamy 2004), however, the focus of current literature is now shifting to recognise that multiple actors contribute in value co-creation through resource integrations (Tether and Tajar 2008; Vargo and Lusch 2011). The evolution of SDL highlights that organisational boundaries are becoming increasingly porous where organisation and customers are embedded within networks of other organisations, customers and partners etc. (Edvardsson et al. 2011; Vargo and Lusch 2011). This shift to a value co-creation perspective with multiple actor involvement challenges traditional organisational culture models. Firstly, existing organisational culture models are constrained from facilitating co-creation as they do not acknowledge the interconnectedness of all actors across traditional organisational boundaries. The Competing Values Framework (CVF) model does not include the customer per se (Lukas et al. 2013) and has a restrictive external and internal focus (Quinn and Rohrbaugh 1981, 1983); hence the shift towards value co-creation is not reflected in current studies related to organisational culture (Büschgens et al. 2013; Lukas et al. 2013; Storey and Hughes 2013). Thus, the objective of this research was to identify and explicate the

characteristics of an organisational culture that supports co-creation, i.e. a co-creation culture. By conducting an exploratory study this research makes a theoretical contribution to the literature of co-creation and SDL and directly addresses the request for further investigation into organisational culture which supports the approach of customer value co-creation (Karpen et al. 2015; McColl-Kennedy et al. 2012). The first contribution in this second phase of the research is the development of middle range theory of co-creation culture that enables application of SDL in practice (Brodie, Saren and Pels 2011). The second contribution arises from the findings defining Shared values and behaviours that underpin a co-creation culture. Our findings show that a co-creation culture orientation is built around a series of core and support co-creation behaviours. In identifying and defining co-creation and engagement behaviours the research builds on recent research in the value co-creation literature (Jaakkola and Alexander 2014; McColl-Kennedy et al. 2012; Payne et al. 2008; Yi and Gong 2013) and on previous research related to a market-oriented culture (Gebhardt et al. 2006; Homburg and Pflesser 2000). Although some of the values identified (eg respect, trust etc.) and behaviours (eg market intelligence) are also present in market oriented culture literature, the findings of this study demonstrate that in a co-creation culture they manifest differently, as these behaviours reflect co-creative practices and values that enhance resource integration. A further contribution is to organisational culture literature through examining culture from an SDL perspective and illustrating the limitations of 'CVF', the most widely used framework of organisational culture, as the organisation boundaries are becoming permeable unlike the assumptions embedded in the CVF, which only has an external and internal focus.

As the emphasis on customer integration is increasing, various organisational benefits of customer value co-creation have been identified in the literature (Bitner et al. 2008; Gallan et al. 2013; Sawhney et al. 2005). Only recently research has started to address the influence of value co-creation for customers when they participate in their own care plan (Guo et al. 2013; McColl-Kennedy et al. 2012; Mende and Van Doorn 2015; Sweeney et al. 2015). However these studies do not address well-being outcomes that are generated when customers are co-creating services for the benefit of an organisation, community group or society. As co-creation is evolving towards resource integration by multiple actors (Vargo and Lusch 2008) researchers have started to acknowledge that customers can play various roles in value co-creation (Chou and Yuan 2015). In this research we have identified three co-creative roles customers can play: co-producer, strategic partner and citizen and demonstrate how these roles influence well-being outcomes. In identifying various co-creation roles customers can undertake this research builds on the work of McColl-Kennedy et al. (2012) and Jaakkola and Alexander (2014) who identified different types of customer co-creation and engagement activities. Through this exploratory research the author makes theoretical contributions to the co-creation and TSR literature and addresses the call of service science priority to explore ways of improving well-being through transformative health care services (Ostrom et al. 2015; Ostrom et al. 2010). Firstly, the thesis explores the well-being outcomes generated from various co-creative roles of customers and illustrates a connection to the individual's need for self-determination. Self-determination theory (SDT) identifies that when the individual's competence, autonomy, and relatedness needs are satisfied they become more self-determined and this contributes to their sense of well-being (Ryan and Deci

2000). These research findings illustrate that the co-creative roles of customers provided all three elements of SDT and hence improved customer well-being. These findings contribute to the TSR and co-creation literature by using self-determination theory for establishing well-being as an outcome of co-creation of value as an extension of the work of Guo et al. (2013) and Mende and Van Doorn (2015). Secondly, though the well-being of individuals has been emphasised earlier in TSR (Guo et al. 2013; Mende and Van Doorn 2015; Sweeney et al. 2015) the present research identifies and examines multiple ways by which customers contribute in co-creating value for the individual, collective and society which provides a greater sense of accomplishment to customers and contributes to their well-being. In this way, we further extend the body of literature that connects co-creation and well-being. Thirdly, previous studies have mostly examined the hedonic dimension of well-being which is based on the concept of sensory pleasure (Carruthers and Hood 2004; Diener and Lucas 1999; Kahnemann et al. 1999) rather than eudaimonic well-being based on people's potential to fulfil their life purpose (Ryan et al. 2008; Ryff and Singer 1998, 2000). Our findings support the notion that well-being is a multidimensional concept which includes not only the hedonic wellbeing characteristics of pleasure and happiness but also eudaimonic well-being which provides a sense of accomplishment to customers. The author has used the construct of SDT to identify different aspects of eudaimonic well-being which occurs with value co-creation at all levels, but is more predominant when the value co-creation is for the collective and society, as there is sense of common purpose and a sense of social contribution. We expanded the knowledge of eudaimonic well-being by showing that connections to autonomy, relatedness, and control exist at individual, collective and society level.

5.2 Managerial Implications

From the results of this study, a number of key implications can be derived for health care practitioners. First, the findings illustrate that customers are willing to take a more active role in the provision and development of health care services for themselves, as well as for the benefit of the community and the society. Health organisations raised the concern that they lack the abilities to facilitate an active customer role. However, this research provides detailed knowledge of capabilities, culture and resources that can guide practitioners to actively develop strategies aimed at facilitating co-creation for health care management. Health care organisations can benefit by providing opportunities to their customers for constant dialogue and interaction to facilitate co-creation behaviours. Second, our research presents organisational level evidence to practitioners that to adopt collaborative practices and co-creation practice styles they must build on their abilities to facilitate customer participation and not just focus on their internal operations. The organisational capabilities of organisation and customer activation, the interaction capabilities and learning agility, and the co-creation culture identified and explicated in this research can guide managers to effectively encourage the co-creation of value with customers. The practitioners can reinforce these capabilities, core and supportive co-creation behaviours and values through strategic initiatives, role-model behaviour, and formulation of the organisation's policies and philosophy.

Third, our findings demonstrate to practitioners that organisations can benefit by providing opportunities for their customers to participate in health care services. The

ongoing nature of this collaboration between customers and employees provide avenues for constant dialogue, capability development, and interactions that facilitate co-creation behaviours and practices. Customers chose to participate not only in their care but also in organisational systems and processes. Therefore, practitioners should provide multiple opportunities and avenues for customer participation. They can connect customers to the resources beyond their organisational boundaries such as social groups, support groups, and online communities.

Fourth, our findings suggest that there are transformative benefits for customers arising from co-creation, which have a positive impact on their well-being. As a consequence of different co-creation activities that customers can participate in, it is essential that the organisations invest in developing the skills and competences of customers so that these customers are better prepared and feel ready to act as co-creators. For them to effectively participate throughout co-creation processes, the customers need to believe in their knowledge and experiences. When customers skills and competence are improved they are more willing to not only engage in co-creative activities within the organisation but they also start to integrate resources from outside the organisation and this increases their sense of autonomy, competence and relatedness which has an impact on their well-being.

Last, our findings provide implications for health care policy makers. They should create policies for strategising engagement of customers not just at the point of care but to engage them more broadly and widely. They should support customers' social networks as customers integrate resources beyond organisation boundaries (McColl-Kennedy et al.

2012). This not only has positive impacts on customer well-being, but there are also positive outcomes at a collective and societal level.

5.3 Limitations and Future Research

As with any other research there are limitations associated with this study which also bring opportunities for future research. First, the conditions of co-creation were identified in a health care setting in Australia and health care systems are invariably set up differently in various countries. Therefore, to enhance the generalisability, future studies can involve a broader range of health care professionals, government departments and other external sources including from other countries with different health care systems to refine the insights generated.

Second, the applicability of this research beyond health care services, in particular mental health services, may be a limitation as health care customers have unique challenges, abilities and preferences to be involved in the co-creation of value. So, future research should evaluate the applicability of these results beyond health care as the results may not be directly comparable to other service settings. We believe that the findings from this research are potentially more transferrable for high contact and high involvement service settings such as financial services, consulting services, education etc.

Third, the exploratory nature of this thesis has produced findings using convergent in-depth interviews and multiple case studies to present conditions which were appropriate

and effective in exploring the construct of capabilities and culture that supports customer participation in value co-creation. The next step for future researchers is to confirm the key findings by empirically testing the theoretical relationships identified through quantitative studies. The data can also be enriched by using an ethnographic approach, as it can be more participatory. Future research could extend the findings of this study, also by using an ethnographic approach.

Fourth, the focus of this research was to identify the organisational factors that can support value co-creation practices with the customers. Several of the capabilities, core and supportive co-creation behaviours and well-being outcomes have been identified in our research but the researcher has made no judgement about which ones are more important for an organisation. Future research can make an important contribution by critically examining these individually to capture explicitly their effects on co-creation practices.

Fifth, the success for co-creation not only depends on the capabilities and culture of the organisation but also on the leaders in the organisation. Future researchers can investigate the role of the leader in instituting capabilities and culture that support co-creation especially to identify the role of leaders in encouraging behaviours that inspire co-creation.

Lastly, the exploratory study shows that the well-being of customers is influenced by their co-creative roles within the organisation. However, the co-creation role and well-

being of other actors such as employees was not explored. As customer well-being and customer value co-creation roles are interrelated, future researchers can investigate the well-being outcomes for other actors such as employees when they participate in value co-creation.

APPENDICES:

Appendix 1: Chapter 2 – Convergent Interview Guide

Thank you for taking your time to participate in this research. Before starting the interview I would like to give you a brief introduction about this research project. The latest approaches of innovation are evolving into co-creative service innovation where both the provider and users are participating across the value chain to innovate services. It is different from a one-sided role of organisation in which the organisation just ask customers for their ideas and then work independently to figure out what to do with those ideas. Instead, in this form of innovation customer contribute his resources and skills beyond ideas and feedback to innovate services. To get this type of innovation it is essential to actually engage customers in co-creation. This study is looking at dynamics of engaging customers for co-creative `service innovation. This research project is important both academically and practically, considering the potential for involving customers in co-creation of innovative services and the lack of academic research about realising that potential.

Specifically, we are looking at two issues:

1. How does customer engagement facilitate co-creative service innovation?
2. What is the general process organisation undertake to co-create service innovation with the customers?

Housekeeping items:

- Any information in this interview today will remain confidential.
- Also I would like to ask for your permission for using tape recorder and taking notes. But you can push the pause button anytime.
- Are there any questions you would like to clarify before the interview begins?
- Would you like a copy of the report of this study?

Start tape

Interview questions

General Introduction

(Purpose to 'warm up' the respondent and get them to speak 'top of mind' about the area you are researching)

1. Could you please just start by telling me a bit about yourself and your role within (their current organisation)?

2. Could you explain to me some of the experience you have had particularly regarding when you have been involved in innovating, or improving health services?

3. When you have been involved in service innovations, what have been some of the things that have worked well?

4. ... and what have been some of the biggest challenges you faced?

Role of the Customers

1. When you have been involved in service innovations in the past, what role have customers played in this process? [PROBE: input of ideas, testing of technology, feedback on service improvements]

2. Do you think that attitudes towards the customer's role in healthcare are changing? If so, how?

3. [If yes at Q6] Given this, is it changing the way companies innovate their healthcare services? How?

4. What are your expectations of the <u>behaviours</u> customers undertake when contributing to a service innovation?

5. Do customers have an understanding of these expectations? Are their expectations different?

6. How have you communicated with customers what was expected of them?

7. What do you see are the benefits of customers collaborating in the service innovation process?

Engagement Activities

1. In your past experience, have customers been generally been willing or reluctant to take part in the service innovation process? (could you explain)
2. How did you (or the organisation) initiate getting customers involved in this collaborative process?
3. How did you keep them engaged and motivated throughout the innovation process?
4. What activities were most effective at getting customer engaged?
5. What challenges did you face keeping them engaged in this process?
6. What were the benefits of this ongoing engagement to the organisation (for example, were they engaged in activities beyond the innovation project)?
7. When academics speak of engagement they often refer to attitudinal and cognitive engagement as well as behavioural engagement. Do you think that customers were engaged both mentally and emotionally? [Probe: Why/Whynot?]

Service Innovation Process

1. Thinking about a successful service innovation project that you have been involved with, what processes or activities do you think made it successful?
2. Of all the ideas we have discussed today, (what are the most important factors for ensuring successful collaborative innovation? [PROBE for 5 – 6 factors]
3. Is there anything else that we are yet to talk about that you think is important for me to know when researching this area?

Appendix 2: Chapter 3- Case study Interview Guide

General thoughts and top of mind comments

In recent years there has been a shift in the healthcare industry in the role that customers and patients can take in an organisation. Many customers are getting more involved in developing services, managing their own health experiences, and in other ways….

1. Is this something that you've identified as occurring within in your organisation?

   [If yes] How have things changed? What specifically are you seeing?
   [If no] Is it something you would like to see occur more? What in particular would you like to see occur in this area?
2. What strategic emphasis have you been placing on customer participation? Can you give me an example?
   a. Why do you think this is necessary?
3. Are there formal roles that customers take in your organisation? Informal roles? [What do you mean by 'roles' can you provide an example if required]

Engagement, communication and interaction

4. How do you engage customers with your organisation? [Probe here specifically to find out how they communicate, what sort of dialogue they have, what access they provide to customers] –
   a. How do customers interact with you?
   b. Who initiates the interaction, the organisation or the customer or both? Can you give me some examples
5. How do you communicate with customers? How often?
6. What do you discuss with customers?

Resources, systems and processes

7. What systems and processes are in place to engage customers?
8. What resources have you provided to help facilitate customer interaction with the organisation?

(these two questions might be similar but could draw out different responses)

9. How does your management team show their commitment to customer participation?
    a. How would you describe your leadership style and that of your leadership team?
    b.

Strengths and challenges

10. What are some of the challenges you've faced in encouraging customer participation in the organisation?
11. Are there time when it all 'breaks down' and doesn't work well? Why do you think this is?
12. Has there been any employee resistance to customer participation in the organisation? How has this been overcome?
13. In contrast, are there times when it does work? What usually is good about it?
14. What could you add or improve for encouraging customer participation in your organisation?

Co-creation of innovation

Lets talk for a moment specifically about the role customers take in the innovation of new healthcare services.

15. How do you collaborate with your customer? Could you give an example of a successful collaboration with a customer?
16. How do you support this involvement ongoing? What strategies do you have in place?
17. How are customer accepted as part of the team by employees (if at all)? How do you know this?
18. How do you capture the customers' input? What do you do to act on it?

Evaluation

19. How has customer participation benefited your organisation? Can you give me an example?

20. How do you assess the effectiveness of your strategies to integrate customers into the organisation?

Values, norms, artefacts & behaviours

[The direct questions about culture can sometimes be hard for people to see who are living it every day. Some other questions in to explore this notion without being too direct]

21. How would you generally describe or characterise the culture of your company?
22. How you have built customer participation into your organisational culture?
23. Are there any stories, or myths, that are often Shared throughout the organisation that relate to customer participation or involvement? (Rather than a story that depicts the culture ask if there is a story that is often told about how employees work together with customers)
    a. You could also probe here Rituals, Language, other evidence of support for customer participation
24. What are some of the behaviors and activities that are essential to support customer participation in the organisation?
25. How would you describe the values of your organisation that underpin the approach to customer participation?
26. What are some of the behaviors that you are trying to cultivate in the organisation to support these values?
27. What are some of the activities that are essential to support these values?

END

28. Do you have something else to add?

Appendix 3: Chapter 4: Focus Group Interview Guide

Section 1- Set the scene for co-creation

1. What does participation means to you?
2. How is this organisation involving you in their activities/practices?
3. If you think about the time you are with this organisation what are the various opportunities they have given you to participate?
4. What motivates you to participate?

Section 2- Co-creation behaviour influence on well-being

5. What do you think are the benefits of consumer participation approach at MIFSA
    - For you as an individual
    - For other customers
    - For employees
    - For mental health sector in general
6. How do you think your participation is impacting your quality of life or your well-being? Can you give examples
7. What is the difference you are observing in your well-being since you started participating?
8. How do you think your participation has improved well-being of other consumers? Can you give example?

Section 3- Specific questions around collective well-being

9. How has participatory behaviour impacted the access to services for you and other customers?
   (Probe- how it has improved their ability to use the service)
10. How has participatory behaviour impacted your competence or capability to co-create services?
    (Probe- how it has improved their ability to communicate or utilise their skills and knowledge effectively when they are engaging with MIFSA)
11. How has participatory behaviour impacted the decision making for you and other customers?

12. How has participatory behaviour impacted the way you and other customers contribute in service development or delivery?
13. How do you think participation has impacted other aspects in your and other customers' life?

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