Engagement of citizens and public professionals in the co-production of public services

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CHAPTER 2

Why people co-produce: analyzing citizens' perceptions on co-planning engagement in health care services

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Chapter 2 – Why people co-produce: analyzing citizens' perceptions on co-planning engagement in health care services

ABSTRACT

The aim of this chapter is to comprehend the motivation of citizens to co-produce. More specifically, it considers citizens' motivations to engage in co-planning activities of health care services. The chapter brings together theoretical insights and empirical data. First, we integrate insights from different strands of literature. We combine literature on citizen participation, political efficacy, co-production, volunteerism, public service motivation, and customer engagement to offer a first understanding of citizens' motivations to actively engage as co-producers of public services. Next, empirical data are derived from one specific case: citizens participating in client councils in health care organizations. Q-methodology, a method designed to systematically study persons' viewpoints, is used to distinguish different perspectives citizen have on their engagement in co-production. Our analysis of citizens' motivations to engage in client councils enables us to identify four types of citizen co-producers, which we label: the semi-professional, the socializer, the network professional, and the aware co-producer. Implications for future research studying citizens' motivations in a broader range of co-production cases are discussed.

2.1 INTRODUCTION

In a context of financial crisis, austerity in public finances, and legitimacy crisis of both the public sector and the market, engaging citizens in the production of public services is an important topic of discussion; both from an ideological (cf. 'big society' debate) and academic perspective (cf. Alford 2009; Ishkanian and Szreter 2012; Pestoff, Brandsen and Verschuere 2012). Co-production refers to

> "the mix of activities that both public service agents and citizens contribute to the provision of public services. The former are involved as professionals, or 'regular producers', while 'citizen production' is based on voluntary efforts by individuals and groups to enhance the quality of the services they use" (Brandsen, Pestoff and Verschuere 2012: 1, based on Parks et al. 1981).

In co-production, both citizens and government are involved. This positions co-production against other (recent) developments in 'active citizenship', such as citizens producing public value without government (see, for example, on social entrepreneurs: Dees (2001); Marinetto (2003), and Santos (2012)).

Definitions of co-production vary widely. Strict definitions limit the concept to the service delivery phase (Alford 2009). Others find the concept of co-production to be relevant not only to the service delivery phase, but to refer to service users being part of service planning, delivery, monitoring and/or evaluation (Bovaird and Löffler 2012a). Co-production is studied as an inherent characteristic of public service processes (cf. Osborne 2010) and the literature indicates that many public services "(...) simply cannot function without client co-production" (Alford 2002a: 33; Alford 2002b). How this client co-production is organized can differ widely, however. Next to "full user / professional coproduction" (Bovaird 2007: 848) in which service users and professionals both function as co-planners and co-delivers of the services, other types of co-production exist. Bovaird and Löffler (2012a) summarize a range of service activities each emphasizing different elements of co-production, such as co-planning, co-design of services, co-prioritization, co-financing and co-delivery.

In this chapter, we focus on a specific type of co-production, namely co-planning of services. We analyze citizens' perceptions on co-planning engagement in health care services through client councils. In these councils, citizens deliberate the management of the organization and the quality of health care. Clearly, citizens do not participate in the provision of the service (i.e., elderly care) itself. Rather, their co-productive task is to provide advice to the management.

Existing studies of co-production generally focus on collaborative networks, processes, and organizations (cf. Brandsen and Van Hout 2006; Joshi and Moore 2004). However, conditions for successful co-production also need to be studied at the level of the individuals involved. Individual characteristics, such as the capacity and willingness of citizens to co-operate, are likely to strongly affect the course and outcomes of co-production processes; yet only scarcely empirical attention has been paid to this. The central question of this chapter therefore is: *What motivates citizens to engage in co-planning of health care services?* The chapter contributes to the co-production literature in an important way, because it provides useful empirical insights on citizens' motivations to co-produce; a topic that has been studied only rarely. Focusing on the specific case of health care client councils, in this chapter co-production is approached as a deliberate choice to increase involvement of citizen-users and the question why individuals take up this challenge is both of theoretical and practical relevance.

As the concept of co-production is "at the crossroads between several academic disciplines" (Verschuere, Brandsen and Pestoff 2012), we first outline potential motivations different streams of literature suggest. Next, empirical data are derived from one specific case: citizens participating in client councils in health care organizations. Q-methodology, a method designed to systematically study persons' viewpoints, is used to distinguish different perspectives citizens have on their engagement in co-production. Our data analysis leads to the identification of four different types of citizen co-producers and a discussion of different motivations found to drive citizens' engagement. Finally, we discuss theoretical and practical implications, and consider avenues for future research.

2.2 THEORETICAL INSIGHTS INTO CAPACITY AND WILLINGNESS TO CO-PRODUCE

The literature on co-production provides some first, yet still limited insights on citizens' motivations to actively co-produce. In a presentation of the current state of the art, Verschuere, Brandsen and Pestoff (2012) relate main theoretical considerations to the work of Alford (2009) and Pestoff (2012). Citizens are motivated to engage because of certain incentives (Alford 2002a; 2009). First, from an economic perspective people are assumed to seek material rewards like money, goods or services. Second, solidary incentives derive from associating with others. Third, expressive incentives relate to feelings of satisfaction when contributing to a worthwhile cause (Sharp (1978a) in Alford (2002a)). In addition, Alford distinguishes intrinsic rewards, for example enhancing one's sense of competence and self-efficacy, and sanctions resulting from legal obligations as possible sets of motivators for client co-production. Next to this, Pestoff (2012) points at the importance of both the ease of becoming involved in the process and the salience of the services delivered. This relates to circumstances hindering or facilitating co-production (Verschuere, Brandsen and Pestoff 2012). It can also be argued, however, these are *necessary conditions*. Before motivations are put into practice, attention is paid to the possibility of becoming involved. Without finding (or *perceiving*) it easy enough, a citizen will not consider the option of taking part. In the current co-production literature, however, it remains unclear how these conditions relate to individual behavior, how motivations result in behavior, and how ease and salience influence that process.

Input for solving this gap could be provided by related strands of literature. Different literature streams, next to research on co-production specifically, have a potential to provide insights into citizens' engagement in the co-production of public services (Van Eijk and Steen 2012b). The literature on government-citizen relations, citizen participation, and active citizenship focuses on capacities of individuals to act. As co-production is a kind of engagement with society, we expect similarities in the motivations citizens have to engage in other ways with society. The *political participation* literature points at socioeconomic variables (Sharp 1984; Timpone 1998) and networks (Amnå 2010; Putnam 1993). Additionally, the concepts of salience (Verhoeven 2009), and internal and external efficacy (Andersen, Kristensen

and Pedersen 2011) are derived from this literature strand. Salience points at the necessary condition citizens' attention is directed to the possibility of becoming involved. Only when citizens argue a topic "salient enough" they will have a willingness to consider active engagement and weigh up the investments of efforts. Internal and external efficacy reflects citizens' perceptions about, respectively, their competences to understand and to engage effectively, and the usefulness of investigating all the necessary efforts (Craig, Niemi and Silver 1990). Citizens' trust in government to deliver services and to provide opportunities to meaningfully engage (Craig, Niemi and Silver 1990) can also help explain citizens' willingness for co-production.

Next to this, the concept of *public service motivation* (PSM) has a potential for contributing to our understanding of citizens' motivations for co-production, as it offers insight into community-centered motivation: a focus on the public interest, where this focus originates from and how it influences behavior (Perry and Hondeghem 2008). PSM has been used to explain public sector employees' engagement not only in their daily tasks as public sector employees but also in meaningful civic action (Brewer 2003; Pandey, Wright and Moynihan 2008). There has been an impressive increase of knowledge about the (public sector) motivation of public servants, yet this has not yet been paired with studies of the (public service) motivation of citizens.

Closely related is research on *volunteerism* that has extensively focused on motivations to volunteer. Studies of volunteerism suggest altruistic/egoistic motivations – in addition to contextual opportunities, such as the demand for voluntary work, and larger social forces – to be explanatory to voluntary efforts (Dekker and Halman 2003; Reed and Selbee 2003; Steen 2006). The study of volunteerism can also shed some light on the motivations to co-produce. It should be noticed, however, that although strongly related volunteerism and co-production differ in an important respect: citizens efforts in processes of co-production are not solely directed to the benefits of others as citizen co-producers often are also users of the public services. Furthermore, co-production reflects the interaction between citizens and professionals; regular voluntarism does not take place in similar professionalized service delivery processes (Verschuere, Brandsen and Pestoff

2012). As such, we can expect not only altruistic motivations but also more self-centered motives to drive the engagement of citizens in co-production, as already mentioned by Alford (2002a).

Next to research on volunteerism, links can be made with another research field outside of public administration research: service management and marketing research that study customer engagement or interactivity between customers and a company. The service dominant logic finds that, through the service encounter, customers are an integral part of service delivery and thus every customer is also a co-creator (e.g., Vargo and Lusch 2008). Other scholars have a more narrow view of customer engagement, making the question what drives customer engagement more pertinent. Next to firm- and context-based constructs, reference is made to individual constructs. Both self-centered explanations for customer behavior, e.g., maximizing consumption or relational benefits, and altruistic motivations such as providing useful suggestions to other customers or helping service employees to better perform their job, are discussed. Next to this, trust and previous experiences with a firm or brand are found important. Furthermore, reference is made to customer resources in terms of time, effort, and money (for an overview, see Van Doorn et al. (2010)).

In conclusion, while specific insights in citizens' motivations for co-production is still limited, related streams of literature point at factors that have a potential for explaining citizens' decision to become active co-producers. The literature indicates that both capacity and willingness (motivation) are important in explaining why citizens participate in co-production. Capacity relates to both human capital (socioeconomic variables, such as income and education) and social capital (belonging to networks, availability of time). Capacity is expected to affect the likelihood that a citizen will find it relevant (salient) to engage, and how he/she will judge his/her competences to do so (efficacy). Next, literature distinguishes self-centered (egoistic) motivations, such as acquiring new skills or material incentives, and community-oriented (pro-social) motivations, such as PSM. Our research aims to provide a more systematic and empirical basis for those considerations. We not only study citizens' motivations empirically, we also do this using a grounded method hereby gathering insights that can add to the current literature.

2.3 METHODS AND DATA

Empirical data is derived from one specific case, citizens participating in client councils in Dutch health care organizations. Q-methodology, a method designed to systematically study persons' viewpoints, is used to distinguish different perspectives members of health care client councils have on their engagement.

2.3.1 Client councils in health care organizations

While being inherently central to health care, patients role in relation to both health care organizations and professionals has changed over time. In the Netherlands, since the last decades particularly, patients are perceived as active participants and partners of professionals rather than merely passive patients in a paternalistic relation (Van den Bovenkamp 2010: 81). This also impacted the way in which citizens – or patients – became involved in health care. Although patient organizations representing patients with specific diseases (e.g., cancer) or belonging to specific groups in society (i.e., elderly) are still important, citizens now are also able to get involved in health care organizations on an individual basis. Patient organizations have had an important say in this development. In the 1980s and 1990s, they started to co-operate within larger networks, they institutionalized and as a result became jointly responsible for governmental policy-making, implementation and service delivery. Due to this (corporatist) position, the patients' representatives contributed to some major reforms in the health care system such as the introduction of client councils (Wetenschappelijke Raad voor het Regeringsbeleid (WRR) 2004: 169).

Client councils within health care were introduced by the *Wet medezeggenschap cliënten zorginstellingen* (Participation by clients of Care Institutions Act)[4]. This act obliges all health care organizations to have a client council but does not subscribe the (minimum) number of members or who those members should be. Every provider of health care services is required to make its own specific rules on those issues (Overheid.nl 2012a). As a result, client councils not only consists of patients or direct users of the services provided but also of spouses or other family members of the patients and volunteers (Zuidgeest, Luijkx, Westert and Delnoij 2011). We even found neighbors of the organization being

4 This Act dates from February 29, 1996 (Overheid.nl 2012a).

member.

The main task of the council is to deliberate the management of the organization and the quality of health care. To enable clients to fulfill this task, the council holds the right to be informed (Rijksoverheid [National Government] 2011). The management should inform the council at the earliest phase as possible about new policy plans, so the council has the opportunity to deliberate the plan and advise about it (Overheid.nl 2012a; Zuidgeest, Luijkx, Westert and Delnoij 2011). The council's right to advise makes that councils can advise both asked-for and unasked-for on issues like policy changes, policy aims, mergers with other organizations, a movement of the organization to another location, financial issues, and issues concerning the daily-care of patients. On the latter, in particular, the management cannot ignore the given advice due to the council's right to consent. Plans regarding for example safety, hygiene, food and drink, leisure, and recreation should be approved by the client council; without this approval the management is not allowed to implement changes (Overheid.nl 2012a; Zuidgeest, Luijkx, Westert and Delnoij 2011).

2.3.2 Q-methodology

In order to examine the motivations of client council members, we use Q-methodology, a method designed to systematically study persons' viewpoints. The method makes use of statements that are formulated by the respondents themselves instead of statements that are a priori developed by the researcher (cf. Van Exel and De Graaf 2005). As such, it looks somewhat like 'grounded-theory' as the researcher goes into the field with an open mind to explore the issue at hand. In addition, the results can be surprising, running contrary to the researcher's expectations (Dryzek and Berejikian 1993: 50). In contrast to techniques concerned with patterns across variables, Q-methodology is concerned with patterns across individuals (Dryzek and Berejikian 1993: 50). Therefore, after having collected statements through (group)interviews, we asked a second set of respondents to rank statements. As respondents are asked to evaluate statements in relation to other statements, the method produces a comprehensive view of an individual's viewpoint (Brewer, Selden and Facer 2000). Q methodology measures perceptions

rather than actual behavior. Factor analysis is used to identify groups of respondents who rank statements in a similar way, and so to identify different viewpoints that exist on the topic studied. While Q-methodology is concerned with studying subjectivity, it is constrained by using statistical tools. This makes the method also explicit and replicable. In public administration studies, Q-methodology has for example being used to investigate how public employees and students of public administration and government view motivations associated with public service (Brewer, Selden and Facer 2000).

2.3.3 Concourse, Q-sample, and P-sample

We started with the collection of a diverse set of statements about the motivation to engage in co-production. As it is important that statements represent existing opinions and arguments from relevant actors (Van Exel and De Graaf 2005: 4), we organized two open-ended group interviews in which client council members were invited to talk freely about their engagement in the client council. A first meeting was organized in a nursing home in Haarlem. One resident and three caregivers (*mantelzorgers*) of ex-residents took part in the interview. Second, an interview was organized with two client council members of an assisted living center in Alphen aan den Rijn. Here, one interviewee was a resident of the center, and another was a caregiver of an ex-resident. We made literal notes of the discussion in these focus group interviews and transcribed all literal statements made by the respondents, resulting in a list of 182 statements. We used a residents' magazine of an assisted living center in Heemstede (Heemhaven 2009) to see if additional viewpoints could be distinguished, which resulted in 14 extra statements being added to the concourse.

Next, out of the total of 196 statements formulated in the concourse, we gathered a subset of 45 statements. We will refer to this selection as the Q–sample. Although this selection is "of utmost importance" it "remains more an art than a science" (Brown 1980: 186). One general rule of thumb is that a subset should be selected that is both representative for the interviews and includes statements differing widely from each other. To make sure the selection of statements is not done arbitrary we used "a discourse analysis matrix" (cf. Dryzek and Berejikian 1993). The

matrix, as shown in Figure 2.1, consists of the discourse element (columns) and type of argument (rows). For the first dimension, we have chosen to include motivations, behavior, and tasks/responsibilities. These elements are relevant in relation to the topic we are investigating (i.e., citizens' motivations) and the context we are looking at (i.e., client councils in health care organizations). The second dimension is based on the type of claims that can be made and includes designative, evaluative, and advocative arguments. This dimension is inspired by the matrix as developed by Dryzek and Berejikian (1993). To come up with a Q-sample of 45 statements, we placed five statements within each cell. In order to do so, we first labelled each of the 196 statements with the letter of a cell. Some statements turned out to be unclear and so not useful. They were not labelled and removed from the list. After all statements were labelled we selected five per cell. In this selection, we made sure the chosen statements were well-written and obvious in meaning, different from each other, and as diverse as possible. This selection resulted in a list of 45 statements as shown in Table 2.1.

Figure 2.1 Discourse analysis matrix

Discourse element	**Motivations**	**Behavior**	**Tasks / Responsibilities**
Type of argument			
Designative	a	b	c
Evaluative	d	e	f
Advocative	g	h	i

Table 2.1 Selected 45 statements	
1	*Je groeit er eigenlijk een beetje in zeg maar.* You grow into becoming a council member.
2	*Je kijkt regelmatig rond en ziet dingen die anders kunnen.* You look around regularly and see things that could be done differently.
3	*Je kan het niet loskoppelen, cliënten en verzorging.* You cannot separate clients and care.
4	*Voor je het weet ben je lid, maar daar leer je natuurlijk ook van.* Before you actually realize you have become a member. But of course you learn of those experiences.
5	*Er kwamen best zware klachten binnen, die moet je dan proberen af te handelen.* We received some quite heavy complaints that we should try to solve.
6	*Je krijgt ook heel veel papiermassa binnen over nieuwe regels enzo, dus dan moet je wel goed papieren kunnen lezen, dossiers kunnen lezen en over dingen mee kunnen praten.* You receive a lot of documents, about new policies for example. You must be able to read these documents and to discuss the issues at hand.
7	*Je moet wel over voldoende vrije tijd beschikken om dit te kunnen doen.* You need to have enough free time / leisure to do this.
8	*De cliëntenraad moet opletten of cliënten geen problemen hebben en er geen klachten zijn.* The council has to make sure to notice if clients are facing troubles or having complaints.
9	*Als voorzitter moet je ook soms met de hamer slaan.* As a chair, sometimes you have to gavel.
10	*Ik zeg altijd je moet wel rechtvaardig zijn.* I always say: you need to be fair.
11	*Toch heel prettig om erbij te horen, ja, vind ik wel.* It is nice to be part of it, yes I think so.
12	*Het blijkt dat de CR met de bewoners daadwerkelijk invloed kan uitoefenen op (de gang van zaken en) het beleid.* It turns out that client council and residents together can have a real influence on the policies.
13	*Toen (Als) ik hier mijn vrouw bezocht (famielid bezoek) zag ik wel eens wat en dan grijp je in.* When I am visiting my family relative here, sometimes I see things happen and then I step in.
14	*Het is ook een kwestie van ervaring.* It's also based on experience.
15	*Ik ben gewend te vergaderen, dat is niet zo moeilijk voor mij.* I am accustomed to attend meetings. That is not difficult to me.
16	*Het is de taak van een cliëntenraad verbeteringen aan te dragen.* It is the council's task to suggest improvements.

17	*Je hebt niets aan mensen die alleen maar meekomen voor de gezelligheid.* It is useless when people come here only because they are finding it cozy.
18	*Als lid probeer ik dingen aan te dragen.* As a member I try to contribute ideas.
19	*Je kunt dan een beetje meer sturen.* You can steer.
20	*Je bent natuurlijk sterk afhankelijk van het management.* Of course you are very dependent of the management.
21	*Het moeten mensen zijn die toch het een en ander kunnen.* It should be people who possess some skills.
22	*Ik zou eigenlijk wat meer mensen vanuit het huis willen hebben.* I would like to have more people coming from the organization itself.
23	*Ik denk dan 'we moeten samenwerken, we werken samen voor de cliënten van dit huis en jullie werken niet zelfstandig en wij ook niet'.* I think we need to do this together. We have to work together for the clients in this house and you do not work on your own and we do not either.
24	*Je moet wel sociaal zijn.* You have to be social.
25	*Het is belangrijk dat je je makkelijk tussen de mensen begeeft.* It is important that you easily mingle with other people.
26	*Wij mogen ons met stevige veranderingen bemoeien.* We may meddle in substantial changes.
27	*Dit is pure liefhebberij.* This is pure pastime.
28	*Je moet natuurlijk vertrouwen krijgen.* You should receive trust.
29	*Het is natuurlijk heel belangrijk dat inzicht in de zorg.* Having a clear understanding of health service is very important.
30	*Ik vind het makkelijk om een praatje te maken en dan hoor je nog eens wat.* I easily talk with other people and then you hear what is happening.
31	*Als je iets ziet dan steek je je kop ertussen natuurlijk.* When you see things happen, you do not stick your head in the sand.
32	*Het vraagt ook best een heleboel werk.* It requires a lot of work.
33	*Als we samen niet door één deur kunnen, dan was ik zo weg.* If we as members would not match, I would leave soon.

34	*Ik heb geleerd dat ik voor mezelf moet opkomen.* I have learned how to stand up for myself.
35	*Informatie, zoals over de kleinschalige zorg die onlangs is ingevoerd, dat horen we vooraf te krijgen.* We must receive information beforehand, for example regarding the newly implemented small-scale care.
36	*Ik vind het in ieder geval heel belangrijk dat (nieuwe) leden menselijk zijn.* I find it very important that (new) members are human.
37	*Het is belangrijk dat de communicatie met de zorg heel open en eerlijk is.* It is important for communication in health care to be open and honest.
38	*Ik zie ook dat het nuttig is.* I also find it useful.
39	*Ik vind het ook gezellig.* I find this enjoyable.
40	*Ik denk: 'wat staat mij straks te wachten als ik oud ben?'* I think: 'what is going to happen when I am old?'
41	*Je moet er soms wel voor knokken.* Sometimes, you have to fight.
42	*Je raakt geïnteresseerd.* You simply become interested.
43	*Ik vind zelf dat we heel veel hebben bereikt.* I think we have achieved a lot.
44	*Organiseren is echt mijn ding.* I love organizing. Organizing is a real passion.
45	*De cliëntenraad moet de belangen van de bewoners behartigen.* The client council should represent the residents' interests.

Third, the selected statements were presented to a second group (the P or person sample), consisting of 32 respondents from six different client councils in Haarlem, Heemstede, Leiden en Noordwijkerhout. Although perhaps at first sight limited, for Q-methodology a P-sample of about 30 respondents is typical. The respondents are as diverse as possible, as the method's intention is to identify the different perspectives that exist among the population. The respondents, however, need not necessarily be representative for the larger population, nor are they randomly assigned (Van Exel and De Graaf 2005). As a consequence, the results

of the Q-methodology study cannot be generalized to a larger population. Follow-up survey research is generally suggested in order to test the importance of the different perspectives among the overall population.

The respondents were asked to rank the statements according to a suggested quasi-normal distribution ranging from strongly disagree to strongly agree (see Figure 2.2), resulting in 32 Q-sorts. After the sorting, we invited additional comments from the respondents about the reasons for their selection of statements they agreed or disagreed with most. To check the representativeness of the statements, we asked the respondents if they missed any aspect they believed to be relevant to their motivation for engaging in the client council. No major contributions to the existing statements were made. Finally, additional demographic information was asked. These questions include information on gender, age, education, job sector (i.e., public, private, non-profit), job group (e.g., management, industry, arts), and participation in other voluntary activities.

Figure 2.2 Distribution of statements

Disagree					*Neutral*					*Agree*
-5 (1)	-4 (2)	-3 (3)	-2 (5)	-1 (7)	0 (9)	+1 (7)	+2 (5)	+3 (3)	+4 (2)	+5 (1)
--	-- --	-- -- --	-- -- -- -- --	-- -- -- -- -- -- --	-- -- -- -- -- -- -- -- --	-- -- -- -- -- -- --	-- -- -- -- --	-- -- --	-- --	--

Q-sort directions

1. There are 45 cards numbered from 1 to 45. Read the cards and order them in three groups: agree with, disagree with and neutral.
2. From those cards you agree with, select the statement you agree with most and put this one in the +5 box. Repeat this for the statement you disagree with most and place that one in the -5 box.
3. Select the two statements you now most (dis)agree with and place those in the +4 and -4 boxes respectively.
4. Repeat this until you have filled in all cards you agreed or disagreed with.
5. Now turn to the group with neutral statements. Place those statements in the remaining boxes (in the boxes 0, -1, +1).
6. Now, you should have rank ordered all statements. You should have no cards left and no blank spaces in the form.

Table 2.2 Factor loadings for 32 Q-sorts*

Q-sort	Factor 1	Factor 2	Factor 3	Factor 4
1	-0.4840X	0.3013	0.0919	0.2062
2	-0.0707	0.4307X	0.2941	0.0977
3	0.2737	0.3178	0.2568	0.5698X
4	0.4296X	0.0855	0.0544	0.1634
5	0.0969	0.1220	0.2589	0.4261X
6	0.4106	0.2314	0.2520	0.5958X
7	0.1232	0.4565	-0.0764	0.4426

8	0.3491	0.1461	0.3760	0.3926
9	0.3924X	0.2801	-0.0135	0.1787
10	-0.0147	0.0934	0.2995X	0.2131
11	0.1537	-0.0987	0.6840X	-0.0493
12	0.5687X	0.1294	0.3730	-0.0104
13	0.1264	0.2791	0.3263	0.4487X
14	0.2677	0.0879	0.2483	0.6285X
15	0.1386	0.4951X	0.0027	0.1362
16	0.5717X	-0.0212	0.0839	0.0777
17	0.2344	0.1119	0.4830X	0.3668
18	-0.0943	0.1416	0.4755X	0.0618
19	0.2758	0.0385	0.5233X	0.2256
20	0.2110	0.1835	0.0893	0.4550X
21	-0.0122	0.1450	0.1851	0.3888X
22	0.2035	0.3497	0.4863X	0.2349
23	-0.0584	0.0600	0.3200X	0.2558
24	0.3073	0.0261	0.7451X	0.1359
25	0.1414	0.2966X	-0.0861	0.0159
26	-0.2085	-0.1579	0.5873X	0.3715
27	0.5913X	0.2605	0.0221	0.2367
28	0.0873	0.3341X	0.0819	0.1295
29	0.1979	0.4640X	0.1985	0.2107
30	-0.0510	0.0162	0.0051	0.5503X
31	-0.2070	0.5605X	0.2159	0.1944
32	-0.0289	0.5904X	-0.0047	-0.0145

*Note: * X indicating defining sort*

2.4 ANALYSIS

We calculated the correlation among the Q-sorts of all participants, resulting in a 32 x 32 matrix, reflecting the similarities and dissimilarities in viewpoints between the respondents of the P-set. Using PQMethod,[5] we factor analyzed the matrix with a QCENT factor analysis[6] and varimax rotation (cf. Abdi 2003). Here, "(...) the objective [is] to identify the number of natural groupings of Q sorts by virtue of being similar or dissimilar to one another, that is, to examine how many basically different Q sorts are in evidence" (Van Exel and De Graaf 2005: 8). All respondents who load significantly on a factor hold similar viewpoints on engagement in co-production. The analysis resulted in four distinct factors, as concluded out of the Eigen values and the so-called 'flags' (i.e., a factor needs to have a substantial number of associated respondents in order to be recognized as a distinctive factor). Table 2.2 presents factor loadings for each of the 32 Q-sorts, indicating the correlation of each Q-sort with the four factors, and representing the individual's viewpoints on engagement in co-production.

Next, factor scores were calculated in order to form the ideal-model Q-sort for each factor and to make visible how an 'ideal' respondent with a 100 per cent score on that factor would have sorted all the statements. This is done through calculating the Z-score: "(...) the normalized weighted average statement score ... of respondents that define that factor" (Van Exel and De Graaf 2005: 9). The four ideal model Q-sorts are presented in the Table 2.3. The table indicates the extent to which each of the statements characterizes each of the four factors, and therefore is basic to our interpretation of results (Brown 1993; 1996).

2.5 FINDINGS AND DISCUSSION

Based on the four ideal type Q-sorts, we can identify four different discourses or perspectives on engagement. After describing these perspectives, we focus in more detail on the specific motivations and incentives that drive the different groups to engage in client councils.

5 Downloaded from http://www.lrz.de/~schmolck/qmethod.
6 We used the Brown QCENT analysis instead of the Horst.

2.5.1 Four perspectives on engagement in co-production

Our Q-method-based analysis of citizens' motivations to engage in health care client councils specifies four different perspectives on co-production. This enables us to identify four types of citizen co-producers, which we label: the semi-professional, the socializer, the network-professional, and the aware co-producer. Each type of co-producer reflects a unique set of perceptions on motivations and engagement in client councils. In the description of these discourses, we will refer to the statements as presented in Tables 2.1 and 2.3.

Table 2.3 Factor scores ideal model Q-sorting

Statement	Factor 1	Factor 2	Factor 3	Factor 4
1	0	3	0	-1
2	1	-2	2	-1
3	1	0	1	4
4	-4	1	-4	-4
5	0	-1	0	-3
6	1	-2	1	1
7	-3	-3	-2	-1
8	2	2	1	0
9	-2	-3	0	-2
10	1	3	0	1
11	2	3	-5	0
12	3	2	3	3
13	-3	-5	-2	-2
14	2	-2	-1	0
15	2	-4	0	1
16	5	2	4	2
17	-5	0	0	-2
18	3	0	2	4
19	0	0	1	-2

20	-1	0	4	-1
21	-2	-1	-1	0
22	-1	-2	-1	1
23	-2	1	3	2
24	0	2	0	1
25	1	-1	-1	3
26	4	-2	3	0
27	1	-1	-3	-5
28	-1	4	1	1
29	3	0	-1	2
30	-1	2	-3	2
31	-1	-4	2	-4
32	-1	0	0	-1
33	-4	-1	-2	-3
34	-2	0	-4	-2
35	-3	1	0	2
36	0	1	-2	-1
37	2	5	2	3
38	4	0	2	1
39	1	-1	-2	0
40	0	-1	-3	-3
41	-2	1	1	-1
42	0	1	-1	0
43	0	1	1	0
44	-1	-3	-1	0
45	0	4	5	5

Discourse 1: the semi-professional

Individuals loading on the first factor are much concerned with the impact they can make through the client council. The client council focuses on improving the functioning of the health care organization and helps introduce changes (statements 16 and 26). The individuals feel they are actively taking part in this by making suggestions for improvement (statement 18). They feel that their efforts are making a difference, as the client council can really impact on the health organizations' policy (statement 38 and 12). Also, they agree that in order to make this difference, knowledge of the health care sector is needed (statement 29). We label client council members adhering to this discourse 'semi-professionals', as they are primarily concerned with the contribution they can make to the well-functioning of the health care organization through their involvement in the client council, and feel that basic knowledge of the sector is a prerequisite for this. Semi-professionals see their involvement in the client council as a deliberate choice. They did not by accident become a member of the client council (statement 4). Their engagement is strictly instrumental, as having some minimal social accordance among the client council members is not found to be important for their personal engagement (statements 33). Despite the focus on the results of their engagement, the social aspect is not put aside. In contrast to their personal, instrumental focus, the semi-professionals believe that other members who are mainly driven by social motivations can still make a valuable contribution (statement 17). Table 2.4 presents the statements highlighting discourse 1.

Table 2.4 Identifying statements Discourse 1 – The semi-professional

Statement		Factor 1	Factor 2	Factor 3	Factor 4
16.	It is the council's task to suggest improvements.	5	2	4	2
26.	We may meddle in substantial changes.	4	-2	3	0
38.	I also find it useful.	4	0	2	1
33.	If we as members would not match, I would leave soon.	-4	-1	-2	-3
4.	Before you actually realize you have become a member. But of course you will learn of those experiences.	-4	1	-4	-4
17.	It is useless when people come here only because they are finding it cozy.	-5	0	0	-2

Table 2.5 Identifying statements Discourse 2 – The socializer

Statement		Factor 1	Factor 2	Factor 3	Factor 4
37	It is important for communication in health care to be open and honest.	2	5	2	3
45	The client council should represent the residents' interests.	0	4	5	5
28	You should receive trust of course.	-1	4	1	1
15	I am accustomed to attend meetings. That is not difficult to me.	2	-4	0	1
31	When you see things happen, you do not stick your head in the sand.	-1	-4	2	-4
13	When I am visiting my family relative here, sometimes I see things happen and then I step in.	-3	-5	-2	-2

Discourse 2: the socializer

Individuals ascribing to discourse 2 are concerned with building trust relations between the client council and the (management of the) health care organization. Open and transparent communication is an important instrument for this (statements 37 and 45). Interest representation is a major concern for the client

council (statement 45). Yet, this is not done through ad hoc actions when one notices a malfunctioning in the organization (statements 31 and 13). In contrast to the semi-professionals, these respondents which we label 'the socializers' do not feel that the client council can make a major impact in the health care organization, as the client council is not involved in major reforms (statement 26). The socializers do not feel they possess professional competences such as knowledge of organizing and managing, or experience with meetings (statements 44 and 15), nor do they feel much free time is needed in order to be a member of the client council (statement 7). Based on the additional questions asked, we found that all respondents belonging to this discourse are retired. Almost all are themselves residents of the health care organization and non-active in other volunteering activities. A potential explanation could be that these respondents have both time available for and easy access to the client council, yet do not put much real effort in it nor look for other opportunities for co-production due to their rather passive attitude. In line with the importance attached to smooth relations and the rather passive stance towards the contribution they can make as client council members, the socializer does not expect the chair of the client council to gavel (statement 9). Table 2.5 presents the statements highlighting discourse 2.

Discourse 3: the network professional

Similar to the socializer, individuals loading high on discourse 3 find interest representation to be a major concern for the client council (statement 45). However, they highly contrast with the socializers on their assessment of the impact that the client council can make and their personal involvement herein. This group, which we label network professionals, shares a similar view with the semi-professionals on the functioning of the client council. The client council is there to improve the functioning of the health care organization and does so through introducing changes (statements 16 and 26). The network professional feels that, in collaboration with the patients, the client council indeed has an impact in the health care organization (statement 12), albeit that the client council is strongly dependent on the management of the organization (statement 20). Similar to the semi-professionals, the network professional did not become a member of the client

council by accident (statement 4). Their engagement is a deliberate choice aimed at having an impact for the patient; it is not just a hobby or a social activity (statements 4 and 11). Elements of a PSM can be detected among the network professional, as they disagree with egoistic-based motivational statements (statement 34 and 40) and primarily see the client council as a means to do good for the benefit of the clients in general. Interestingly in this respect is that most respondents in our panel adhering to this discourse are active also in other volunteering activities, for example in cultural, sports, or religious organizations, and that the respondents still active on the job market are all working in the non-profit sector. Table 2.6 presents the identifying statements of discourse 3.

Table 2.6 Identifying statements Discourse 3 – The network professional

Statement		**Factor 1**	**Factor 2**	**Factor 3**	**Factor 4**
45	The client council should represent the residents' interests.	0	4	5	5
16	It is the council's task to suggest improvements.	5	2	4	2
20	Of course, you are very dependent of the management.	-1	0	4	-1
4	Before you actually realize you have become a member. But of course you will learn of those experiences.	-4	1	-4	-4
34	I have learned how to stand up for myself.	-2	0	-4	-2
11	It is nice to be part of it, yes I think so.	2	3	-5	0

Discourse 4: the aware co-producer

The individuals loading high on discourse 4 again find interest representation to be a major concern for the client council (statement 45). Similar to the network professional, the aware co-producers disagree with egoistic-based motivational statements, such as a concern for their own future as potential clients (statement 40) or having to stand up for one's own interests (statement 34); although this feeling is much stronger compared to the network professional. The engagement of the aware co-producers certainly is not a mere hobby (statement 27) or something

that happened by accident (statement 4), and social relations among the members of the client council are not felt to be a prerequisite for the functioning of the client council (statement 33). Similar to the semi-professionals, the aware co-producers feel they are actively taking part by making suggestions for improvement (statement 18). Yet, this is not be achieved by ad hoc interfering in the organization (statement 31). The individuals belonging to this discourse are the only ones mentioning the importance of clients having a voice: clients and health care cannot be separated (statement 3). This combination of viewpoints makes us to argue that these individuals are very conscious about their engagement in the client council and what they can contribute to the well-functioning of the health care organization and its residents. Therefore, we labelled these individuals the aware co-producers. Table 2.7 presents the statements the aware co-producers (dis)agree with most.

Table 2.7 Identifying statements Discourse 4 – The aware co-producer

Statement		**Factor 1**	**Factor 2**	**Factor 3**	**Factor 4**
45	The client council should represent the residents' interests.	0	4	5	5
3	You cannot separate them, clients and care.	1	0	1	4
18	As a member I try to contribute ideas.	3	0	2	4
4	Before you actually realize you have become a member. But of course you will learn of those experiences.	-4	1	-4	-4
31	When you see things happen, you do not stick your head in the sand.	-1	-4	2	-4
27	This is pure pastime.	1	-1	-3	-5

2.5.2 Capacities and motivations for engagement in co-production

The factor analysis revealed that engagement in client councils is driven by different motivations, as it distinguished four different discourses or perspectives. In this section, we analyze the link between these four perspectives and the insights debated in the theoretical framework. The question is: what drives the semi-

professional, socializer, network professional and aware co-producer?

Community-centered motivations

All four groups attach importance to the contribution client councils can make to the functioning of health care organizations. Most specifically, the high factor scores on statement 45 ('The client council should represent the residents' interests.') for discourses two, three and four, stand out. While the semi-professionals are neutral towards this statement, they do feel strong about the impact of the council, as the statements they agree with most relate to the client council being able to improve the functioning of the health care organization and help introduce changes (statements 16 and 26). We can conclude that for all groups, even for the socializers who we defined as rather *passive co-producers*, the engagement in a client council is explicitly defined by the mission of the client council and the pro-social output that the council can produce in the organization.

The picture is less clear in terms of supporting the interests of the health care organization's patients in general versus supporting specific (individual) client interests, although a more community-centered motivation seems to prevail. Factor scores are neutral or slightly positive on statement 8: "The council has to make sure to notice if clients are facing troubles or having complaints". The factor scores for all four groups are negative on statement 13 ("When I am visiting my family relative here, sometimes I see things happen and then I step in."), yet are mixed on statement 31, which is similar to statement 13 as it relates to taking ad hoc actions when one sees a mis-functioning in the organization, yet does not refer to a family-bond with the patient at hand.

Self-centered motivations

The four groups all tend to disagree with, or at best to be neutral towards egoistic-based motivational statements, such as a concern for their own future as potential clients (statement 40) or having to stand up for one's own interests (statement 34). Issues as engaging in a client council in order to have a hobby (statement 27), to make social contacts and find a pleasant environment (statements 33 and 39; an exception being statement 11 with positive factor scores for discourses one and

two), or to learn (statement 4) in general also have negative or neutral factor scores.

Human and social capital, internal efficacy

The interpretations of the discourses are based on the characteristic statements of the factor, those statements that rank highest or lowest (highest negative value) in the composite sort. When discussing differences and similarities among the four perspectives, it is also interesting to see which statements are not defining features for any of the four discourses found. A substantive number of statements collected through the focus group discussions relate to the competencies needed of client council members, supporting the importance attached to 'capacity' in our theoretical discussion. It is interesting to find that these statements in general did not stand out as statements characterizing the perspectives. Statements concerning the need for council members to have general competencies (statement 21), being able to build on experience (statements 14), or being knowledgeable about the dossiers discussed (statement 6) do not seem to provoke explicit viewpoints. An exception is found among the semi-professionals who find knowledge of the health care sector to be necessary (statement 29), while, in contrast, the socializers explicitly disagree with the need to possess professional competences such as knowledge of organizing and managing, or experience with meetings (statements 44 and 15). Furthermore, statements that relate to finding social competencies important, such as being strong in social contacts (statements 24 and 25), being just (statement 10) and human (statement 36) do not stand out as characterizing one of our four perspectives found. In general, we find that individuals loading high on one of the factors/perspectives do not seem to explicitly agree, nor do they explicitly disagree with the notion that competences are important for individuals engaging in a client council. While in the group interviews feelings of personal competence were discussed as being relevant drives for engagement, our Q-analysis does not confirm the importance attached to the concept of 'internal efficacy' – defined in our theoretical framework as the co-producers' feelings of personal competence to understand and affect the delivery of the service at hand and to participate in the mechanism of co-production.

2.6 CONCLUSION AND DIRECTIONS FOR FUTURE RESEARCH

Our research on motivation for engagement in co-production reveals four perspectives. We distinguished the semi-professional who wants to contribute to health care organizations and is focused on the structures and policies. Competences are important and efforts are not ad hoc. The socializer is much more passive. Trust and open relations between members and between the organization / residents and the council are important. The network professional wants to improve the functioning of the health care organization and approaches the council as a mean to do good for the benefit of the clients in general. Elements of PSM are detected in this perspective. Finally, we distinguished the aware co-producer who is also opposing egoistic motives. Patients and health care cannot be separated and so the aware co-producers want to take part actively by making suggestions for improvement, yet feels this should not be done through ad hoc activities.

Relating these perspectives with the theoretical framework, we found that all groups adhere more to community-centered than self-centered motivations. In general, little importance is attached to competences. The literature on political participation, PSM, volunteering, and customer engagement provided useful insights that help us to better understand engagement in co-production. Yet, at the same time, our case study of individuals engaged in health care client councils shows that what drives these individuals cannot be understood by reference to active citizenship or customer behavior only. Interesting is also that, through the use of Q-method, different perspectives, and thus different drivers for engagement, are found.

While our study provides first insights into the motivation of citizens to engage in co-production, it opens up different avenues for future research. Additional research is needed to assess the importance of the four perspectives found among co-producers. Q-methodology can assure that the discourses found actually exists, as it “will generally prove a genuine representation of that discourse as it exists within a larger population of persons” (Dryzek and Berejikian 1993: 52). Q-analysis, however, cannot eliminate the possibility that other discourses exist among persons outside the sample. Small but diverse P-sets are sought to minimize this treat (Brewer, Selden and Facer 2000: 262; Dryzek and Berejikian 1993: 51). In

our study, we tried to find a diverse set of respondents as we contacted different types of health care organizations in different cities of different sizes. Furthermore, the insights of Q-methodology cannot be generalized to a larger population. In order to have more insight on the proportions of the general population of client council members sharing these discourses, a follow-up sample survey is needed. Moreover, our study is limited to one type of co-production: engagement in client councils of health care organizations. In order to have a more general impression of motivations of co-producers, research in different types of co-production initiatives is needed. We also focused on studying people that are already engaged in co-production. In future research, it would be interesting to contrast the insights found with the perspectives of people who are not active in co-production. Finally, it should be taken into account that the four perspectives or discourses found reflect different perceptions on motivations and engagement, rather than real behavior. Another question which has not yet been addressed therefore is on the consequences of the perspectives held: how do these different perspectives affect the behavior of co-producers?

Our research provides important insights for practice, as it offers lessons for organizations on how to encourage public service users to co-produce. In the case of client councils in health care organization this is especially relevant as the number of clients participating is too low rather than too high, and organizations are in constant need to find ways to motivate clients to participate in the council. As different perspectives exist on engagement in co-production, organizations need to emphasize different motivational incentives in their communication to potential new client council members. For example, some people would appreciate to make new social contacts (i.e., socializer) while others certainly do not see their engagement as pastime (i.e., aware co-producer) or something cozy (i.e., semi-professional). Different discourses emphasize the contribution that the council can make in enhancing the quality of the health care service provided. Moreover, open and honest communication is appreciated in all discourses. The organizations should therefore take care in enabling the council to have a real impact, and open communication between regular producers and co-producers is essential for this.