The Pitfalls of a Popular Concept: Co-Production in Times of Individualization, Marketization, and De-Politicization

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Abstract

Co-production between public administrators and citizens has attracted renewed interest in recent years. Co-production is predominantly perceived as something desirable and is claimed to improve service efficiency and outcome and user satisfaction, at the same time as addressing democratic ideals. Drawing from interviews with public administrators and patients in a Swedish healthcare context, this paper seeks to nuance the often overly positive notion of co-production by understanding these micro-level practices as being embedded in a macro-level societal context. Theorizing the empirical material based on three features of contemporary society – individualization, marketization, and de-politicization – we argue that co-production risks placing a burden and responsibility on individual users and creating a (welfare)market in which better-off people are recruited and benefitted. In this sense, co-production may consolidate or reinforce inequalities. Through de-politicization, political issues may appear as value-free; however, as long as market-logics prevail, the welfare system and practices of co-production will, in some respects, be impotent to address crucial societal issues. Co-production as a collective practice targeting democratic standards is called for, rather than an efficiency focus, preferably by taking the recruitment of those in the greatest need seriously – scaffolded by a revitalized public service ethos of public administrators and their organizations.

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Introduction

The concept of co-production was first developed in the 1970s (Ostrom et al. 1978; Percy 1978) and has again become popular in recent years (Bovaird et al. 2019; Cepiku et al. 2021; Isett and Miranda 2015). The rise of co-production may be a consequence of the emergence of the governance concepts in the late 1990s (Pollitt and Bouckaert 2017) that emphasized a plurality of actors contributing to public policy and service delivery (Osborne 2006), including promotion of agency–client relationships (Dunleavy et al. 2006), informality, trust, non-hierarchy, and partnerships (Klijn and Kopenjaan 2012; Pollitt and Bouckaert 2017). Co-production also falls in line with the ideals of deliberative democracy – highlighting dialogue and active participation – and the ongoing political ambitions to expand the democratic system by including aspects of deliberation into the administration of representative democracy (Amnå 2006; Chambers 2003).

The traditional definition of co-production focuses on service delivery and challenges the traditional public administration's role casting, in which public services are delivered to citizens and users who consume them (Bovaird 2007; Brandsen and Honingh 2016). Instead, expedient service delivery requires expertise among professional providers, along with the knowledge, experiences, and efforts of unpaid citizens/users (Brudney and England 1983; Percy 1978). A

common example is the importance of relationship and combined knowledge and experience of police and community members in preventing and solving crimes, something that is negatively affected when police patrol the streets by car instead of by foot (Parks et al. 1981). This type of co-production in service delivery is also common in healthcare, where patients' relationships with healthcare staff are essential for successful treatment (e.g., Olsson 2016).

Today, a consensual understanding is believed to exist in which co-production is no longer limited to service delivery, but rather occurs at all policy cycle phases (Bovaird and Loeffler 2012; Jakobsen et al. 2019; Nabatchi, Sancino, and Sicilia 2017); besides delivery, these phases comprise planning, design/improvement, and assessment. At the minimum level, direct interactive efforts between employees and citizens/users are required for co-production to take place (Bovaird et al. 2016), and both parties contribute significantly (Parks et al. 1981). Consequently, co-production ranges from face-to-face interactions between public employees and individual users (Normann 2001) to large deliberative forums (Munno and Nabatchi 2014).

The alleged benefits of co-production include increased democracy and equality, improved output and outcomes, and increased service delivery efficiency and user satisfaction (Andersen, Nielsen, and Thomsen 2020; Eriksson 2023; Munno and Nabatchi 2014; Nabatchi, Sancino, and Sicilia 2017; Thomsen and Jakobsen 2015). Recently, it has been argued that co-production (and similar overlapping concepts) tends to overemphasize the benefits at the expense of the shortcomings (Cluley, Parker, and Radnor 2021; Dudau, Glennon, and Verschuere 2019; Williams, Kang, and Johnson 2016).

The present paper seeks to contribute to the "disenchantment" of co-production (Dudau, Glennon and Verschuere 2019) by addressing less elaborated and potentially negative aspects of co-production, without necessarily disagreeing with the well-documented benefits. Drawing on interviews with public administrators and patients in a Swedish healthcare context, the purpose of this paper is to understand how micro-level co-production practices may be impacted by and reproduce macro-level features of contemporary society: individualization, marketization, and de-politicization.

Background – the societal and administrative landscape

In this paper, the "contemporary society" discussed is situated in a specific Western context, characterized by individual freedom and sovereignty and the supremacy of economic rationalities over social considerations and moral imperatives (Bauman 2011; Miller and Rose 2008). The welfare system in such a society is driven by market logic, in which social problems are understood as individual shortcomings rather than being explained by structural and contextual circumstances. This increases the pressure on individuals to take responsibility for their own welfare, while the collective responsibility and the responsibility of the state is toned down (Clarke 2013). In line with market logic, citizens/service users are reformulated as "customers" and "consumers", or even "producers" of their own welfare (Köppe, Ewert, and Blank 2016). Within this discourse, any type of user involvement focuses on organizational functionality rather than democratic influence (Eriksson 2018). It has also been argued that democratic erosion is a consequence of an expanding consensus discourse (Garsten and Jacobsson 2011), where political decision making and policy processes are increasingly understood as administrative issues, agreement about which is reached through collaboration, resulting in political/ideological matters appearing as technical and value-neutral (Hasselbladh, Bejerot, and Gustafsson 2008).

The development of the concept and practice of co-production is intimately connected to the changing landscape of public administration. The abovementioned features of contemporary society have been accentuated during the (neo)liberal ideological turn (Clarke 2013), through which ideas from the private sector have become increasingly popular since the 1980s, not least the Scandinavian countries; this is often labeled New Public Management (NPM) (Hood 1991). Despite NPM being far from cohesive (Pollitt and Bouckaert 2017), there are some commonalities. One aspect is marketization and the belief that competition, the introduction of private actors, and the individual free choice of services will improve public services (Dunleavy and Hood 1994; Green-Pedersen 2002). Another aspect is the focus on increasing efficiency by adopting practices from industrial quality management (Osborne, Radnor, and Nasi 2013). Here,

the value chain model (Porter 1985) has introduced process orientation in public services in which output is measured and controlled within delimited units, which is also decentralized accountability of their performance (Verbeeten and Speklé 2015). Criticism of NPM has increased, not least in Scandinavia (e.g., Lundquist, 2001).

The next reform wave of public administration is often understood in relation to NPM, commonly as the opposite of NPM. A variety of collaborative or network "post-NPM" approaches emerged in the early 2000s (e.g., Christensen and Lægreid 2011; Klijn and Koppenjan 2012) as responses to NPM's intra-organizational focus, which is said to have focused too narrowly on efficiency of internal processes and, as a consequence, contributed to fragmentation or siloization between public service organizations and created a system that is difficult for citizens/users to navigate (Christensen and Lægreid 2011; Pollitt 2003). The outward orientation and ability to collaborate with other actors – organizations as well as citizens – have been described as necessary for addressing complex challenges that are often ambiguous and uncertain in nature and that characterize the interdependent and plural contemporary societies (Christensen and Lægreid 2011; Osborne 2020). These challenges include pollution, aging societies, pandemics, forced migration, poverty, and inequality (Christensen 2012; Klijn and Koppenjan 2012).

The notion of co-production has changed with the changing landscape of public administration. In the beginning, co-production was a practice that concerned the citizen/service user and public employee, but similar to later developments of co-production (and co-creation, see below), this is now a practice that often involves a multiplicity of actors (Osborne 2020). Rather than control and formal contracts of NPM, these multi-actor collaborations are characterized by informality, trust, and relationships as a management ideal, in which consensus is sought among equal actors (Eriksson and Hellström 2021; Ferlie et al. 2016). Moreover, expectations of co-producing users have gone far beyond actively participating in service delivery (as in the early developments) to encompass all phases of the service cycle, including planning and designing services (Bovaird et al. 2016). Similarly, what is regarded as value – the output or outcome of co-production – is not a matter of elected politicians to decide, but up to each individual service user (Grönroos 2019). Thus, the features of contemporary society we will focus on in the article may even have been reinforced, along the changing landscapes of public administration from NPM to "post-NPM" (e.g., Pollitt and Boukaert 2017).

Contribution and disposition

This paper contributes theoretically by increasing the understanding of the embeddedness of co-production, and other similar concepts in public administration and management, in contemporary society. With empirical support, the paper contributes by displaying how aspects of individualization, marketization, and de-politicization permeate the understanding and practice of co-production, arguably creating unwanted effects. The contribution to policy and practice is a call for public administrators and managers to reflect critically upon the potential consequences of fashionable concepts (Alvesson and Spicer 2012) for employees and citizens/users. The paper also contributes by raising awareness of how the broader economic and social context may bring structures that reproduce and reinforce injustices and inequities (Adler, Forbes, and Willmott 2007).

The remainder of this paper is organized as follows. Next, the concept of co-production is presented, drawing on existing literature. This is followed by a closer representation of three selected features that characterize contemporary Western society: individualization, marketization, and de-politicization. The methods section presents the setting, collection, and analytical procedure of the empirical cases. These empirical cases are then used to support our theoretical discussion in the following section, elaborating on the consequences of co-production's embeddedness in the era of individualization, marketization, and de-politicization. The paper concludes with an expended presentation of the study's contributions.

Co-Production

Co-production may be understood as a virtue in itself, based on normative reasons, such as social capital (Nabatchi, Sancino, and Sicilia 2017) or the (deliberative) democratic ideal of participation (Chambers 2003; Michels 2011). Co-production may also be argued for based on instrumental reasons, such as a means, or tool, to improve the innovation, efficiency, and effectiveness of public services (Neshkova and Guvo 2012; Vamstad 2012). In this sense, co-production may also be understood as a means to achieve ends at various levels. It does so for the involved citizen/user themselves (Bovaird et al. 2016) by increasing empowerment or wellbeing. At group level, this is done in the form of equity and inclusion (Vanleene, Voets, and Verschuere 2018), or for society, by contributing to the public interest and common good (Alford 2002, 2009; Nabatchi, Sancino and Sicilia 2017). Consequently, rather than a trade-off, instrumental motives may well address normative goals (Munno and Nabatchi 2014).

Co-production can benefit the different levels of individual, group, and/or society, and may also be understood as either an individual or collective practice, where input is provided by either individual citizens/users, groups of citizens/users, or the entire collective or community (Bovaird et al. 2016; Brudney and England 1983; Nabatchi, Sancino, and Sicilia 2017). To Pestoff (2014), each level is important for different purposes and types of services. Others have argued that the individual level is generally the most important one, since it is the only level at which the person who provides input also consumes the actual public service; this is rare among people involved in group level co-production (volunteers, for example) or whole collectives (such as citizens) (Alford, 2002, 2009). Moreover, individual co-production is also important for addressing specific customer needs (Alford 2009). Recent streams of co-production that draw inspiration mainly from the private sector also seem to favor individual co-production, a consequence of the emphasis of interactions between the individual customer and frontline staff as co-production (Hardyman, Daunt, and Kitchener 2015; Normann 2001). Others favor the collective levels of co-production because it has the potential not only to benefit the individual, but also may lead to a communality of benefits, which is of course essential for public services (Brudney and England 1983; Eriksson 2019, 2022; Rosentraub and Sharp 1981).

Naturally, all levels of co-production have their challenges. Thomsen, Baekgaard, and Jensen (2020) found that the co-producing individual may experience such as stigma, stress, and loss of autonomy. Group-level co-production may reinforce stereotypes by problematizing certain segments of the population (Eriksson 2019; Olsson et al. 2014). All levels – but perhaps particularly co-production practices addressing whole communities or the general citizenry – suffer from recruitment challenges. More specifically, questions have been raised about whether co-production addresses those in greatest need (Jakobsen 2013; Jakobsen and Andersen 2013) and whether disadvantaged groups are often excluded from co-production (Brandsen and Honingh 2016; Cepiku and Giordano 2014). On the contrary, the risk that those participating voluntarily are representing advantaged groups in terms of income, education, and so on has been highlighted at least since the 1980s (Brudney and England 1983; Warren, Rosentraub, and Harlow 1984). The skewed representation may reinforce inequities (Eriksson 2022; Williams, Kang, and Johnson 2016), meaning that co-production may implicitly "exacerbate gaps between the advantaged and disadvantaged classes" (Rosentraub and Sharp 1981, p. 517).

The concept of co-creation has increasingly been used in the public sector recently, often interchangeably with co-production (Voorberg, Bekkers, and Tummers 2015). Co-creation is at heart of the so-called public service logic (Osborne 2020), service management and marketing adaptations to a public sector context (Eriksson and Hellström 2021). In this logic, co-production echoes from the goods-manufacturing logic of NPM that entail a linear and dyadic idea limited to public service user and provider (Osborne 2020). On the contrary, co-creation entails a service logic that emphasizes dynamic relationships among a multiplicity of actors in so-called service ecosystems (Petrescu 2019). Co-creation is also argued to be a broader term that frames the traditional definition of co-production (Eriksson and Hellström 2021).

Co-production and co-creation have gained increased popularity in Scandinavian public administration. This has probably been most evident in a healthcare context, in which co-production has been broadly used within whole regions (Persson et al. 2021), in disease

prevention (Eriksson 2019), staff–user interaction in special residences (Wallin et al. 2021), improving healthcare services (Suutari et al. 2021), and in compulsory care for substance abusers (Reitan 2019). However, Scandinavian examples of co-production also include improvement of services in local communities (Agger and Jensen 2021), childcare (Pestoff, 2012), and within the context of COVID-19 (Andersen et al. 2020).

Three Features of Contemporary Society

Many features are more or less specific to contemporary society, focusing on aspects such as technological advancements, globalization, trust, time/space, and reflexivity (see, e.g., Beck, Giddens, and Lash 1994). Here, we describe three features of contemporary society that we believe have had a particular impact on co-production and similar practices. Rather than being separated, these three features should be understood as closely intertwined.

Individualization

To Beck and Beck-Gernsheim (2002, p. xxii), individualization means that the individual is now, for the first time in history, "becoming the basic unit of social reproduction". Because ways of living are no longer embedded in traditional and interconnected – and often inherited – social arrangements, social and/or material categories such as family, gender and class appears as less important than before (Beck 1992). Previous ways of living and organizing society have been systematically disembedded; but instead of being replaced by a void, they have been re-embedded as new and fluid, non-stable, or volatile categories (Bauman 2000, 2001). Consequently, individuals are, in some sense, becoming increasingly free of structural constraints or hindering norms, while simultaneously required to "invent" themselves, by engendering and maintaining their own personal identities.

The gained freedom also means that the individual is a responsible subject – not only responsible for opportunities, but also for risks (Beck 1992). Because of the disembedding of collectives, the individual faces these risks alone. The individual can seek guidance from experts, but is now responsible for making final decisions alone when the recommendations of various experts and institutions are contradictory (Beck 1992; Beck and Beck-Gernsheim 2002). Thus, through the ideology of privatization, macro-level issues such as unemployment and security are "privatized" for the individual to solve themselves (Clarke 2013). In Beck's (1992, p. 137) words, ways of living become a "biographical solution to systemic contradictions".

Bauman (2000) suggested that the individual is given legislative rights and possibilities of self-realization ('individuality *de jure*'), but that, in practice, many people lack the resources to realize these rights and possibilities ('individuality *de facto*'). Some groups of individuals are even left without the formal rights connected to citizenship altogether (see, e.g., Standing 2011). Thus, Bauman (2000) argued that a clearly defined and democratically organized common (welfare) state, as distinct from the individualized and "free" market system, is actually a prerequisite for freedom, as it provides guidance on how to act, as well as a basis to enforce formal rights, basic security, and predictability. In sum, freedom may seem to offer sheer emancipation, but it also brings risk-handling and responsibility.

Marketization

Several aspects of the marketization of the welfare system have already been touched upon in the above presentation NPM, and the arguments for the liberal transformation of the welfare system have stated that competition and market logics will increase efficiency and create improved services; however, this logic has been seriously questioned (see, e.g., Hasselbladh, Bejerot and Gustafsson 2008). On the contrary, Bauman (2011), among others, has stated that these changes in the welfare system increase inequality and aggravate the situation for the most vulnerable groups in society. From this perspective, the continuous "failures" of the welfare system to meet the needs of the citizens can be interpreted not as an efficiency failure or a lack of quality of services, but rather as a consequence of a deliberate political policy, where the social aspects and equalizing ambitions of government have been replaced by other objectives that fulfill the needs of the market (cf. Miller and Rose 2008).

Market logics have spilled over and become norms in other spheres in society, such as public services or family life (Ritzer, 2000), which led Sandel (2012) to claim that many Western countries have moved from being market economies to market societies. Combined with individualization, marketization has led to individuals becoming commodities or goods. Like all goods, individuals – or rather, their needs, labor, identity, etc. – can be bought and sold and must be marketed to increase demand and salability (Bauman 2001). Thus, consumption in contemporary society is not necessary to satisfy needs; rather, making "oneself a sellable commodity is a DIY [do-it-yourself] job, and individual duty" (Bauman 2007, p. 57). To an increasing extent, individuals need to be able to present proper attributes – a proper identity – to be able to find work (Standing 2011), as well as to be admitted welfare services and to be viable actors within welfare organizations (Eriksson 2023). Our need to market ourselves is a consequence of the (forced) reflexivity of contemporary citizens (Standing 2011), where individuals have become commodities in multiple ways.

While selling one's labor is certainly not a new phenomenon, several theorists have referred to a re-commodification of labor, where individuals in contemporary society are increasingly dependent on their ability to sell their labor to ensure their wellbeing; as austerity and workfare politics is the new norm (Holden 2003). Moreover, individual wellbeing is also being bought and sold on the deregulated welfare market, where individuals must enact the role of worthy recipients of benefits (cf. Lipsky 2010). Again, salability may be easier for those who are better off, and difficult for disadvantaged people with few opportunities to consume or to be consumed.

De-politicization

A consequence of the fact that contemporary welfare services are guided by economic rationality and market logics is that values regarding recovery, workplace democracy, social equality, and wellbeing are being toned down (Miller and Rose 2008). Thus, power imbalances and inequalities are pushed aside by the dominant market logics (Dahl and Soss 2014). These and similar values may be addressed, but only as resources or means, rather than as ends in themselves (Adler, Forbes and Willmott 2007). It has been argued that even if political and ideological polarization and conflict increase in society, contemporary politics in practice is characterized by de-politicization (Garsten and Jacobsson 2011). An issue could be understood as "political" when it concerns the understanding or organization of society and has inherent moral and/or ideological dimensions. Within a parliamentary representative democracy, "politics" takes place when elected politicians – based on their political mandate and beliefs – decide how to approach and handle various societal issues. According to Mouffe (2002), constructive conflict and open ideological debate is vital for a political democracy. Even so, contemporary politics have a tendency towards collaboration and consensus (Garsten and Jacobsson 2011). This is seen as an indication of de-politicization as the desire, and requirement, to reach consensus risks concealing the prevailing and increasing differences and inequalities in society (cf. Bauman, 2011; Standing, 2011), rather than overcoming them (cf. Garsten and Jacobssen 2011; Mouffe 2002).

Another aspect of de-politicization connects to the ongoing individualization process, where citizenry has dissolved because collective and democratic concepts such as equality, social justice, or the common good are perceived as hindering the individual from satisfying their own needs or intruding the individual's freedom. What is left for the public administration to do, is to guarantee "human rights" defined in terms of liberal freedom. According to Bauman (2001), shifting the focus away from equality and social justice towards "human rights" aligns with the individualized society as it seeks to enable people to choose their own way. Paradoxically, this could reduce many individuals' opportunities to realize these rights, as there is no common good to support them in doing so. Consequently, critiques of structural conditions and inequalities are now changed to a focus on criticizing self; however, as a result of focusing on ourselves, we lose control over societal and democratic aspects that shape our lives. Public space is occupied with individuals discussing their individual and private problems, while finding it difficult to address the societal conditions that made these problems occur or to understand the problems as political issues (Clarke 2013; Garsten and Jacobsson 2011).

Processes of de-politicization also include the fact that issues appear as if they are not political; that is, as having no ideological dimension. The introduction of market-logics and NPM within the public administration is said to bolster such de-politization, as welfare problems are continuously treated as technical and administrative issues that are handled at the administrative level, rather than as sociopolitical matters solved at the political level (Hasselbladh, Bejerot, and Gustafsson 2008). The increased use of performance measurements, balanced scorecards (Moore, 2003), and other "technocratic tool[s] for measuring value" (Lee, Oakley, and Naylor 2011, p. 298), or "instrumental means toward the realization of managerial visions of the common good" (Dahl and Soss 2014, p. 500) means that technical rationality and market-orientation prevail. It has been claimed that these business-like arrangements erode democratic principles, including transparency (Lundquist 2001), and diminish democracy as managers rather than elected politicians are responsible (Shaw 2013), or diminish the power of common people (Dahl and Soss 2014).

De-politicization is part of the same structure as marketization, but also as individualization, in which health, safety, etc. become the individual's responsibility rather than issues of the political sphere (Clarke 2013). The individualized notion of NPM and its focus on customer satisfaction, customer focus, etc. means that collective values are often reduced to an aggregation of individual preferences that is translated into political policies (Lee, Oakley, and Naylor 2011), leaving no place for collective aspirations and political debate. Therefore, "politics (like the market) can only legitimately and practically deliver on personal preferences" (Morgan 2003, p. 129–130). In the same vein, when participatory processes, such as co-production, are implemented within a neo-liberal administration, Clarke (2013) argued that those practices also risk leading to de-politicization as the involved subjects are expected to act as "ordinary people" or lay-experts, rather than as politically active subjects.

Table 1. Summary of the features of contemporary society

	Individualization	Marketization	De-politicization
Key aspects	Dissolution and obscuration of social categories	Efficiency, economic rationality, and market logics, rather than common good, equality, and social logics	Consensus and collaboration, rather than conflict and debate
	Individual responsibility for opportunities, risks and wellbeing, rather than collective and public responsibility	Private actors on a welfare market in a market society, rather than public actors in a welfare society	People acting out of free will to satisfy individual goals, rather than acting out of political will to reach ideological goals
	Individual subjects acting solitary, rather than groups acting collectively	People as commodities need to market themselves, rendering social exclusion	Inherently (socio)political and ideological issues are understood as technical and administrative matters
	Groups that lack resource or formal rights are not recognized and supported	Re-commodification of labor	Participation based on collaboration and individual expertise, rather than debate and ideological beliefs

Material and Method

Setting

The empirical material in this paper is retrieved from two settings in the Western part of Sweden: (1) a regional county council's healthcare organization, and (2) the development of a new patient association in a mid-sized city. Because the understandings and perceptions of the professionals and patients were central, we favored a qualitative research strategy (Stake 2010). Since the primary purpose of this paper is not to present empirical findings, the empirical material should rather be understood as context to support our theoretical arguments. Before data collection

started, the research project was approved by the national ethics committee (registration number: 2019-02280).

Data collection

The primary empirical material was retrieved from 30 interviews with public administrators and patients; see Table 2. The administrators worked with equality, patient focus, quality improvement, or disease-specific areas. Some were also clinically active healthcare professionals (mainly nurses and physicians). The experience of working with co-production varied among the administrators; some had long experience from various forms of co-production, whereas others had just started. Similarly, while all patients had experience with participating in co-production, experience varied within the group. Apart from co-production during the service delivery of their own care and treatment, some had little experience of co-producing together with public administrators and professionals, whereas others had participated in various forms of co-production at different phases of the policy cycle (Jakobsen et al. 2019).

The interviews were semi-structured (Silverman 2005) and conducted between autumn of 2019 and spring of 2020. The topics addressed co-production specifically, but also perceptions of healthcare and welfare services in general. The present paper focused on the aspects of the empirical material concerning co-production. The interviews took place at the respondents' work, the interviewer's university, patients' homes, or a patient association. A few interviews were conducted through video call over the Internet. On average, the interviews lasted around one hour. All interviews were transcribed verbatim, and all names and other characterizing attributes have been altered or removed herein to ensure anonymity.

Table 2. Respondents' backgrounds

Role	Sex
Public administrators	14 women, 6 men
Patients	8 women, 2 men
Total: 30	

Analytical process

The analysis followed a similar thematic analysis as template analysis (Brooks et al. 2015; King 2012). First, the transcriptions were read and discussed. Next, the empirical material was coded based on the three features of individualization, marketization, and de-politicization. In this phase, empirical material that was not coded as any of these categories was omitted. In the following phase, a selection of transcriptions was randomly selected and codes within each category of individualization, marketization, and depoliticization were compared and clustered into themes based on differences and similarities. Next, a template was developed, and themes were continuously modified as the remaining transcriptions were analyzed. The final themes of each feature of contemporary society were:

- Individualization: person-centered practice and individual representation; tokenism and patient selection; beneficiary
- Marketization: technical rationality; remuneration and gig economy
- De-politicization: abdicate from responsibility; consensus-orientation; inability to address structural causes.

Examples of the final themes from the empirical material are presented in Table 3 at the end of the results section. To address the qualitative rigor of public administration research (Nowell and Albrecht 2018), the empirical material was continuously validated at meetings and presentations with respondents, as well as other stakeholders (Lincoln and Guba 1985) after data collection to validate that nothing was misinterpreted or misunderstood.

Tracing the Contemporary State In Co-Production

In public administration, co-production is widely understood as a desirable practice that has valuable benefits and merit. However, we argue that when the practice of co-production takes place in a broader context characterized by individualization, marketization, and de-politicization, some of the alleged benefits of co-production might be lost or even counteracted. This section presents how the three abovementioned theoretical concepts and features of contemporary society echo and manifest in the empirical material. Again, even if they are separated here for the sake of clarity, processes of individualization, marketization, and de-politicization should be understood as being intimately intertwined.

Individualization

Person-centered practice and individual representation

Recently, the term "person-centered care" (a holistic focus on the individual rather than their diagnosis only) became popular and was mentioned in many of the interviews. One respondent reflected that this was an example of the trend of individualization in healthcare, just as in society at large and the fixation with "individuals, individuals' stories." Following this person-centered logic, many co-production initiatives recruited a single co-producing patient to represent the entire patient group. These patients participated in meetings to improve services with administrators by providing feedback. Thus, rather than requesting the collective knowledge of the patient group, individual patients – often without any base in a larger collective, such as a patient organization – tried to speak for the group based on their individual experiences. Some of these co-producing patients expressed doubt regarding whether they could really contribute with anything relevant, both because much of the discussions in these meetings concerned medical matters, and because they had no insights in the experiences of other patients. Still, they felt that the professionals expected their input on a variety of issues. However, this order was questioned by some of the patients: "I know there are a lot of patients who had it much more difficult than I have had. How can I represent? What can I say to those patients? Will they recognize themselves in my experiences?"

Tokenism and patient selection

On some occasions, the patient was recruited by their treating physician to participate in a team with approximately 20 professionals. Some administrators saw this as a benefit, in that the already-established relationship created a more relaxed situation for the patient; others argued this was inappropriate and that the patient was taken "hostage" since it was difficult to express their true opinions about healthcare with their treating physician in the same meeting. Another administrator regarded the one-individual type of co-production as "tokenism", since the patient alone could not possibly represent the entire patient group. Similarly, a patient who was the only co-producing individual argued that she was probably not representative since she was satisfied and had received good care, something she knew that most patients had not: "It should have been someone less satisfied. But they say I am good. Apparently, it is hard for them to get patients involved in this." Overall, most of the co-producing patients interviewed appreciated the Swedish healthcare system, and the individualized logic guiding many co-production initiatives facilitates a practice where the healthcare system can select "good" co-producing patients. A patient who had been involved in co-production (but with a group of patients) argued that public organizations often wanted particular types of patients who fitted the organizations tasks and expectations rather than the "real lived experience" of the co-producing patients:

> I experience many times that they [public administrators] try to make reality become a square, but it is round. And then they knock on that round thing until it becomes a square. And if it does not become a square, then it is something wrong with the roundness, not the square.

Indeed, if certain individual patients – those who fit the square – are selected to represent the entire patient group in co-production, these practices risk falling into tokenism rather than elevating a critical discussion concerning the administration.

Beneficiary

Discussing the gains of co-production, benefits for the participating individuals themselves were often highlighted, including the social value of meeting other people while co-producing, input in terms of knowledge from both other patients and healthcare staff, and empowerment by talking in front of other people. "To share one's story" and similar expressions were probably the most important benefits mentioned by the co-producing patients. The possibility of improving services for future patients was also a major reason for co-producing. However, discussing gains in these terms reveals aspects of individualization, as the benefit for the individual takes precedence over the general benefits for the patient group, as well as precedence over benefits for society more broadly. Benefits on the societal level were mentioned seldomly. Some interviewees wanted to "return the favor" by helping develop tax-financed healthcare services, or to fulfill their duty as "good citizens" to contribute to the common good.

Marketization

Technical rationality

One of the most common reasons mentioned by public administrators for co-producing was to improve services. While many argued that improved service would benefit the patient group, such statements were regularly accompanied by an economical rationality stating that it would simultaneously improve "efficiency." Some even understood patient co-production solely in instrumental terms, as an important resource to make clinical practice more efficient and "reduce waste", as one administrator put it. However, many had a more nuanced viewpoint, viewing co-production as a way of including a resource, quality, or competence that was not normally present in healthcare. At the same time, co-production is also "a justice thing" or "about democracy". The reason for involving patients at all was a question of "human rights". Thus, even if a technical rationale following market logics was clearly salient in the administrators' reasoning concerning the reasons for working with co-production, other reasons were acknowledged as well.

Remuneration and gig economy

The question of whether to pay patients to participate in co-production divided the respondents. Some thought that since the co-producing administrators were getting paid, the patients would too. Another respondent argued that because co-production typically occurred during work hours, only those patients who could afford to take a couple of hours off or those on sick leave could participate if they were not paid. Regarding this discussion, the mere fact that remuneration of the participating patients is a topic of debate clearly indicates that market logics inflict on the practice of co-production.

One administrator raised the risk of a "gig economy," whereby a paycheck from the public administration would become essential for the patient and affect what they could say during co-production: "Is it even possible to be an inconvenient patient if you get paid? Don't you risk not getting gigs in the future?" In this regard, the respondent perceived "a risk that patients will make a little business around this", repeatedly seeking out new "gigs", not least since some patients had reduced income due to their illness. Such a practice could create a new form of dependency on the healthcare system and its co-production activities, as a source of income. Another respondent argued similarly that there was:

> A risk that people see this as a job, or an income they rely on so that they want to participate as much as possible – and with this comes that they may say what they think the staff wants to hear and not cause too much trouble.

In terms of marketization, co-production practices in themselves might create something of a (gig) labor market, where the participating patients become a specific type of "employees" who sell their labor. One patient said that she had had a "patient representative career", starting at local patient associations, through developing strategies at the national level, to actively working in the Europe Union as a patient representative. Similarly, other patients had extensive experience working with healthcare staff and administrators and: "you may say that I am sort of professional in this area."

One administrator argued that, similar to union representatives, patient associations should choose their representatives in larger co-production initiatives – not the public administrators or that any patient could choose to participate as a "gig". If representing an association, one patient could represent many patients. However, both administrators and patients argued that patient associations did not mirror society since younger patients, foreign-born patients, and other groups were often not involved. Still, the fact that individuals participating in co-production are increasingly being recruited and remunerated by the public administration, rather than elected by the patient group or recruited through patient organizations, indicates that market logics wins at the expense of democratic logics.

De-politicization
Abdicate from responsibility
One administrator said there was a risk in allowing and expecting patients to participate in all administrative issues, and that it might be difficult for a public administrator to see when "it had gone too far". This was perceived as particularly relevant in co-production together with so-called "expert patients". There was currently a discussion that this term was inappropriate and could be interpreted as healthcare having "abdicated its responsibility" to act as experts. Highlighting expert patients as an admired ideal could be a way for healthcare to implicitly say: "you manage this yourself", as one official said. The worries raised here concern both the displacement of responsibility from the public to the individual, as well as a form of de-politization, where issues that should perhaps be resolved at the political level are allocated to the expert level in the administration – to healthcare professionals, or even perhaps to the patients themselves.

Consensus orientation
As mentioned, often one type of patient was sought for – one that was easy to work and cooperate with – to reach consensus. A few administrators referred to these patients as "capable" patients, implicitly referring to patients who speak Swedish, have no intellectual disabilities, are comfortable speaking in front of a crowd, and are not eager to "make a fuss". One administrator admitted that these patients were chosen not to make public situations awkward or to embarrass themselves. Another respondent answered that a reason for selecting "capable" patients was to avoid too clearly mirroring the subordinated position of patients at public events. It appears as if the patients that are favorably selected to co-produce are those who do not deviate too much, both in terms of social skills and in terms of their opinions. Such a selection ensures that co-production runs smoothly and reaches consensus concerning the topics discussed. Simultaneously, because some (kinds of) patients are excluded, such practice risks suppressing constructive conflicts and concealing existing inequalities.

Inability to address structural causes
Equality in healthcare has been a prioritized issue among politicians at the national and regional levels. However, a respondent noted that the popularity of person-centered care meant that the group level was often neglected and therefore structural factors not revealed and considered. Another respondent said that person-centeredness was often explicitly mentioned in all important documents in healthcare, and that practitioners consequently took pride in saying "we don't talk in terms of groups, we talk in terms of individuals". This, the respondent argued, made it difficult to address structural inequalities. In these statements, a process of de-politization becomes visible, where the strong focus on the individual patient makes it harder to perceive issues concerning healthcare as relevant to address at a structural (that is, political) level.

Similarly, a common approach among the healthcare professionals was that they only saw "the individual, the patient, the human being" in the patient they met. While such a perspective might at first seem unprejudiced and open-minded, it also raises the question of whether they were able to perceive the individual as situated in and affected by larger structures based on, for example, their gender, ethnicity, or socioeconomical background. These aspects are also important to account for in the interaction with the individual person. Moreover, perhaps as a consequence of the popularity of "patient-centeredness", relatively few co-production initiatives

have taken the opportunity to target particular subgroups that could be favored by being highlighted within the healthcare system because of their particularly precarious positions or difficulty accessing care. However, a few projects were mentioned for addressing foreign-born inhabitants in disease prevention and pain management between men and women.

Some administrators argued that co-production should focus on improving public services for those who are worst off. For everyone to have equal access to healthcare services, it was deemed essential to make an effort to find disadvantaged voices and to invite them to co-produce. This was seen as essential from a democratic standpoint. However, most respondents did not mention democracy, justice, or equality as a reason to co-produce. When asked, this was understood as a possible side effect of co-production. As mentioned, the most common motivation for co-production was to increase efficiency. In this, some respondents felt that issues of equality were often "pushed aside" – despite there being broad political consensus to work with equality in healthcare in the region. Therefore, a common strategy to address equality was to work with the issue in a way that linked to efficiency and quality, often quantitatively. However, this strategy was not always appropriate since factors such as power asymmetries and causes of inequality were rarely explicated. Consequently, in terms of de-politization, several processes in the implementation of co-production work to circumvent the structural and ideological dimensions of the issues at hand, while highlighting their technical and administrative qualities.

Table 3. Summary of themes and empirical material

Contemporary feature	Theme	Empirical example
Individualization	Person-centered practice and individual representation	Co-production as an individual practice as an ideal, due to the popularity of the person-centered approach in healthcare
	Tokenism and patient selection	One co-producing patient only, commonly selecting those who are well-known and relatively satisfied
	Beneficiary	Co-production benefits the individual self and others of the patient group, but more rarely "the common good"
Marketization	Technical rationality	Efficiency and improvements more prominent reasons than democracy, justice, etc.
	Remuneration and gig economy	Co-producing patients as labor that want "gigs" and avoid being too critical
De-politicization	Abdicate from responsibility	Displacement of responsibility downwards, finally at the patients themselves
	Consensus-orientation	"Capable" patients who are easy to work with are involved in co-production, while others are excluded
	Inability to address structural causes	Focus on the individual, while neglecting social structures and ideological aspects

Discussion

Following the empirical presentation above, this section completes the theoretical discussion. Specifically, we focus on the consequences of micro-level co-production practices when understood as being embedded in, and impacted by, the macro-level features of contemporary society: individualization, marketization, and de-politicization.

Individualization (Beck and Beck-Gernsheim 2002) may be a reason why individual input in co-production is discussed in the interviews more than collective forms (Bovaird et al. 2016; Brudney and England 1983), such as citizen dialogues. The individual, rather than the collective, is the responsible unit in contemporary society (Bauman 2000, 2001), besides the areas of health, education, and employment – probably also for co-producing these services. The

increased responsibility – and freedom – for the individual also means that they must deal with the consequences (Bauman 2001). Consequently, emphasis on the individual patient limits the space for collective problem solving, responsibility, and co-production. Thus, rather than setting high standards of good-quality services and promoting social equality for all citizens, co-production depends heavily on the individual's ability and position (cf. Bauman 2001). Even when co-production was arranged with a collective of patients, such as in workshops, sharing one's own patient story is central in the interviews (cf. Eriksson 2018; 2023).

The focus on individual co-production may be due to practical reasons, in that individual forms are considered easier to arrange than collective forms that require more formalization (Brudney and England 1983); this could also be why citizens/users – who are equally embedded in an individualized society – often seem to prefer individual forms (Bovaird and Loeffler 2009; Bovaird et al. 2016). The individual focus may also be due to market logic, at the heart of which is the interaction between the individual customer and frontline staff (Normann 2001). In a highly individualized context, it is likely that this form of co-production is favored not only because it is easier than collective forms to carry out, but also because such forms become easier to comprehend: the individual patient provides input and then enjoys the benefit when consuming the healthcare service (Alford 2002, 2009).

The respondents made relatively little mention of collective forms of co-production in which the general population is invited, especially concerning input. The societal level as a beneficiary of co-production was mentioned, including public interest, common good, and democratic aspects, but rarely further reflected upon. Group-level co-production was also less commonly highlighted in the interviews. Unequal opportunities to co-produce for certain groups (cf. Brandsen and Honingh 2016; Cepiku and Giordano 2014) do not seem to have disappeared, but they are perhaps less acknowledged today, when inequalities are understood as "psychological dispositions: as personal inadequacies, guilt feelings, anxieties, conflicts, and neuroses" (Beck 1992, p. 100), rather than a consequence of structural factors. Overall, the respondents, both administrators and patients, reflected little on these different levels of input and output and the purposes for which they could be fit (Pestoff 2014).

In line with the marketization and individualization features in which the public organizations' responsibility is toned down (Clarke 2013) and the individual becomes responsible for their own welfare (Köppe, Ewert and Blank 2016), it was noted that co-production may go too far in terms of which public organizations "abdicated from responsibility", making patients responsible instead. The blurring of responsibilities between staff and users (Köppe, Ewert and Blank 2016), which evidently takes place, may also lead to uncertainties.

The benefits of co-production based on normative or democratic ideals (Michels 2011) were only mentioned briefly, both by administrators and by patients. Due to individualization, in which the individual person is benefited and remunerated, the ideal of co-production to contribute to the common good may be hard to achieve, even if some patients argued that it was the duty of a citizen to participate when the public called, and to contribute to the common good (cf. Alford 2002, 2009; Nabatchi, Sancino and Sicilia 2017). In terms of de-politicization (Garsten and Jacobsson 2011), many administrators talked about co-production as being detached from ideological conflict and political context, instead adopting the logic and vocabulary of a market rationality (cf. Hasselbladh, Bejerot and Gustafsson 2008); terms such as "[reduction of] waste" and "customer focus" were used to describe co-production.

Payment as an incentive to increase participation (Fung 2003; Nabatchi 2012), particularly among the disadvantaged, was discussed. Some administrators were positive since, if participants were not paid, only those who could afford to take time off could participate. Others were more skeptical, arguing that patients may rely too heavily on this income and therefore not risk future "gigs" by being overly critical (cf. Eriksson 2023). In line with marketization, there is a risk that citizens would be transformed into commodities (Bauman 2007), in which these co-producing patients need to present themselves as proper, sellable, and employable commodities (Bauman 2007, Standing 2011). Clearly, some patients had made a business out of their patient experience, having had "international careers". Similarly, in contemporary society, institutionalized user involvement activities within welfare services are founded less on

democratic logics (Eriksson 2018) and increasingly take the shape of a "market of own experience", where service users experiences are bought and sold as commodities (Eriksson 2023). To be able to sell their expertise on this market (that is, participate in co-production), the involved individuals must enact the role of a cooperative partner – not being too critical, radical, or "political" (cf. Clarke 2013).

Although equality was mentioned as being important to contribute to through co-production, it is clear in the interviews that not just anyone is invited to co-produce. The word that the public administrators used (albeit reluctantly) is "capable", which addresses people who are well-spoken and well-behaved, well aligned with the expectations of the active – but not activist – user that comes with marketization and individualization (Bauman 2000; Beck and Beck-Gernsheim 2002; Clarke 2013). Many of the recruited co-producing patients had backgrounds as healthcare managers or politicians; it is widely acknowledged that public administrators tend to (often unconsciously) recruit patients similar to themselves (Mifune, Hashimoto, and Yamagishi 2010; Van Ryzin, Riccucci, and Li 2017; Williams, Kang, and Johnson 2016). The skewness of recruiting the advantaged population was highlighted in the co-production literature in the 1980s (see, e.g., Brudney and England 1983; Warren, Rosentraub, and Harlow 1984), and seemingly continues to enable a smooth-running consensus-oriented practice. The consequence of not including disadvantaged people in co-production has been identified as reinforced inequities, both in early (Rosentraub and Sharp 1981) and recent (Williams, Kang, and Johnson 2016) co-production research.

One way of understanding the apparent difficulties in addressing issues of equality and justice may be through the lens of de-politicization and individualization, in which such issues become pushed aside since they hinder individual freedom (Bauman 2001). There are ways to improve inclusion of the disadvantaged, but neither purposively broad recruitment (Fung 2003; Nabatchi 2012) nor random selection (Nabatchi 2012) were mentioned in the present empirical material. Instead, market techniques such as recruiting and remunerating handpicked individuals, or constructing focus groups in which collective will risks being reduced to aggregation of individual preferences (Lee, Oakley, and Naylor 2011), were highlighted. It was also suggested in the interviews that patient associations should choose their own representants in co-production. However, such processes were usually dismissed with the argument that some patients, such as young people, are often not involved in collective associations – like what is often suggested for the individualized millennials in general (Jensen 2018). Respondents also mentioned that communication technology was used as an opportunity to co-produce. However, the possibilities offered by these media may also create inequities due to inaccessibility for some groups of patients, as well as increasing responsibility and risk-handling for outcomes for those with access (Visser et al., 2019).

A core argument for co-production is still that it enhances a participatory democracy (Eriksson 2019) that link with and form public value in deliberative forms of democracy (Hartley et al. 2017). However, co-production can also damage democracy through the redistribution of power among actors, in that "the balance of representative democracy, participative democracy, and professional expertise" may be called into question (Bovaird 2007, p. 856). Some would also argue that tendencies of de-politization and shift in responsibility from state to the individual are a consequence of deliberative democratic ideals gone too far (e.g. Jarl 2003; Amnå 2006). Instead, we argue that deliberative and participative initiatives have the potential to complement representative democracy in a meaningful way if implemented adequately (cf. Chambers 2003). However, such adequate implementation demands a clear (rather than, as shown in this article, obscured) division of responsibility, a wide inclusion of perspectives, as well as the opportunity for a vital constructive conflict and debate at all levels of co-production. The latter is hampered by the strong tendencies towards consensus that appear in present co-production practice (cf. Eriksson 2018).

Eriksson (2022) argued that both external and internal exclusion hindered minorities from inclusion in co-production activities. External inclusion – similar to inclusiveness of Leach (2006) – means that foreign-born inhabitants, disabled and other disregarded social group members are not even offered a place; they are not even included in co-production. In internal exclusion – similar to the deliberativeness of Leach (2006) – these minorities are offered a place

(they were externally included), but they are not offered a say. That is, they were not given a chance to voice their ideas and discuss on equal terms with those who are strong in resources.

Conclusion

Based on an assumption that the wider societal and political context impacts how we organize and manage institutions, we argue that it must be recognized how co-production practices are influenced by features that are salient in contemporary society, such as individualization, marketization, and de-politicization. Given that all these features are manifested in public administration and management practices, such as co-production, it is important to bring them to the surface in order to provide a more balanced picture of co-production than is commonly the case (Dudau, Glennon, and Verschuere 2019; Williams, Kang, and Johnson 2016).

In some way, co-production and similar practices have given citizens and public service users a greater say and freedom. However, individualization entails that this also includes increased responsibilities for risks. Through marketization, patients are no longer only making free choices on quasi-markets, but have transformed to become commodities on a market. As such, they are expected to market themselves as sellable "co-producing" patients. On such a market, people who are better off have better opportunities to be recruited in co-production, and their contribution is likely to benefit those similar to themselves. In this sense, co-production may do more harm than good by consolidating or reinforcing inequalities.

As a customer, designer, producer, or peer-supporter, there is no limit to what the patient (or student, or client) is expected to do. Co-production may seem to build on collaboration and a common consensus, but these alleged properties of the practice actually "hide" other distinctive purposes of activating co-production. They bring forth the economic rationality – focus on efficiency and instrumentality – by de-politicizing political/ideological matters and making it appear as if there is unity in addressing these seemingly value-free issues. A risk herein is that co-production will be reduced to box-ticking by focusing on the measurable.

In order to address systematic discrimination, structural exclusion, etc., individualized solutions simply will not suffice. Instead, co-production should be used to target democratic standards and as a collective practice to target common issues in the welfare state, such as improving the situation for disadvantaged groups and those in the greatest need. Ensuring that these groups can impact development of policy and public services, it is essential that their voices are included and heard in co-production practices. This should be ensured and scaffolded by a revitalized public service ethos (Cluley, Parker and Radnor 2021) and the values of public administrators and their organizations.

The contribution of the present paper to policymakers and practitioners is to "disenchant" co-production, at the same time as emphasizing its true potential. It is important to highlight the risk of reproducing inequities through co-production, as well as the risk of thinking one is working for noble values, whereas these may in fact risk being treated in a de-politicized and non-democratic fashion. Therefore, it is important for public staff to reflect more on who they involve, how they involve them, and put more effort into recruitment strategies.

Other contemporary features, such as technological advancements, globalization, trust, time/space, and reflexivity, are only touched upon briefly, and would be fruitful topics for further investigation of co-production or other central concepts in future research of public administration.

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