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# User-Centered Approach to Service Quality and Outcome: Rationales, Accomplishments and Challenges

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**Abstract**

This paper addresses the rationales, accomplishments, and limitations of the User-Centered Approach (UCA) to service provision, proposed and practiced as a solution to the problems of poor quality and insufficient outcome of services observed in impact evaluations. After discussing conceptual and analytical approaches to the question, a conceptual articulation of the nature of services and classification of services based on degrees of discretion and transaction-intensity is provided, followed by observations on two types of failures in service delivery. Next, a discussion on the effectiveness of the UCA models (co-production and self-management), on the definition and articulation of two key concepts (agency and motivation), and on the typologies of user-provider relations and of user agency in service transaction and utilization is presented. Some of the important proposals and experiences of UCA are summarized in the form of general propositions on co-production in public services, people-centered primary care, and chronic illness care, and in the form of case studies of two salient programs in social work. As the central argument of the paper, the activation and development of user agency for effective partnership in co-production and for self-management is emphasized. This is achieved by making reference to a general conceptual examination of "empowerment," and to important cases of intervention for agency activation and development, with a view to drawing generalizable implications. A brief discussion on the rationale, accomplishments and limitations of UCA concludes the paper.

**Keywords:** service quality and outcome, User-Centered Approach (UCA), co-production, self-management, user agency

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## Introduction: Question and Focus

This paper addresses the rationales, accomplishments, and limitations of the User-Centered Approach (UCA) to service provision proposed as a solution to the problems of poor quality and insufficient outcomes in the provision of public services. The *Global Monitoring Report (GMR) 2011* (World Bank 2011), provides a useful review and analysis of an apparent "disconnect between spending and outcomes," as observed in impact evaluations of health and education in developing countries[1]. It states that while increased spending for improving access to services has met with some success, it has been much more difficult to improve the quality of services and to achieve positive changes in human development outcomes. This recognition calls for a thorough review of the links in the service provision and uptake chain, and possibly a search for nonconventional approaches to service provision.

This situation is a matter of general significance, insofar as all development efforts are conducted ultimately for the realization of greater well-being outcomes among populations. For JICA, in particular, it should serve as a call to review and re-evaluate its traditional approaches to capacity development based on a strong emphasis on supply-side institutional development. While it is true that projects for supply-side institutional development often incorporate components of user-side organization and of arrangements for collaboration between the two sides, oftentimes, however, there is limited attention given to factors affecting the quality and outcomes of the services generated.

[1] In Chapter 3, *Linking Spending and Outcomes: Some Lessons from Impact Evaluations in Education and Health* (World Bank 2011).

The paper is organized as follows: Section 1 provides conceptual and analytical approaches to the question of service transaction and utilization. First, an analytical framework on supply-uptake-utilization links is presented, followed by a conceptual articulation and classification of the nature of services based on degrees of discretion and transaction-intensity, and observations on the two types of failures commonly found. Next, in discussing the effectiveness of the UCA models (co-production and self-management), the definition and articulation of two key terms, agency and motivation, is presented, followed by the typologies of user-provider relations and of user agency in service transaction and utilization to be employed in the following sections of this paper.

Section 2 reviews and highlights some of the important proposals and experiences of applying UCA. Proposals and experiences are summarized in the form of general propositions on co-production in public services, people-centered primary care and chronic illness care, and in case studies of two salient programs in social work: Nurse Family Partnerships (NFP) and Chile Solidario (CHS). Next, Section 3 addresses the activation and augmentation of user agency for effective partnership in co-production and for self-management. Following a general conceptual examination of "empowerment," important cases of intervention for agency activation and agency augmentation are discussed, with a view to drawing generalizable implications. A brief discussion on the rationales, accomplishments and limitations of the UCA concludes the paper.

## 1. Public service failures in developing countries and the UCA as a possible remedy

The *Global Monitoring Report (GMR) 2011* (World Bank 2011) identifies the wide-ranging phenomena, as well as the sources, of the problems of poor quality of services and limited outcomes, and reports on previous evaluations of the effectiveness of attempted remedies. It cites the results of impact evaluations on some of the standard measures that are based on conventional wisdom, and concludes as follows with reference to schooling:

> "Attempting to fill narrowly defined resource gaps in schooling by increasing the provision of traditional inputs has not been very successful for improving learning outcomes. Traditional inputs that have been tested on this dimension include textbooks, school meals, blackboards and other visual aids (like flip charts), teacher training, and even smaller class sizes" (World Bank 2011, 83).

With regard to Conditional Cash Transfers (CCTs), the Report's summary statement reads as follows:

> "CCTs help increase the uptake of services, but their impact on health and learning outcomes is mixed" (World Bank 2011, 84).

As stated in the quotations above, neither input-related measures on the provider side nor financial incentives on the user side seem to be effective in bringing about improvements in service outcomes. Inconclusive as they may be, these findings suggest the significance of desire and capacity on the user side as determinants of service utilization and outcome.

The GMR2011 makes a cursory mention of the role of service users when it states that it is important to ensure that "potential clients have the ability and desire to use services efficiently and hold service providers accountable for quality" (World Bank 2011, 72). It places, however, particular emphasis on the latter role of service users, or incentive and accountability issues associated with the lack of effective governance mechanisms on the behavior of front-line service providers, by making reference to the analytical framework presented in the *World Development Report (WDR) 2004* (World Bank 2003), while virtually disregarding the former (i.e., "ability and desire to use services efficiently" on the part of potential users).

Conspicuously absent from the review and discussion of service provision in developing countries in GMR2011, and in WDR2004 for that matter, is any attention to attempts to increase the role of service users in the process of production of services, and thus change supply side-dominated nature of service provision. Such attempts represent a non-conventional

approach, commonly called a "User-Centered Approach (UCA)," for the improvement of the quality and well-being outcomes of services. [2]

With this overall assessment of the service quality and outcome question as a backdrop, this paper has a narrowly limited purpose of examining some of the proposals and experiences in the UCA to service provision. Specifically, we take up two models of UCA in which service users make significant contributions in the process of production of services[3]: the first being "service co-production," which involves users in the process of service production. In this model, service users are viewed as active participants and partners in the production of services. JICA's promotion of a Child-Centered Approach (CCA) in education, and WHO's advocacy of People-Centered Primary Care (PCPC) in public health are important examples of this model used in developing countries. It is also the central philosophical pillar of the on-going reform of public services in the United Kingdom; and the second model that emphasizes self-management as a stronger case of UCA. Its application is most prominent in the domains of the care of chronic diseases, such as the *Improving Chronic Illness Care* (ICIC) program, and of social work, such as the *Nurse-Family Partnership (NFP)* program and the *Chile Solidario* (CHS) program.

In this paper we address the question of the quality and well-being outcomes of services, paying particular attention to the principles and experiences of these two models of UCA, with a view to identifying their rationales, accomplishments and limitations. The co-production model deals with communications and collaborations in the process of service transactions. By contrast, the self-management model, taken singly, focuses on the service user as central provider of the service. In reality, however, most cases self-management are prompted, guided and supported by

[2] One model of UCA works at the upstream, or design and decision-making stages, of the supply of services, and tries to have user demands and desires reflected therein. Community-Driven Development (CDD) and Community-Based Management of Schools (CBMS) are examples of this model. This model is relatively well-documented and covered in the review and evaluation reported in both GMR2011 and WDR2004.

[3] WDR2004 does refer to service users as "co-producers," but only in the role of monitors of the actions of service providers.

professional service providers like doctors and nurses, thus constituting a component of the co-production model as broadly defined.

As a philosophy and principle, both of the UCA models discussed in this paper, with the potential of being humanistic and efficacious at the same time, are to be recommended. In the policy domain, co-production of public services constitutes one of the central pillars of the reform of the public sector in some European countries, most notably the United Kingdom.

On the academic front too, Elinor Ostrom has made an important call in relation to the crucial role of co-production in service provision in developing countries:

> "[C]oproduction of many goods and services normally considered to be public goods by government agencies and citizens organized into polycentric systems is crucial for achieving higher levels of welfare in developing countries, particularly for those who are poor. Prior efforts directed at improving the training and capacity of public officials have frequently had disappointing results. Efforts directed at increasing citizen "participation" in petitioning others to provide goods for them have also proved disappointing. Efforts directed at increasing the potential complementarities between official and citizen production or problem-solving activities may require more time at the initial stage of a process, but promise a much higher, long-term return" (Ostrom 1996, 1083).

Ostrom documents the case of low-cost waterborne sanitation systems in Brazil as a case of the effective co-production of public services.[4]

Increased attention to the role of service users entails better understanding of the user-side conditions impinging on the production and utilization of services, and their resulting impacts on activities of daily living. Eligibility to receive, and the availability of services, are conditions set by the supply side and do not, in and of themselves, guarantee the accessibility to and uptake/utilization of services by (potential) users. User-side conditions are multifaceted, ranging from physical to psychological, from technical to behavioral, and from individual to

[4] In the present paper our main attention is on those types of services where direct interactions between providers and users are involved in service transactions. Cases of infrastructural services are not covered. Incidentally, Ostrom's case of sanitation service co-production incorporates self-management on the part of service users as one component.

relational. We address this conundrum in the latter part of the paper when focusing on the psychological, behavioral and relational aspects of the activities of daily life of service users.

Discussion of the co-production model centers on the interactions between service users and providers. There are two contexts in which user-provider interactions are involved. One is of general relevance, and refers to the increased and indispensable role of users in service transaction processes. The second consists of psycho-social support for the enhancement of psychological, behavioral and relational (pre)conditions for effective participation of users in service transactions and the utilization of services. Process and activity in this second context is commonly referred to as the "empowerment" of service users. When empowerment is attempted, there are two different settings: in the first case, empowerment is effected simultaneously within the context of service transactions; in the second case, empowerment is conducted as a separate stage prior to the initiation of the service transaction. In terms of agency on the service user's part, the first case may be conceived as activation of the existing stock of agency, while the second can be seen as augmentation of the stock of agency. In the first case, the provision of psycho-social support is of a short-term, catalytic nature. In the second case, by contrast, psycho-social support is of a long-term, transformative nature.

The above discussion on empowerment is equally relevant to the self-management model. The only distinction might be found in the following point: while the directly relevant type of empowerment for the co-production model is "relational empowerment," the most important type for the self-management model is "personal empowerment," as discussed in Section 4. It is also to be noted that psycho-social support is an extremely transaction-intensive type of service with heavy counseling characteristics. Thus, to be effective, psycho-social support itself may also need to be conducted in a co-productive manner.

## 2. Analytical framework, conceptual articulation, and conjectures

In this section, we first present an analytical framework for service transactions, followed by an articulation and elaboration of the key concepts employed to classify services into four distinct types. Particular attention is paid to "practice"-type services, and conjectures are put forth regarding possible failures in the provision of that form of service. Secondly, we propose another set of conceptual-analytical schemes for the understanding of the place and role of agency on the part of service users in the transaction and utilization of services.

### 2.1 Analytical framework on supply-uptake links

The GMR 2011 (World Bank 2011) proposes an analytical framework that can be applied to the question of the disconnect between spending and outcomes. It argues that the causal chain that links public spending to changes in outcomes needs to be understood through a focus on the behaviors of agents involved, most importantly front-line service providers and service users, and on variables influencing these, such as capacity, resources, information, incentives and accountability. This position is informed by insights gained fromNew Institutional Economics, and highlighted by the World Bank (2003). The main features of this analytical framework may be summarized as follows.

The links between public expenditure and outcomes (in terms of increased well-being) are stylized as:

1) Public financial, physical and human resources → 2) Generation of goods and services → 3) Uptake of goods and services → 4) Well-being outcomes.

The first link (i.e., components 1 and 2 as well as the arrow connecting them) represents supply-side factors and processes, including policy decisions and the administrative realities of the organizations involved. The availability of resources, the resource allocation and deployment

decisions made, and effectiveness of governance of administrative behavior are important elements on the supply side. The second link (components 2 and 3 and the arrow connecting them) incorporates the behaviors of, and interactions between, front-line service providers and users in specific contexts of service transaction. Here, capacities, constraints, attitudes and motivations on the part of providers and users, as well as any incentives faced by them, are important determining factors of how services are delivered and received. The third and final link (components 3 and 4 and the arrow connecting them) represents user-side factors and processes, and is importantly affected by the conditions, attitudes and behaviors of service users in the context of their daily life. This link has traditionally received much less attention than the first two.

The present paper addresses some of the important factors impinging on service delivery and uptake from micro and system analytic angles, building on the foundational contributions made by Pritchett and Woolcock (2004): first, a conceptual articulation based on a two-way classification of types of services according to degrees of discretion and transaction-intensity and secondly, hypotheses on the mechanisms of systemic and persistent implementation failures (Pritchett, Woolcock and Andrews 2010). We pay significant attention to the second and third links, highlighting the importance of user-side factors and conditions for effective uptake and utilization of services.

### 2.2 Conceptual articulation and classification of services

Services may be classified into four types, based on a two-by-two framework according to degrees of discretion and transaction-intensity. The labels and characteristics of those four types are as indicated in Table 1 (Pritchett and Woolcock 2004, 194-5). In Table 2 we provide an illustration of the four types of services from the education and health fields. “Transaction intensity” refers to the extent to which the delivery of a service (or an element of a service)

requires purposive actions on the part of service providers, oftentimes involving some face-to-face contact. Services are "discretionary" to the extent that their delivery requires decisions by providers to be made on the basis of information that is inherently imperfectly specified and incomplete, thereby rendering them unable to be standardized. As such, these decisions usually entail professional (gained via training and/or experience) or informal context-specific knowledge. Discretionary decisions are taken within the process of service delivery; the right decision depends on conditions that are difficult to assess (*ex ante* or *ex post*), and hence it is very difficult to monitor and determine whether or not the right decision has been made.

It is important to distinguish clearly these different modes of services and understand their distinctive characteristics and challenges for effective delivery: "policies" are primarily technocratic; "programs" are primarily bureaucratic; and "practices" are primarily idiosyncratic. The primary challenges for "programs" are technical (finding an effective and least-cost solution) and logistical (carrying out the mandated actions reliably). In contrast, the provision of those elements of services which are discretionary and transaction-intensive ''practices'' poses inherent difficulties for public administration, because they are intrinsically incompatible with the logic and mechanism of large-scale, routinized, administrative control. Large organizations, by nature and design, are essentially constrained to operate exclusively in terms of "policies" and/or "programs," and are not able to manage "practices" effectively.

We accept and adopt the definition and characterization of the distinctive natures of the four types of services proposed by Pritchett and Woolcock (2004). However, we find it necessary to apply a number of comments for further articulation of their definition and characterization. Our comments relate to both "transaction intensity" and "discretion:"

*Transaction intensity* refers to the extent to which the delivery of a service requires interactive transactions, nearly always involving some face-to-face contact:

Comment #1: There are distinct differences in required degrees of interaction in service transactions between "practice" and "program."

Comment #2: Interactive transactions entail ability and willingness to engage on the part of both providers and users of services.

*Discretionary decisions* are taken in the process of service delivery and uptake; the right decision depends on conditions that are difficult to observe or assess (*ex ante* or *ex post*), and hence it is very difficult to monitor and determine whether or not the right decision was taken:"

Comment #3: There is room for front-line service providers to reduce "interactive transactions" by standardizing and routinizing transactions (i.e., turning "practice" into "program") in an attempt to minimize transaction intensity (and thus levels of time/psychic costs entailed).

Comment #4: There is room for service users to reduce "transaction intensity" in the interactive process of service transactions. Users also could use discretion in utilization of services proffered (as in failure to adhere to instructions and prescriptions).

**2.3 Conjectures on two types of failures in service provision**

Discretionary and transaction-intensive services have the characteristics of being interactive, collaborative and co-productive, and these features apply not only to service providers but to users as well. Thus, not only teachers (clinicians) but also students (patients) need to be meaningfully engaged in the transactions for a higher quality of services, and well-being outcomes, to be achieved. As a consequence, there are two types of failures related to the generation and uptake of discretionary and transaction-intensive services:

Type 1: Opportunistic behaviors on the part of front-line service providers and service users toward minimization of transaction-intensity.

Type 2: Idealistic pursuit of the maximization of transaction-intensity on the part of policymakers and aid agencies.

Type 1 failures in "practices" take the form of the minimization of transaction intensity. Front-line service providers (teachers and clinicians) may not be able (or willing) to achieve the stipulated modes and levels of transaction-intensity, with a consequent deterioration in the quality of service, as the discretionary nature of the engagement may allow them to disregard required standards. This is observed in education in monotonous lecturing, and in health care as routinized diagnosis and prescription. Similarly, service users may not be able (or willing) to achieve the stipulated modes and levels of transaction-intensity; in effect they may not be sufficiently attentive or responsive in classrooms or clinics.

Type 2 failures in "practices" may possibly arise from idealistic pursuits of the maximization of transaction-intensity. Trying to realize stipulated engagement from users may excessively heighten the demand for transaction-intensity on the part of service providers, resulting in persistent implementation failures. This concern seems to be particularly pertinent in the assessment of feasibility and effectiveness of the user-centered approach.

In parallel with the above-stated failures in service transactions, there may also be failures (on the part of service users) in self-management of the services proffered, as mentioned in Comment #4 above.

**2.4 Definition and articulation of agency and motivation**

In discussing the effectiveness of the UCA models (co-production and self-management), it is essential that we have a systematic understanding of the subjective and objective conditions of

the (potential) users of services. Among the important subjective conditions are agency and the motivation of the user with regard to the transaction and utilization of services. Here we propose working definitions for two terms, agency and motivation, their conceptual clarification and articulation, and an analytical framework for the understanding of the relationship between them.

In this paper, agency is defined as "disposition and capacity inherent in an individual for self-determination and self-management." It is postulated as a latent potentiality and something generic, with a potential for application in a wide range of contexts and activities. By contrast, motivation is defined to be "a factor or process by which agency is activated in a specific context or activity." Here, it is important to distinguish between "agency in existence (AE)" and "agency activated (AA)." We postulate that AE, which is latent, is activated and realized up to the level of AA, to the extent that an individual is "motivated" to direct and exert AE to carry out a specific activity. The level of AA exhibited in a certain activity is thus a function of the level of AE and the intensity of motivation to be involved in the activity in question. The level of AE at any point in time, on the other hand, is determined by the following three factors: the initial level of AE, the level of AA over time, and external influences affecting the level of AE.

The conceptualization of latent and activated agency, as well as the functional relationship between them, may be viewed as being analogous to that of potential and actual power generated by an engine. Engines are built to generate a certain maximum level of power. But the actual power generated by an engine will be determined by the rate at which fuel is supplied to it. In the extreme case of no fuel supply, the actual level of power generation will be zero. Similarly, the function tracing the trajectory of the level of latent agency can also be understood by analogy with an engine. There may be decay in capacity with a passage of time, wear and tear from use, but also the restorative effects of tune-ups. Interestingly, in the case of agency, there might not be any decay in AE with the passage of time, and its use as expressed in the term AA might exert a positive effect on AE if, as is imaginable, the exercise of agency leads

to an enhanced state of agency rather than a depleted state. For the third term, influences and support provided from outside will be the functional equivalents of tune-ups in the case of an engine.

### 2.5 Typology of user-provider relations and user agency in service transaction and utilization

In the context of service transaction and utilization, both the level of the existing stock of agency and the intensity of motivation for its activation in the specific context or activity of the service in question are relevant. In terms of immediate action, what matters is that the intensity of motivation as the level of the existing stock of agency is given and unalterable at a point in time. Over time, however, the level of the stock of agency can be augmented. In discussing the role of agency in service transaction and utilization, an additional scheme of classification of services is in order. Unlike the previous classification scheme, this one places direct focus on different modes of interactions between the users and providers of services, with particular attention to the subjective condition of the service user (Table 3). We propose a four-way classification of the user-provider relationship: "(user-driven) service delivery," "consulting" services, "counseling" services, and "pre-counseling" services.

In some cases, the user clearly identifies the service that is wanted, and is capable of conveying this to the provider as "demand." The provider responds to the demand and delivers. These cases may be classified as "(user-driven) service delivery." In some other cases, the user has broad idea as to what is wanted but needs to consult with the provider on the appropriate specification of the services to be provided to meet this desire. In such cases, provision of service will contain elements of "(technical) consulting" in the process of reaching an "informed decision." In yet other cases, the user may desire to change the situation but may not be clear as to what service they want. In such cases, the service will take on the nature of "(psycho-social) counseling," consisting of clarifying the situation, identifying possible solutions, accompanying

and providing moral support throughout the process of mental and behavioral changes. In all cases discussed so far, the service user has ability and willingness to engage in service transactions. But in some other cases that might not apply, and the provider side might operate proactive "outreach" activities so that potential users of the service are contacted and brought into service transactions, oftentimes of the counseling type.

It should be recalled that user-provider relations are characterized not only by differing levels of transaction intensity, but also by varied degrees of discretion on both sides. Transaction intensity entails sustained attention, judgment and communication, all of which demand the exercise of cognitive resources. Discretionary services allow room for reducing transaction intensity. Discretion refers to the condition of service transaction and/or utilization in which effort level realized is left to the person in question. When services are discretionary, there is room for reduced intensity in transaction and/or self-management, thus undermining the quality and outcome of the service. Focusing our attention on the user side, the ability and willingness on the part of (potential) users to engage in service transactions is determined by the activated level of agency. In the short term, with the level of potential agency given, it is a matter of motivation; in the long term, however, it is a matter of agency development, or a change in the level of potential agency. The same considerations apply to self-management in the utilization of services on the part of the service user.

These different types of user-provider relations are associated with varying degrees of transaction intensity, and discretion on the part of both front-line service providers and service users (Table 4). In the case of "(user-driven) service delivery," interactions between service users and providers tend to be highly standardized and pre-programed and involve low levels of transaction intensity and discretion.

Both "consulting" and "counseling" services constitute instances of service co-production insofar as they involve the user and the provider in close communication and collaboration. They also have aspects of self-management on the part of the service user to the

extent co-produced services need to be implemented and internalized into the user's routine activities. There seems, however, to be a difference in degree between "consulting" and "counseling" in the levels of transaction intensity and discretion on the part of both service user and provider.

While in "consulting services" the nature of communication and decision is technical and functional, in "counseling services" it is psycho-social and involves personal relationship between the service user (client) and provider (counselor) as the essential constituent of interactions between them. As such, "counseling services" almost inevitably involve emotions and subconscious factors. That, it is presumed, makes "counseling services" more transaction-intensive and discretionary than "consulting services." Discretion on the part of the client seems to be of particular significance for "counseling service"; in some extreme cases, the client may not show up for an appointment, and when they do they may not engage in conversation with the counselor.

In fact, this is precisely the condition that characterizes the attitude and behavior of potential service users in the state of "self-exclusion" from communication and activity. In such cases, for counseling processes to be initiated, the provider side needs to engage in outreach in a proactive mode. This typically involves sustained attempts at contact and communication on the part of the front-line service providers like social workers or health workers. To that extent and in that manner the pre-counseling outreach" will be transaction-intensive on the part of the provider, if not on the potential user's part. It might also be discretionary when there is no meaningful feedback from the potential user.

From the perspective of user agency (UA), the following characterization for each type of user-provider relations will be in order (Table 5): in "(user-driven) service delivery" UA is manifested as desire for solutions and self-determination of services to be demanded for delivery; in "consulting service" UA is less complete and takes the form of desire for solutions and informed consent to proposals worked out by the consultant; in "counseling services" UA is

even less complete and takes on more fuzzy tones that are generally expressed as a vague desire for the resolution of a problematic situation coupled with willingness, more or less, to engage with the counselor; and finally in "pre-counseling outreach" UA takes on a negative appearance and manifests itself in the act of "self-exclusion" from communication and activity.

The UCA models thus entail certain levels of activated agency on the part of service users in the context of service transactions. Activation of agency is mediated by motivation for the engagement in question. In some cases, this prerequisite for the UCA model may not be met in the short term, and there might be need for preceding, preparatory process of agency development.

## 3. Proposals and experiences in relation to the User-Centered Approach (UCA) to service provision

Two models of User-Centered Approach (UCA) to service provision - co-production and self-management - have been proposed and practiced in recent decades. Co-production and self-management both point to the desirability of an increased role for service users in the processes of transaction-intensive services when attempting to achieve an improved quality, a better outcome, and a higher level of satisfaction from the services. Here we review in a summarized fashion some of the representative initiatives and practices of these two models of UCA, with particular attention to the need and support for empowerment. Co-production and self-management are conceptually distinct models, but in practice they are often applied in combination. We cover various modes of such combinations in our review of some general propositions, and of important cases of social work.

### 3.1 General propositions

Here we review some general propositions in the form of proposals for and summaries of experience of the UCA to service provision.

***Co-production in public services (UK Government)***

Unlike goods, which can be pre-fabricated, services are generated and received simultaneously in the process of transactions. Therefore, there are bound to be elements of co-production in the realization of service transactions. Going beyond this generality, proponents of co-production emphasizes the importance of expanding and legitimizing the role of service users and thus establishing collaborative partnership between equals. The central question here is whether the providers and users of a service are able and willing to engage actively in the process of transactions as expected in the co-production model. It is precisely for that reason that provider re-training and user empowerment is proposed in the context of the co-production model.

To date, the most comprehensive advocacy of the co-production model, and the UCA for that matter, is found in a report to the UK government on co-production in public services (Horne and Shirley 2009). In this report, co-production of services is defined as "a partnership between citizens and public services to achieve a valued outcome." It is argued that "partnerships empower citizens to contribute more of their own resources and have greater control over service decisions and resources" (Horne and Shirley 2009, 3). With regard to the importance of co-production, the report states that "co-production should be central to the Government's agenda for improving public services because of emerging evidence of its impact on outcomes and value of [sic] money, its potential economic and social value and its popularity," proposing that co-production in public services be accelerated through such approaches and measures as "more control passed down to individual users and front-line professionals, support for civic society and mutual help, and professional training and culture," among others (Horne and Shirley 2009, 3). At the same time, the report duly acknowledges the scope of its appropriate application when it states that the greatest potential benefits are in 'relational' services such as early years' education, long-term health conditions, adult social care and mental health, rather than in episodic services (Horne and Shirley 2009, 5).

In the co-production model, service users are viewed as being able, and are expected, to contribute their own resources in the form of:

- Knowledge, understanding, skill and expertise;
- Time, energy and effort;
- Will power and personal agency;
- Motivations and aspirations; and
- Social relationships within families and communities (Horne and Shirley 2009, 3, 9).

In the 1980s, Warren et al. (1982, as cited in Pestoff 2006, 507), among others, claimed that co-production can lead to expanded opportunities for citizens to participate, higher service quality and cost reductions, thus opening an avenue for the enhanced quantity and quality of public services. In this regard, Catherine Needham, a noted British scholar on public sector management, has identified three advantages of co-production over traditional bureau-professional models of service provision (Needham 2007, 222-3). Firstly, co-production emphasizes the importance of frontline interactions, secondly, it can transform citizen attitudes in ways that improve service quality, with the emphasis on user agency and empowerment facilitating the creation of more involved, responsible users, and thirdly, with user inputs into the productive process, frontline providers and their managers can become more sensitive to user needs and preferences, and better tailor services to them, improving the relevance, effectiveness and efficiency of service provision.[5]

There are challenges as well. Co-production demands mutual readjustment on both providers and users of services. We will return to this issue in some specific contexts below.

[5] Durose et al (2014), while stating that there is some evidence that co-production may lead to better quality service provision, cautions that there are inherent difficulties in applying standard evaluation methodology based on outcome indicators to co-production practices. There are emotional and reflexive elements involved in service transactions. Co-production is described as a process through which the emotional knowledge of users, such as the experience of having a particular disease, is taken into account. It is relational aspects of care that patients prioritize (respect, dignity, being treated as an individual) and these intangibles are hard to pin down in quality indicators.

***People-centered primary care (WHO)***

The World Health Organization (WHO) called for a switch to "people-centered primary care" in its flagship publication *World Health Report 2008* (WHR2008) featuring primary health care (WHO 2008). People-centered primary care was characterized in this report, in contrast with conventional medical care, as being "focused on health needs" as against on illness and cure, "continuous personal relationships" as against episodic encounters, and on "partnership in health management" as against subjugation and passivity (WHO 2008, Table 3.1, 43).

According to the WHR2008 report, in conventional medical care, clinicians rarely address their patients' concerns, beliefs and understanding of illness, and seldom share problem management options with them. They limit themselves to simple technical prescriptions, ignoring the complex human dimensions that are critical to the appropriateness and effectiveness of the care they provide. Thus, technical advice on lifestyles, treatment schedules, or referrals, all too often neglects not only the constraints of the environment in which people live, but also their potential for self-help in dealing with a host of health problems (WHO 2008, 46).

There has been progress in recent years, more notably in high-income countries. Confrontation with chronic disease, mental health problems, multi-morbidity, and the social dimension of disease has focused attention on the need for more comprehensive and people-centered approaches and continuity of care. This has resulted not only from client pressure, but also from those professionals who have realized the critical importance of such features of care in achieving better outcomes for their patients (WHO 2008, 45-46). A considerable body of research evidence has shown that people-centered primary care measurably improves the quality of care, the success of treatment and the quality of life of those benefiting from such care (WHO 2008, Table 3.2, 47).

There remain challenges, however. Few health providers have been trained for people-centered care. Lack of proper preparation is compounded by cross-cultural conflicts, social stratification, discrimination and stigma. As a consequence, the considerable potential of

people to contribute to their own health through lifestyle modifications, behavioral changes, and self-care, and by adapting professional advice optimally to their life circumstances is underutilized. There are numerous, albeit often missed, opportunities to empower people to participate in decisions that affect their own health and that of their families (WHO 2008, Box 3.4, 48).

***Improving Chronic Illness Care Programs (Robert Wood Johnson Foundation)***[6]

The Improving *Chronic Illness Care* (ICIC) Program was initiated in 1998 by the Robert Wood Johnson Foundation, a US philanthropy with strong interest in the improvement of health care practice, with a view to addressing the problem of treatment of patients with ongoing, incurable illness. The ICIC Program endorsed and helped propagate the *Chronic Care Model* (CCM) proposed by Dr. Edward Wagner. The CCM is designed to help facilities improve patients' health outcomes by changing the routine delivery of ambulatory care through six interrelated system changes meant to make patient-centered, evidence-based care easier to accomplish. The aim of the CCM is to transform daily care for patients with chronic illnesses from being acute, reactive and episodic, to planned, proactive and population-based. It is designed to accomplish these goals through a combination of the following measures: effective team care and planned interactions; self-management support bolstered by more effective use of community resources; decision support integrating medical and psycho-social considerations; and patient registries and other supportive information technology. These elements are designed to work together to strengthen the provider-patient relationship and improve health outcomes (Coleman et al. 2009).

A Rand Corporation study examined fifty-one organizations, posing the following two questions: first, can practices implement the CCM? and secondly, if they can, will their patients benefit? (Cretin et al. 2004) The study's summary propositions read as follows: On the first question, intervention practices were able to implement the CCM, making an average of

[6] This section draws on information provided on the homepage of the Robert Wood Johnson Foundation (RWJF), http://www.rwjf.org/en/our-work.html (accessed November 4, 2014).

forty-eight practice changes across all six CCM elements. Three-fourths of practices had sustained these changes one year later, and about the same proportion had spread the CCM to new sites or conditions. On the second question, the patients of intervention practices had received improved care compared to patients in control practices, as reflected in knowledge level, increased uptake of recommended therapies, fewer days in the hospital, fewer visits to the emergency department, and an improved quality of life.

However, the real-world implementation and sustenance of the CCM in busy practices is not without challenges. The typical primary care situation in the United States as of the ear1y 1990s was described by Dr. Edward Wagner as follows (Wielawski 2006, 5):

- The typical primary care office is set up to respond to acute illness rather than to anticipate and respond proactively to patients' needs, and is therefore unable to meet the needs of chronically ill patients in order to avoid acute episodes of illness and debilitating complications;
- Chronically ill patients are not sufficiently informed about their conditions, nor are they supported in self-care beyond the doctor's office; and
- Physicians are too busy to educate and support chronically ill patients to the degree necessary to keep them healthy.

This might well be the typical condition in many developing counties at present.

In the process of introducing the CCM in the United States, there have been many obstacles for individuals and organizations in seeking to change long-standing ways of practicing medicine. Physicians are not immediately comfortable with transferring clinical responsibilities to colleagues traditionally viewed as subordinates. The chronic care model's emphasis on clinical teamwork thus challenges medicine's traditional hierarchy, forcing recognition of other health care professionals as equal or superior to physicians in certain patient

care tasks. Neither do patients necessarily jump at the chance to become collaborators and self-managers after years of following doctors' orders (Wielawski 2006, 8).

### 3.2 Case Studies

***Nurse-Family Partnerships***[7]

The Nurse-Family Partnership (NFP) program constitutes an important case of co-production and self-management. The program was developed in the United States, where it has been rigorously tested over the course of 35 years. In NFP, trained nurses visit first-time young mothers 64 times over a 30-month period covering six months of pregnancy before the birth of a child, and the first two years of the child's life. The program focuses on low-income, first-time mothers - a vulnerable population segment that sometimes has limited access to good parenting information or role-models. When a young woman becomes pregnant before she is ready to take care of a child, the risk factors for the entire family escalate, often resulting in dysfunctional family life. The transition to motherhood can be particularly challenging for many low-income, first-time mothers, since many are socially isolated or are experiencing severe adversity in their everyday lives. An early intervention during pregnancy will allow for any critical behavioral changes needed to improve the health and welfare of the mother and child in this situation.

The NFP program is informed by the following four philosophical standpoints:

- **Client-Centered**: the nurse is constantly adapting to ensure that the visit and materials are relevant and valued by the parent. The goals and aspirations of the nurse and family are aligned and a sense of responsibility is established in the client, along with a clear structure and understanding of what the program entails;

[7] This section draws on information provided on the homepage of the Nurse-Family Partnership (NFP), http://www.nursefamilypartnership.org/ (accessed November 4, 2014).

- **Relational**: the relationship between the nurse and the client is the fundamental basis for learning and growth in each family served, with intimacy and continuity building trust. The nurse provides care and guidance for mothers and family members to help them deal with stress and anxiety;
- **Strengths-Based**: the intervention is based on adult learning and behavior change theory. Adults and adolescents make changes most successfully when they are building on their own knowledge, strengths and successes. Building on the person's strengths and previous successes leads to improved self-efficacy;
- **Multi-Dimensional**: the life of each program participant is viewed holistically, and what the program offers is tied to multiple aspects of personal and family functioning. Personal and environmental health, parenting, life course development, relationships with family and friends, and community connections are some of those aspects.

In accordance with the above-mentioned philosophical perspectives, the NFP model is expressed in terms of 18 elements covering principles and operational guidelines. Among them the following are of particular interest (underlines added):

- A Client participates voluntarily in the Nurse-Family Partnership program (Element 1);
- A Client is visited one-to-one, one nurse home visitor to one first-time mother or family (Element 5);
- A Client is visited in her home (Element 6);
- Nurse home visitors, using professional knowledge, judgment, and skill, apply the Nurse-Family Partnership visit guidelines, individualizing them to the strengths and challenges of each family and apportioning time across defined program domains (Element 10);

- Nurse home visitors apply the theoretical framework that underpins the program, emphasizing self-efficacy, human ecology, and attachment theories, through current clinical methods (Element 11);
- A full-time nurse home visitor carries a caseload of no more than 25 active clients (Element 12);
- A full-time nurse supervisor provides supervision to no more than eight individual nurse home visitors (Element 13);
- Nurse supervisors provide nurse home visitors clinical supervision with reflection, demonstrate integration of the theories, and facilitate professional development essential to the nurse home visitor role through specific supervisory activities including one-to-one clinical supervision, case conferences, team meetings, and field supervision (Element 14).

The NFP is designed to achieve the following three goals by means of home-visitor nurses offering a combination of technical advice and practical support (on breastfeeding, child development and childhood illnesses), coaching in life skills, and addressing psychological issues:

- Improve pregnancy outcomes by helping mothers engage in good preventive health and prenatal practices, including getting appropriate prenatal care from healthcare providers, improving their diet, and reducing their use of cigarettes, alcohol, and illegal substances. Nurses also help the mother prepare emotionally for the arrival of the baby by educating her on the birth process and the immediate challenges of the first few weeks after delivery (e.g., breastfeeding and potential post-partum depression);

- Improve child health and development by providing individualized parent education and coaching aimed at increasing awareness of specific child development milestones and behaviors, and encouraging parents to use praise and other nonviolent techniques;
- Improve the economic self-sufficiency of the family through life coaching, i.e., helping parents develop a vision for their own future, plan future pregnancies, continue their education, and find work.

The effectiveness of the NFP interventions has been rigorously demonstrated.[8] Three well-conducted randomized controlled trials were carried out, each in a different population and setting. The specific effects that were replicated, with no countervailing findings, in two or more of the trials – and thus are the most likely to be reproducible in a program replication – are: (i) reduction in measures of child abuse and neglect (including injuries and accidents); (ii) reduction in mothers' subsequent births during their late teens and early twenties; (iii) reduction in prenatal smoking among mothers who smoked at the start of the study; and (iv) improvement in cognitive and/or academic outcomes for children born to mothers with low psychological resources (i.e., intelligence, mental health, self-confidence). It is also important to recall that the three trials all found that the program produced sizable, sustained effects on important mother and child outcomes, which provides confidence that this program would be effective if faithfully replicated in other, similar populations and settings.

***Chile Solidario***[9]

The *Chile Solidario* (CHS) program, first introduced in 2002 and gradually phased in over time, is an important poverty program which targets indigent families. It attempts to lift families out of

[8] The Top Tier Initiative's Expert Panel has identified NFP intervention as *Top Tier,* meeting the Congressional Top Tier Evidence standard, defined as: *Interventions shown in well-designed and implemented randomized controlled trials, preferably conducted in typical community settings, to produce sizable, sustained benefits to participants and/or society.* See Coalition for Evidence Based Policy, http://toptierevidence.org/programs-reviewed/interventions-for-children-age-0-6/nurse-family-partnership (accessed September 24, 2014).

[9] This section draws heavily on Carneiro et al (2009).

poverty through a coordinated set of stimuli to the demand and supply of social services, and the provision of psycho-social support to families. The population which is most in need of these programs is usually at the margins of society, being hard to reach and hard to change. The stimulus to demand is achieved through visits of social workers to poor families; informing, encouraging and helping them to apply to the network of available services they are entitled to. On the supply side, different government agencies and local providers of social services coordinate the assessment of the needs of each municipality and the provision of an adequate supply of services so that programs are channeled and tailored to the neediest population within each municipality. The program also includes a cash transfer component, relatively small in size, which aims at compensating participating households for the transaction costs incurred when connecting to social programs.

The *Chile Solidario* (CHS) program consists of four components:

- An intensive phase of psycho-social support (Puente Program) implemented through the outreach activities by a local social worker to homes of target families. During these visits, the social worker works with the family to identify its main problems, and the steps they need to take to solve these, in the process raising awareness of available social services and stimulating their uptake. The program lasts for 24 months, with decreasing intensity, and provides for 21 visits on average. The multidimensional aspect of deprivation is operationalized in terms of defining a set of minimal critical conditions, which aim at measuring a minimally acceptable level of well-being along different dimensions (identification/legal documentation, family dynamics, education, health, housing, employment, and income). Each family signs a contract with the social worker as indication of its commitment to put its effort in meeting those unmet priority conditions. The essence of this contract lies in the understanding of mutual obligations: the government takes responsibility for supplying services and resources,

and the family commits to overcoming the problematic aspects of their lives, using the opportunities offered by the government.

- Cash transfers conditional on the family meeting the contract (that is in principle, but in practice given to every family). The transfer lasts for 24 months and the amount declines over time. The transfer is uniform across families, and it is meant to be a compensation for the transaction costs that households incur when connecting to the supply side of services within their respective municipalities (learning about the eligibility and program rules of various programs, and the processing costs associated with the application process).
- Guaranteed subsidies, whereby families are guaranteed all subsidies they are entitled to. Until September 2004, families applying for subsidies through CHS were allocated to vacancies assigned to the municipalities of residence, and had to compete with non-CHS families. Over time, the constraint on the vacancies on these cash subsidies has been relaxed, so that all eligible families that apply for the subsidy are automatically enrolled as recipients.
- Preferential access to social services. Even with a given local supply of services, the program has made these available to the CHS population with preferential access, in the sense of providing priority access to the existing supply, should they chose to activate their demand for the services. The concept of preferential access is a crucial factor in the logic of the program, as the target population is made "visible" to the local municipalities. The supply side component aims at ensuring coordination among different social programs and public services at the national and municipal level. Public programs and services were previously available for eligible households only upon demand. CHS works directly with municipalities, which are the local providers of public services, and with national programs, to make sure that the supply side is adequately organized to meet the needs of specific target populations, and any newly

identified demand. These supply-side efforts aim at making sure that the services are pertinent to the needs of these families, which could go as far as inducing changes in design, outreach strategies, or even the organization of new types of programs.

The main result of the CHS program is that it increased the uptake of subsidies and of the employment programs. The main channel driving significant effects in employment, income, and indigence comes from the activation of the labor force of the spouse in bi-parental families. This result is noteworthy in a country with an exceptionally low female labor force participation. The spouse employment effects (and with them the income and poverty alleviation effects) are concentrated among rural households, and in families with a lower educational attainment of the head. There is suggestive evidence that the subgroups that have received the employment programs are more likely to show a positive employment effect.[10]

Families have in this way established access to the public service system, and receive public services assisted and supported by social workers. Insofar as the experience of dealing with officials and receiving responses is positive, families will also be motivated to repeat the service transactions. This will particularly be the case when they perceive that they receive preferential treatment from the government.

The impacts of CHS vary across families with different characteristics and who are located in different municipalities. For example, the impact of the program on the uptake of subsidies is larger in municipalities with a better network of social services, for families served by social workers with relatively low caseloads, and in male-headed families. Similarly, the impact of the program on employment of a spouse is larger in rural areas, and for families served

[10] Set against these positive gains of housewives, it was not possible to detect any positive impacts of CHS on the employment or income of heads of families. While the scope for improvement for male heads has been very small (as the totality of male-headed families had been already working in the absence of the program), the lack of results for female-headed households is important to document, as they represent a sizable vulnerable group within the target population. Employment response and income generation is more difficult for them, as they face more time constraints when combining family responsibilities and work commitments, and have a lower ability to diversify income sources and insure themselves against shocks.

by social workers with a relatively low caseload. Social workers are instrumental in bringing families into contact with public services. Their roles involve not only the provision of information but psychological support through encouragement and accompaniment (Carneiro et al. 2009, 82).

## 4. Empowerment of (Potential) Service Users for partnership and self-management

The term "empowerment" has both broader and narrower referents; in some cases, it may focus on legal stipulation and institutional arrangements; in some other cases, it may refer to the process of enhancement of the technical capacity to conduct certain tasks; and in yet others, it may relate to internal change on the part of an individual, touching on the psychological and attitudinal state of that person. In this section we discuss the most relevant and important aspects and dimensions of empowerment in the context of this paper.

Psycho-social support for (potential) service users constitutes a central component in "counseling" services aiming for effective participation in service transactions and for self-management. Alongside this, there might also be a "consulting" service aimed at providing information and helping with a decision for the service user.

### 4.1 General propositions

One important question in the application of UCA is whether (potential) service users are able and willing to engage actively and positively in the process of service transactions as expected in the co-production model, and/or conduct their daily lives as expected in the self-management model. It is precisely for that reason that user empowerment is proposed in the context of UCA. As empowerment has various aspects and dimensions, it will be useful to clarify the usage of the term in this paper. We rely on Rowlands (1997) as the authoritative guide for our exploration.

Classification schemes on forms of "power" and for dimensions of "empowerment" proposed by Rowlands (1997) have been widely accepted and referred to in the literature. The

schemes relating to power are based on the following four forms of power, and the corresponding understanding of empowerment:

- **power over:** controlling power.
- **power to:** generative or productive power which creates new possibilities and actions.
- **power with:** a sense of the whole being greater than the sum of the individuals, especially when a group tackles problems together.
- **power from within:** the spiritual strength and uniqueness that resides in each one of us and makes us truly human. Its basis is self-acceptance and self-respect (Rowlands 1997, 13).

For the purpose of our paper the most relevant and important form of power is "power from within," which, we presume, essentially coincides with our notion of human agency as disposition and capacity for self-determination and self-management. Rowlands (1997) proposes a three-way classification scheme in relation to the dimensions of "empowerment":

- **personal:** developing a sense of self and individual confidence and capacity, and undoing the effects of internalized oppression.
- **relational:** developing the ability to negotiate and influence the nature of a relationship and the decisions made within it.
- **collective:** where individuals work together to achieve a more extensive impact than each could have had alone (Rowlands 1997,15).

For our purposes the first two dimensions of "empowerment" are more relevant than the third. In particular, we focus on the process of empowerment in relation to the "personal" dimension as an aspect of goal of human development, as a necessary condition for effective partnership in co-production and self-management, and as a necessary basis for empowerment on the other dimensions. In relation to our conceptual configuration, personal empowerment is viewed either "activation of (existing) agency" or "development of agency," depending on the

nature and duration of the process of change. Empowerment on the "relational" dimension is of particular significance in the context of engagement of service users in service transactions.

It is widely recognized that knowledge dissemination alone rarely generates behavioral changes, including those related to uptake and utilization of services. The act of uptake and utilization of services entails a certain degree of activation of agency. The knowledge of eligibility for and availability of services does not automatically translate into such action; accessibility of services for specific individuals and the manageability of the action of uptake and utilization may pose high hurdles that must be cleared before potential users convert themselves into actual users of services, even when these are desired. More fundamentally, services may not be desired to start with due to weak agency (i.e., insufficiency in disposition and capacity for self-determination and self-management).

In the next section, where we review specific cases of interventions for empowerment of (potential) service users, we discuss the nature, intensity and duration of intervention for activation or development of agency as key factor in personal and relational empowerment. Interventions vary in nature, intensity and duration depending on the goals they seek to achieve. For instance, a counseling service may be of short-term or long-term nature: it may aim to increase motivation and thus raise the level of activated agency through a small number of brief interventions; or it may be directed toward a heightened level of potential agency through continuous accompaniment throughout a gradual, cumulative process of internal change in the client.

### 4.2 Cases of interventions for agency activation and agency development

Intervention for empowerment consists of "consulting" (technical support through education and advice), and/or "counseling" (psycho-social support through accompaniment and encouragement). In some cases, intervention is carried out over a short period of time, with relatively more emphasis on consulting, to increase motivation for certain actions. In other cases,

by contrast, intervention continues over a long period of time, with relatively more emphasis on counseling. The former typically aims at motivation and thus activation of agency, while the latter is aimed at the development of agency. Interventions of both types need to be tailored to the conditions of the person attended to, but such considerations will be of higher significance in the case of agency development, as this involves more fundamental changes in strengthening self-esteem, self-control and self-efficacy, and enhancing expectations for positive changes in their lives.

### 4.2.1 Interventions for agency activation

Here we take up two important examples of intervention for agency activation. The first, a patient education program developed at Stanford University called the *Chronic Disease Self-Management Program* (CDSMP)**,** is essentially a form of consulting, offering information and providing technical training for self-management for people with chronic diseases. The second, *Motivational Interviewing* (MI), is in the nature of counseling, providing psychological support for increased motivation for change.

#### *The Chronic Disease Self-Management Program*[11]

The Chronic Disease Self-Management Program (CDSMP) is a short-term consulting cum counseling program offered for two and a half hours, once a week, for six weeks. People with different chronic health problems attend together in community settings such as senior and community centers, churches, libraries, senior housing, retirement communities and physician's offices. The workshops are facilitated by two trained leaders; one or both have a chronic condition. The six-week workshop covers techniques to deal with problems such as: frustration, fatigue, pain and isolation; appropriate exercise for maintaining and improving strength,

[11] This section draws on information from the homepage of the Chronic Disease Self-Management Program (CDSMP), http://patienteducation.stanford.edu/programs/cdsmp.html (accessed September 24, 2014).

flexibility and endurance; appropriate use of medications; communicating effectively with family, friends and health professionals; nutrition; and how to evaluate new treatments.

The details of the six-week workshop curriculum are as follows:

**Session One:**
 Principles of self-management
 Problems caused by chronic illness
 Difference between chronic disease and acute disease
 Common elements of various chronic health problems
 Causes of symptoms
 Introduction of self-management techniques
 Overview of "distraction skill"
 Introduction of action plans as a key self-management tool

**Session Two:**
 Problem-solving techniques
 Discussion and management of anger, fear and frustration
 Benefits of exercise; different types of exercise; choosing an appropriate fitness program
 Action planning

**Session Three:**
 Causes of shortness of breath
 Practice in better breathing techniques
 Introduction to progressive muscle relaxation
 Introduction to causes of pain and fatigue
 Introduction to pain and fatigue management techniques
 Development and monitoring of an endurance exercise program
 Action planning

**Session Four:**
 Overview of good nutrition and rationale for eating better
 Ways to change eating practices and make healthier eating choices
 Future plans for health care
 Techniques for improving communication
 Practice of problem-solving: helping self and others
 Action planning

**Session Five:**
 Medication management
 Differences between drug allergy and side effects
 Strategies to reduce side effects
 Overview of depression symptoms and means of managing minor depression
 Strategies to change negative thinking to positive thinking
 Action planning

**Session Six:**
 Communication skills useful for talking with physicians
 Participant identification of patient's role in care of chronic condition
 Making a plan to deal with future health problems

It is the process in which the CDSMP is taught that makes it effective. Sessions are highly participative, and mutual support and success build participants' confidence in their ability to manage their health and maintain active and fulfilling lives.

The CDSMP was designed on the basis of research at Stanford University, whose purpose was to develop and evaluate, through a randomized controlled trial, a community-based self-management program that could assist people with chronic illness. The CDSMP process design was based on the experience of investigators working on self-efficacy, the confidence that people have that they can master a new skill or affect their own health. The content of the workshop was the result of focus groups in which people with chronic health problems discussed which content areas were the most important for them. There are a number of assumptions that underlie the CDSMP:

- People with chronic conditions have similar concerns and problems.
- People with chronic conditions must deal not only with their disease(s), but also with the impact these have on their lives and emotions.
- Lay people with chronic conditions, when given a detailed leaders' manual, can teach the CDSMP as effectively, if not more effectively, as health professionals.
- The process or way the CDSMP is taught is as important, if not more important, as the workshop's subject matter.

About 1,000 people with heart disease, lung disease, stroke or arthritis participated in a randomized controlled test of the program, and were subsequently followed for up to three years. Changes were recorded in many areas: health status (disability, pain and physical discomfort, energy/fatigue, shortness of breath, health distress, self-rated general health, social/role limitations, depression, and psychological well-being/distress); health care utilization (visits to physicians, visits to emergency department, and hospital stays); self-efficacy (confidence to perform self-management behaviors, manage disease in general and achieve outcomes); and self-management behaviors (exercise, cognitive symptom management, mental stress management/relaxation, use of community resources, communication with physicians, and advance directives).

CDSMP has undergone extensive evaluation in several countries. The program has been proven effective across socioeconomic and education levels, and the health benefits persist over a two-year period even when disability worsens. CDSMP's health and utilization effects, compiled by the Centers for Disease Control and Prevention in partnership with the National Council on Aging, are summarized as follows: there is strong evidence that CDSMP has a beneficial effect on physical and emotional outcomes and health-related quality of life. When participant outcomes were evaluated at four months, six months, one year and two years, program participants, when compared to non-participants, demonstrated significant

improvements in exercise, cognitive symptom management, communication with physicians, self-reported general health, health distress, fatigue, disability, and social/role activities limitations. All outcomes reported have statistical significance.

From the perspective of this paper, it is interesting to note that improvement in communication with physicians is included in the positive outcomes of the program, presumably reflecting the effects of components such as "techniques for improving communication" in Session 4, and "Communication skills useful for talking with physicians" in Session 6 in the six-week workshop curriculum. Judging from the listing of the items in the curriculum, this program seems to be essentially of a consulting nature, offering knowledge and technical skills, with few, if any, elements of psychological support.

***Motivational Interviewing*** [12]

Motivational Interviewing (MI) is a method of counseling that aims to enhance a person's motivation to change problematic behavior by exploring and resolving ambivalence about change. MI is a relatively brief intervention, typically delivered within one to four sessions each lasting 20 to 60 minutes. It can be delivered as a free-standing intervention or as part of other treatments, such as cognitive-behavioral therapies. It has been used extensively to treat substance use and other problems. This is an important instance of the application of Carl Rogers' client-centered approach to counseling. Its central purpose is the efficacious self-management of problematic behavioral tendencies.

MI assumes a collaborative partnership between the client and the practitioner. MI addresses a situation in which client behavior change is needed, thus having a more specific goal than the client-centered method, which is a broad approach to counseling. MI involves an active collaborative conversation and joint decision-making process between the practitioner and the client. MI practitioners seek to activate clients' own motivation and resources for change instead

[12] This section draws on Soederlund (2010) and information on the homepage of Motivational Interviewing (MI), http://www.motivationalinterview.org/ (accessed September 20, 2014).

of just giving them what they might lack, for example, medication or information. This involves connecting behavioral change with a client's values and concerns. This requires an understanding of the client's own perspective and, for that purpose, evoking the client's own arguments and reasons for change (Rollnick et al. 2008).

MI was first developed in the 1980's by William R. Miller, an American psychologist, in response to concerns about the traditional confrontational approach used in addiction treatment, which typically involves overt, aggressive confrontation and challenging people with the threat of the strongest negative effects of their current situation. In MI it is assumed that clients have "intrinsic motivation" to change, and MI's goal is to facilitate movement towards, and consolidate commitment to, change. MI enhances motivation for behavior change by expressing empathy and support, exploring the discrepancies between present behavior and current or future values and goals, eliciting "change talk," "rolling with resistance" rather than arguing for change, supporting self-efficacy and affirming the client's choice and autonomy (Miller and Rollnick 2002).

MI emphasizes helping a client to make their own decisions to change, rather than the client being pressured from external sources. Clients must bear the responsibility of deciding for themselves whether or not to change and how best to go about it. The intention is to transfer the responsibility for arguing for change to the client by eliciting "change talk," that is, overt declarations by the client that demonstrate recognition of the need for change, concern for their current position, intention to change, and the belief that change is possible (Miller and Rollnick 2002). The counselor's role in the process is to help clients clarify their motivations for change, provide information and support, and offer alternative perspectives on the present problem behaviors and potential methods for changing these behaviors (Miller and Rollnick 2002).

There are typically two phases of MI sessions. The client is often ambivalent about change in the first phase and may be insufficiently motivated to accomplish change. Hence, the aim of this phase is to resolve the client's ambivalence, and facilitate their increased intrinsic

motivation to change. The second phase commences when the client shows signs of readiness to change. This may be manifested by talk or questions about change and descriptions that suggest that the client is envisioning a future when the desired changes have been made. The focus in the second phase shifts to strengthening the commitment to change and supporting the client to develop and implement a plan to achieve the changes.

The effectiveness of MI in achieving behavioral changes has been examined in a large number of randomized controlled trials (RCTs) on behavioral changes since the late 1990s. These studies have been conducted in various settings and for a number of health-related behaviors, including alcohol, drugs, diet, exercise, and smoking. The largest body of literature concerns the use of MI in addressing alcohol abuse and dependence. According to the most comprehensive review so far, MI is significantly more effective than no treatment, and generally at least equal to other treatments for problems such as substance abuse (alcohol, marijuana, tobacco and other drugs) for reducing risky behaviors and increasing client engagement in treatment (Lundahl and Burke 2009).

### 4.2.2 Interventions for agency development

Here we take up the two important cases of intervention for agency development introduced in Section 2.2, investigate the nature of long-term intervention carried out, and offer tentative judgments on the necessary conditions for the realization of the development of agency.

#### *Nurse-Family Partnership (NFP)*

First of all, it is important to recall that the Nurse-Family Partnership (NFP) program is designed to have sufficient intensity and duration (64 visits over a 30-month period) for a trustful, committed relationship to be formed between the nurse and the mother. Another important consideration is the level of workload for nurses (no more than 25 active clients), and for supervisors (no more than eight individual nurse home visitors). These stipulations help secure

sufficient intensity of interactions between the nurse and the mother and between the supervisor and the nurse.

It is interesting to note that the impact of the program was more pronounced among children born to mothers with limited psychological resources to properly manage the care of their children while living in concentrated social disadvantage (limited psychological resources manifest themselves in higher levels of depression, anxiety, and lower levels of intellectual functioning and sense of mastery over their lives). This was demonstrated in a lower incidence of injuries and in higher school readiness (i.e., better language development and ability to control impulses), compared with their control-group counterparts. In contrast, there were no benefits of the program for these types of outcomes among children born to mothers with relatively high psychological resources (those with greater wherewithal to manage caring for their children while living in poverty). This contrast seems to imply the existence of a certain threshold level in the mother's psychological resources that is needed to attain sufficient level of agency and to exercise self-control and provide adequate care to their children.

To achieve the third goal of the program, i.e., to improve the economic self-sufficiency of the family, nurses offer life coaching, helping mothers to develop a vision for their own future, plan future pregnancies, continue their education, and find work. While working with their nurse home visitor, many of the young mothers in the Nurse-Family Partnership program set goals for themselves for the very first time. Research shows that NFP does, indeed, improve the maternal life course. Apparently, nurses help a mother to feel empowered to make sound choices about education, workplace participation, partner relationships, and the timing of subsequent pregnancies, that enable her to take better care of herself and her child.

Based on these pieces of evidence, it may be reasonable to conclude that the NFP program has succeeded in the augmentation of agency among participating young mothers, with particularly significant impacts on those of them with less favorable initial conditions. As stated as Element 1 in Section 3.2, the NFP program works with mothers who voluntarily participate.

To that extent it presupposes participants' agency to engage. The nature of user-provider relations is a combination of counseling and consulting, initially relatively more in the nature of counseling, and subsequently and gradually the relative importance of consulting increasing over the course of the program. This represents a cumulative process of activation and development of agency on the part of the client, with their disposition and capacity for self-determination and self-management being strengthened through repeated actions and continued support.

***Chile Solidario (CHS)***

Intervention by social workers in the Chile Solidario (CHS) program consists of "counseling" (psycho-social support through accompaniment and encouragement) and "consulting" (technical support through education and advice), both tailored to the conditions in the family. The counseling function addresses psychological matters related to perceptions, feelings and emotions such as self-esteem, self-control, self-efficacy, and motivation for achievement. The central task is to promote and develop positive elements in perceptions, feelings and emotions, and enhance expectations for positive change in life (MIDEPLAN 2009a, 18).

As stated in Section 3.2, the central objective of the Puente Program is to initiate and promote a process of empowerment of target families with an adult education approach. The learning on the part of families is geared to the acquisition of capacity for self-management and autonomous resolution of problems, encompassing such competencies as the recognition of opportunities, the management and resolution of problems, the determination of alternative courses of actions, and the establishment and utilization of relationships with providers of services. Such learning during the program is expected, as the program is completed in two years, to have enabled the formation of the capacity to formulate projects, and courses of action for their realization. In the Final Note at the time of the termination of the Puente Program, each

participating family expresses their views on the program and an evaluation of their experiences, and also proposes a project for the improvement of their family life.

The central "empowerment" objective of the Puente Program is closely related to the task of rehabilitating sound personal relations within the family, and reestablishing it as source of mutual support and a positive contributor to the resolution of problems. This is clearly indicated in the Final Note of many of the families as shown in the "area of most significant learning" during the program:

Area of most significant learning:

| | |
|---|---|
| Family | 52.5% |
| Institutions | 31.8% |
| Community | 4.4% |
| Others | 11.4% |

*Source:* MIDEPLAN (2009b, Figure 2.1, 71).

Of those that mentioned "Family" as the area of most significant learning, half identified "self-respect and positive attitude," and a quarter "intra-family relations," as the most significant subcategory, far exceeding those that identified learning of more technical nature such as "household management" and "development of abilities."

Subcategory of most significant learning under "Family":

| | |
|---|---|
| Self-respect and positive attitude | 50.4% |
| Intra-family relations | 24.5% |
| Household management | 12.0% |
| Development of abilities | 8.0% |
| Development of values | 8.0% |

*Source:* MIDEPLAN (2009b, Table 2.1, 73).

Some interviewees stated that they recognize the importance of having developed a better capacity to express and verbalize their emotions, and that such capacity was enhanced during conversations with social workers about events and difficulties. They said that such capacity not only contributes to the improvement of intra-family relations, but also to an

increased sense of security, self-efficacy and a positive attitude. These changes contribute directly to the enhancement of agency.

| Area of most significant functioning | |
|---|---|
| Family | 20.9 % |
| Housing | 14.9 % |
| Income | 14.1 % |
| Positive attitude | 10.5 % |
| Public services | 8.8 % |
| Work | 6.5 % |
| Health | 4.1 % |
| Education | 3.4 % |
| Registration | 1.4 % |
| Others | 15.6 % |

*Note:* In the table above "Income" refers to the receipt of cash transfer and subsidies, and the newly acquired practice of saving.
*Source:* MIDEPLAN (2009b, Figure 2.2, 80).

The process of change in mentality and attitude on the part of family members is closely associated with the relationship established between them and the social worker. Such processes of personal change are closely intertwined with changes in intra-family relationships. The social worker works within the family to help members restore their basic socio-emotional capabilities, and to foster behaviors conducive to improved family welfare and labor market success, thereby engaging them in a process to identify a family strategy to exit extreme poverty. The critical role of social workers as change agents is to promote improvements in attitude and behavior toward each other within a family as the basis for a more positive and constructive attitude toward oneself and life in general (MIDEPLAN 2009b, 80 and Carneiro et al. 2009, 28-29).

Social workers are also instrumental in bringing families in contact with public services. This involves not only the provision of information, but also psychological support through encouragement and accompaniment (MIDEPLAN 2009b, 82). As stated in Section 2.2, families in the CHS program established access to the public service system and received public subsidies and services, accompanied, assisted and supported by social workers. Insofar as the experience of dealing with officials and receiving responses is positive, families will be

motivated to repeat such service transactions. This will be particularly true when they perceive that they receive preferential treatment from the government. Such positive experiences and perceptions ("not being left out" and "the state being concerned with the extreme poor like them") lead to increased sense of security and self-efficacy, in turn increasing agency and strengthening the motivation to engage with the public system.

As stated in Section 3.2, the impacts of the CHS vary across families with different characteristics and those who are located in different municipalities. For example, the impact of the program on the uptake of subsidies is larger in municipalities with a better network of social services, for families served by social workers with relatively low caseloads, and in male-headed families. Similarly, the impact of the program on employment of the spouse is larger in rural areas and for families served by social workers with relatively low caseload. It seems that it takes a sufficient intensity and duration of psychosocial support, only possible when the workload of social workers is relatively low, for an increase in uptake of these services to take place. These findings on the workload of social workers seem to indicate a type of threshold in either technical advice (consulting) or psychosocial support (counseling), or possibly in both of them.

It seems that psychosocial support (counseling) is a necessary precondition for the effectiveness of information and technical advice (consulting). A feeling of intimacy and affection between the family and the social worker is necessary for the family to be able to overcome insecurity and low self-esteem, and to acquire a positive outlook on life. This being the case, care is needed so that such emotional attachments will not create psychological dependence, but instead that the family strengthens their independent planning and managing capacities (MIDEPLAN 2009b, 88-89). In this context, the requirement of the declaration of a project at the conclusion of the program serves as an important instrument to gauge the degree of self-determination and self-management capacity in the subject family. A project is to consist of goals set by the family and courses of action to realize them. These projects constitute the

starting point for the trajectory of family life that they make efforts to realize through a series of actions independent of the assistance of the social worker (MIDEPLAN 2009b, 90).

The degree of success in achieving self-determination and self-management capacity varies across families. There seems to have emerged contrasting patterns of virtuous and vicious circles. These circles involve three elements: the condition of family life, the attitude toward government offices, and the relationship with the social worker (MIDEPLAN 2009b, 94). We need to understand the variability in the degree of success in three stages - i.e., pre-program, in-program and post-program. Families with relatively favorable initial psycho-social conditions benefited more from the program, and prepared themselves for the realization of their life goals, while less favorably situated families benefited less from the program and failed to change their outlook on their life prospects. In some of the cases of high attainment during the program, along with an increased sense of self-efficacy, self-confidence and optimism, the goals set for the project by the family reflected future-oriented aspirations in pursuit of a higher standing in society - stable work, higher income, home ownership, and higher education for children (MIDEPLAN 2009b, 111). In contrast however, there are cases of virtually no attainment during the program among the families with unfavorable initial conditions, typically characterized by alcoholism, drug use, and domestic violence.

It has also been found that there are variations in the performance of social workers: some of them make more frequent and longer visits than others. Those families visited by less attentive social workers tend to have poor results in learning, low utilization of the program offerings, and a low evaluation of the quality of the program. Similar negative sentiments were generated when there were frequent changes in social workers, as families felt abandoned and insecure about their relationship with the program. They need to establish expectations of sustained benefits on the basis of correct understanding of the program if their connection with government offices should continue beyond the period of accompaniment and psycho-social support by social workers. For that to happen, an intimate and trustful relationship with a social

worker is indispensable, as family members need to feel safe in discussing most private family matters openly (MIDEPLAN 2009b, 86-87).

It is to be remembered that, unlike in the Nurse-Family Partnership (NFP) program where nurses with a predetermined workload work with mothers who voluntarily participate, the Chile Solidario (CHS) is an outreach program with the policy intention of covering all eligible families. It seems that this situation has inevitably spawned difficult cases based on a lack of preparedness on the part of families and the excessively demanding workload of social workers.

## 5. Concluding remarks

The User-Centered Approach (UCA) has a humanistic as well as a practical appeal. There are certain goals and target populations that can be only reached and served through the UCA. There are cases of notable successes of the UCA in achieving a more active role for service users, with agency activation as in CDSMP and MI, and with agency development as in the Nurse-Family Partnership (NFP) and the Chile Solidario (CHS). These examples highlight the rationales and accomplishments of the UCA. At the same time, however, they seem to point to the rather demanding conditions needed for its successful implementation. Also, they represent cases of experiences from developed countries, with the notable exception of the CHS.

The effectiveness and scalability of the UCA in developing countries needs to be examined against the realities of the public services in question, from the viewpoints of transaction intensity and discretion on the parts of both providers and users of services, and also with service system failures in mind. So far, the evidence base for the experiences of UCA models is limited, and there is little empirical basis to indicate their effectiveness in the context of the dire situation of public service failures in developing countries.

There are ideational and theoretical rationales for the UCA as presented in the advocacy of and the proposals for its application. Nevertheless, it needs to be subjected to a reality check

of feasibility and effectiveness. The UCA entails higher intensities of transactions, thus demanding more psychic and cognitive resources from both sides of the service transactions. Especially for service users, it involves the qualitatively different role of taking charge of their own affairs in partnership with service providers and through self-management. To discharge such roles, they have to activate agency, i.e., pay active attention, interact with others, and make decisions and act on them, all of which demand efforts in the mobilization of cognitive resources and impose psychic costs. As a matter of human nature, transaction intensity tends to induce discretionary responses toward averting such costs, thus avoiding the activation of agency. And, more often than not, there are existing competing demands on the use of these resources. This is, and will likely remain, a fundamental constraint on the scalability of UCA models.

**Table 1: Classification of the nature of service**

| | **Discretionary** | **Non-discretionary** |
|---|---|---|
| Transaction intensive | "Practice" | "Program" |
| Non-transaction intensive | "Policy" | "Rule/Procedure" |

*Source:* Pritchett and Woolcock (2004, 194-5).

**Table 2: Illustration of the four types of services**

| **Type/Sector** | **Education** | **Health** |
|---|---|---|
| "Policy" | Criteria for teacher certification | Criteria for drug certification |
| "Program" | Standardized examination | Vaccination |
| "Practice" | Classroom teaching | Clinical consultation |
| "Rule/Procedure" | Class registration | Clinical registration |

*Source:* Author.

**Table 3: Typology of user-provider relationships in service transactions**

| | |
|---|---|
| **Type 1. "(User-driven) service delivery"** | |
| User side | Desire and sufficient ability to self-determine "solutions" and express them as wants |
| Provider side | Supply of services to meet user wants on demand |
| | |
| **Type 2. "Consulting service"** | |
| User side | Desire, but insufficient ability to self-determine "solutions" or express them as wants |
| Provider side | Consultation and supply of ideas for "solutions" to user desires |
| | |
| **Type 3. "Counseling service"** | |
| User side | Vague desire and lack of ability to identify "solutions" or express them as wants |
| Provider side | Counseling and clarification of recipient's desire (through an interactive process of communication) |
| | |
| **Type 4. "Pre-Counseling service - Outreach"** | |
| User side | Lack of desire and/or willingness to engage in communication or activity |
| Provider side | Proactive attempts at establishing communication with potential users and providing them with support |

*Source:* Author.

**Table 4: Types of user-provider relations and degrees of transaction intensity and discretion**

| |
|---|
| Type 1. "(User-driven) Service delivery" |
| Λ |
| Type 2. "Consulting service" |
| Λ |
| Type 3. "Counseling service" |
| Λ (?) |
| Type 4. "Pre-Counseling service - Outreach" |

*Source:* Author.
*Note:* The sign Λ indicates presumed ascending degrees of transaction intensity and discretion between the four types of user-provider relations.

**Table 5: Typology of services and user agency (UA) …and the implicit stages of agency development**

| | | |
|---|---|---|
| Type 1 | "(User-driven) service delivery" | UA as "Desire and self-determination" |
| Type 2 | "Consulting service" | UA as "Desire and informed consent" |
| Type 3 | "Counseling service" | UA as "Desire and willingness to engage" |
| Type 4 | "Pre-Counseling service - Outreach" | UA as "Self-exclusion" |

*Source:* Author.

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**Abstract (in Japanese)**


**要約**

社会サービスの普及が進む中でその質と効果についての改善が見られないことが指摘されている(Global Monitoring Report 2011)。そのような状況への対応の１つとしてサービス提供での「利用者中心アプローチ(User-Centered Approach（以下、UCA))」が提唱されている。本論文は、UCA の理念と実績を紹介し併せその限界につき検討する、ことを目的とする。この課題に応えるべく、サービスを分類する 2 組の概念枠組が提示される。そして、それらに即して、UCA の２つのモデルである「共同生産(co-production)」と「自己管理(self-management)」に関する一般命題といくつかの重要な事例につき、主体能力と動機付けの観点からの検討と評価がなされる。そこでは、エンパワーメントについての概念整理を参照しつつ、「共同生産」と「自己管理」が効果を持つためにはそれらに向けての主体能力の適用が必要であること、それは短期には動機付けにより既存の主体能力が活用されることで満たされること、長期には主体能力の強化が求められること、などが論じられる。これらを踏まえ、UCA の意義と限界につき判断と評価を示す。なお、本研究での UCA の検討と評価はほとんどすべて先進国での事例を対象としており、国際協力事業でのその適用については、途上国での事例についての研究成果を踏まえた検討と評価が求められる。

**Working Papers from the same research project**

"An Interdisciplinary Study on Agency Enhancement Process and Factors"

JICA-RI Working Paper No. 121

*The Motivation of Participants in Successful Development Aid Projects:*

*A Self-Determination Theory Analysis of Reasons for Participating*

Nobuo R. Sayanagi and Jiro Aikawa