

Chapter 2

The Bright Side of Patient Empowerment

2.1 Patients as Value Co-creators

As argued in the previous section, empowerment could be conceptualized as a practice of freedom (Freire, 1993). When this concept is applied to the experience of patients in the healthcare environment, empowerment is better understood if a relational perspective is adopted (Tang, Funnell, Brown, & Kurlander, 2010). Going more into details, patient empowerment relies on the establishment of a co-creating partnership between the patients and the healthcare professionals: the former accept to actively participate in the design and delivery of care, while the latter perform as enablers of the patients' sleeping resources. Therefore, it could be maintained that value co-creation is a distinguishing attribute of patient empowerment initiatives. Indeed, patient empowerment paves the way for a process of enablement, which is aimed at encouraging patient involvement in shared decision making (Hardyman, Daunt, & Kitchener, 2015). However, it is difficult to provide a comprehensive definition of value and value co-creation in the healthcare service system.

Scholars have widely discussed the meaning and measurement of value in healthcare, claiming the multidimensionality of this concept (Porter, 2010). Different concerns have been raised in the attempt to define the different shades of value in the healthcare environment, including the need to account for: health outcomes, safety, quality, cost, equity and innovation (Yong, Olsen, & McGinnis, 2010). The idea of patient-centered value is gradually emerging as a glue which is able to bind together these various definition of value, synthesizing them (Rollow & Cucchiara, 2016). Moreover, it is worth noting that such a patient-centered interpretation of value is consistent with patient engagement in health protection and health promotion activities.

The value co-creation concept is not odd in the scientific literature (Prahalad & Ramaswamy, 2004). Ultimately, it relies on the assumption that the healthcare professionals and the patients—rather than sticking to a relieving approach,

according to which the providers of care perform as the sole value creators and the patients as mere consumers of health services—have the opportunity to join their efforts, in order to create a unique value, which is worth for both the parties (Vargo & Lusch, 2008). The link between patient-centered care and value co-creation is evident: in fact, patient-centered care inspires a thorough reconceptualization of patients as service co-producers (Moll, 2010), leading toward a shared approach to care (Pritchard & Hughes, 1995).

Drawing on these considerations, scholars are paying a growing attention to value co-creation in the healthcare service system. In particular, patient involvement in the delivery of care has been argued to be crucial to: improve the quality of health services, increase the effectiveness of care, enhance health outcomes and save available resources (Pinho, Beirão, Patrício, & Fisk, 2014). From this point of view, patient involvement is able to match the multidimensionality of value concepts in the healthcare environment. Also, Elg, Engström, Witell, and Poksinska (2012) emphasized that value co-creation could be beneficial for the healthcare providers themselves: they have the opportunity to learn from the patients, who provide relevant insights to improve professional practices. This is possible by generating and collecting the patients' ideas to realize the full potential of patient-centered care and further encourage patient involvement.

Sticking to these arguments, it has been claimed that value co-creation is inherent in the patient-provider relationship (Palumbo, 2015). Nonetheless, a process of empowerment is required in order to raise the awareness of the positive consequences which could be attached to patient involvement, as well as to assist both the patients and the healthcare professionals to establish an effective co-creating partnership (Davis, Jacklin, Sevdalis, & Vincent, 2007). As depicted in Chap. 1, healthcare organizations themselves play an important role in promoting value co-creation. In fact, they are able to support collaborative patient-provider relationships, building an organizational culture which relies on openness and enhancing the ability of the staff to involve the patients in the delivery of care (Renedo, Marston, Spyridonidis, & Barlow, 2015).

Embracing this perspective and defining value co-creation as the “...benefit realized from integration of resources through activities and interactions with collaborators in the customer's service network”, McColl-Kennedy, Vargo, Dagger, Sweeney, and van Kasteren (2012, p. 375) identified five recurring co-creation practice styles which could be applied to health services' design and delivery: (1) passive compliance, (2) pragmatic adapting, (3) partnering, (4) insular controlling, and (5) team management. As reported in Table 2.1, these styles are characterized by increasing levels of patients' participation and, consequently, by varying intensity of patient empowerment.

Passive compliance is characterized by a limited patient involvement in health decision making. The healthcare professionals maintain a significant control over the process of health services' design and delivery; however, patients are encouraged and supported in complying with medical prescriptions, as well as in following healthy life-styles, which help them in coping with their health-related conditions. Therefore, the providers of care do not participate in patient enablement

Table 2.1 Value co-creation styles and levels of patient empowerment

Value co-creation style	Description	Level of patient empowerment
Passive compliance	Patients' participation in the provision of care is limited. In most of the cases, the patients are provided with information and support to comply with medical prescriptions	Patient enablement aimed at improving therapeutic compliance
Pragmatic adapting	The patients are supported in coping with their health-related conditions, developing tailored self-care skills	Patient enablement and activation intended to increase the patients' self-care abilities
Partnering	The healthcare professionals and the patients enter in a co-creating relationships, where both of them contribute in value co-creation	Patient engagement
Insular controlling	The patients gain control over the process of healthcare delivery; they are involved in health decision making, but still rely on the enabling role of healthcare providers	Patient involvement and shared decision making
Team management	The patients are fully empowered and they perform as key actors in the process of value creation. The healthcare professionals stick to a patient-centered approach to care and support patient empowerment	Full-fledged patient empowerment

Source Author's adaptation from McColl-Kennedy et al. (2012)

initiatives which are intended to make the patients able to autonomously make health decisions. As a Consequence, the only contribution of the patients in value co-creation stands in medication adherence and therapeutic compliance.

Pragmatic adapting share several common traits with passive compliance, but it shows a limited activation of the patients for the purposes of health protection and promotion. In fact, the patients are encouraged to recognize and deal with their health status, in order to better adapt their every-day behaviors to the changed circumstances of life which are associated with the emergence of the disease. In this case, the healthcare providers perform as enablers and catalyzers of the patients' sleeping assets, inciting them to participate in the process of value co-creation. Notwithstanding, shared decision making is still limited.

Partnering involves the establishment of a therapeutic alliance between the patients and the healthcare professionals. In fact, the patients are engaged in designing and delivering health services, cooperating with the healthcare providers in order to effectively cope with the illness. Hence, the patients gain greater control over the process of value creation, being engaged in shared decision making. Obviously, patient engagement requires the development of adequate health-related knowledge, skills and attitudes by the side of patients. In this way, it is possible to

enhance their self-efficacy perception and their willingness to perform as value co-creators. Beyond contributing to enable the assets of the patients, the healthcare professionals strive for encouraging patient engagement, in an attempt to collect from the patients as many insights as possible to improve the timeliness, quality and effectiveness of care.

Insular controlling and team management present the greatest intensity of value co-creation. On the one hand, the patients are involved in co-planning, co-designing and co-delivering health services, obtaining a relevant control over the process of value creation. However, they still rely on healthcare professionals, who lead the provision of care. On the other hand, the patients are able to balance the power of healthcare professionals during the medical encounter, being involved at all the stages of healthcare provision. In other words, insular controlling implies the engagement of the patients in health decision making, while team management involves a full-fledged process of patient empowerment, which is based on the establishment of a long-term partnership between the patients and the healthcare professionals and is consistent with a patient-centered approach to care.

Summarizing these considerations, a bidirectional relationship could be argued to link value co-creation styles and patient empowerment. To participate in value co-creation, the patients need to develop adequate knowledge, skills and attitudes, which are required to properly function in the healthcare service system. Patient empowerment allows to enable and activate the sleeping resources of patients, as well as to engage and involve them in the delivery of care. In turn, the participation of patients in value co-creation paves the way for a self-nourishing virtuous cycle of patient empowerment. The more the patients perform as value co-creators, the stronger their self-efficacy perception and, consequently, the higher their willingness to be involved in the appropriate functioning of the healthcare delivery system. From this point of view, patient empowerment and value co-creation could be understood as conjoined twins, which jointly contribute in the transition toward patient-centered care.

2.2 Patients as Service Co-producers

Service co-production is a popular concept in the field of public management (Osborne & Strokosch, 2013). In a quite similar way, it is attracting a growing attention among scholars interested in healthcare management and public health (Palumbo, 2016), where it is dealt with as an innovative approach to care which is intended to improve the overall functioning of the healthcare service system (Loeffler, Power, Bovaird, & Hine-Hughes, 2012). The idea of service co-production was introduced in late '70s, when Ostrom and Ostrom (1977) pointed out that users play a crucial role in the delivery of public services. Echoing this consideration, Sharp (1980) claimed that public services are always the joint products of providers and users. In particular, the users of public services have been argued to perform as

prosumers, that is to say as both consumers and co-producers of public value (Whitaker, 1980; Parks et al., 1981; Riessman & Banks, 2001; Bovaird et al., 2015).

Both patient centeredness and patient empowerment are recurring concepts in the healthcare environment (Rathert, Wyrwich, & Boren, 2013). Ultimately, they imply a shift in the functioning of the healthcare delivery system (Mead & Bower, 2000), which is inspired by a deep reconceptualization of the patient-provider relationship (Dahlberg, 1996; McLaughlin, 2004). Such a shift aims at mitigating the conditions of psychological dependence and information asymmetry of the patient (Freidson, 1970). Actually, a participative care model is introduced (Guadagnoli & Ward, 1998), which recognizes the patients as the subjects—rather than the objects—of healthcare provision (Takman & Severinsson, 1999). From this standpoint, patient centeredness, patient empowerment and co-production of health services turn out to be strictly intertwined: they are intended to improve the quality of care, involving the patients in the protection and promotion of their health conditions and engaging them in a virtuous process of value co-creation (Cramm & Nieboer, 2015).

To involve the patients in the co-production of health services, the healthcare professionals should dismiss the traditional biomedical model to care, according to which the healthcare providers control the medical encounter focusing on the treatment of the illness (Saha, Beach, & Cooper, 2008). Rather, the patients are considered to perform as key partners of regular providers: they contribute in planning and implementing the provision of care, bringing in knowledge, resources, skills and specific information which are essential to design and deliver tailored and effective health services (Palumbo, 2016; Pomey, Ghadiri, Karazivan, Fernandez, & Clavel, 2015). What is even more interesting, is that the healthcare professionals could not benefit from the patients' sleeping assets if they do not strive for enabling and empowering them during the medical encounter, paying attention to the specific patients' health needs (see, among others: Bertakis & Azari, 2011; Cegala, Street, & Clinch, 2007; Weingart et al., 2011).

In sum, the co-production of health services relies on the assumption that the success of healthcare provision does not solely rely on the expertise of healthcare professionals and on their ability to properly diagnose the patients' health-related conditions, in order to arrange an appropriate treatment to cope with them (Bettencourt, Ostrom, Brown, & Roundtree, 2002). Quite the opposite, the participation of patients in self-managing their health conditions and their self-confidence in navigating the healthcare service system are considered to be fundamental ingredients of the recipe for a more effective and appropriate access to care (Needham, 2012).

From this standpoint, the medical encounter is reframed as a relationship between two experts, who jointly participate in the provision of care (Pawlikowska, Zhang, Griffiths, van Dalen, & van der Vleuten, 2012). On the one hand, the healthcare providers contributes in value co-creation with their professional knowledge and skills, which are required to devise a timely health treatment to meet the health needs of the patient. On the other hand, the patient contributes in value co-creation with both the information related to his or her own disease experience—which, in most of

the cases, are tacit—as well as with the activation of the individual sleeping resources to effectively cope with the illness (Mattingly, Tom, Stuart, & Onukwugha, 2016; Murray & McCrone, 2015). Therefore, the medical encounter is not exclusively led by the healthcare professionals. Rather, it is understood as a co-creating partnership, during which the patients and the providers collaborate to co-plan, co-design and co-deliver a tailored and person-centered health treatment (Street, Makoul, Arora, & Epstein, 2009).

Scholars have suggested various taxonomies to shed light on the different approaches to public service co-production. Taking into consideration the breadth and depth of user engagement, Brudney and England (1983) identified three main types of service co-production. Collective co-production is aimed at involving the population served in planning public services, in order to enhance their responsiveness to the evolving needs of the community. In this case, service co-production broadly concerns the potential users of public services, who participate in planning and designing public services. However, the users are generally not allowed to participate in the process of service provision, which still relies on traditional providers (Bovaird, Van Ryzin, Loeffler, & Parrado, 2015; Weaver, 2011). As compared with collective co-production, group co-production shows a greater depth, but a more limited extent of user involvement. In fact, group co-production strives for empowering homogeneous groups of users who express common needs, engaging them in the delivery system, with the purpose of expanding the range of services provided and increasing their effectiveness (Tu, 2016). Lastly, individual co-production entails the establishment of a direct and co-creating relationship between the users and the providers (Wirth, 1991). It attempts to stress the users' role in the process of value co-creation, involving them as active partners in service design and delivery. Hence, this co-production style is deeper, but narrower as compared with both collective and group co-production. Of course, all these co-production styles can be retrieved in the healthcare environment (Fotaki, 2011; Cepiku & Giordano, 2014; Van Eijk & Steen, 2016), as depicted in Fig. 2.1.

Osborne and Strokosch (2013) proposed an alternative taxonomy of co-production modes, focusing the attention on the role played by the users in the process of value co-creation. Drawing on their propositions, three co-production modes could be identified. Consumer co-production is aimed at empowering the users at the operational stage. In fact, the process of empowerment and involvement is conceived as a sheer managerial technique, which attempts to make the users aware of the attributes of the service delivery systems and to increase their compliance with the providers' instructions. The users' ability to collect value from service provision is improved, even though they only partially participate in service design and delivery (Gómez & Jaglin, 2016). Participative co-production goes beyond the operational level, since it concerns both the delivery, the design and the planning of existing services. In this case, user involvement is mainly intended to improve the quality of public services. In fact, users contribute in increasing the effectiveness and the responsiveness of public services by bringing innovative perspectives and non-conventional ideas (Tuurnas, 2015). Last but not least, enhanced co-production challenges the traditional provider-led model of public service provision. Users are understood as the driving

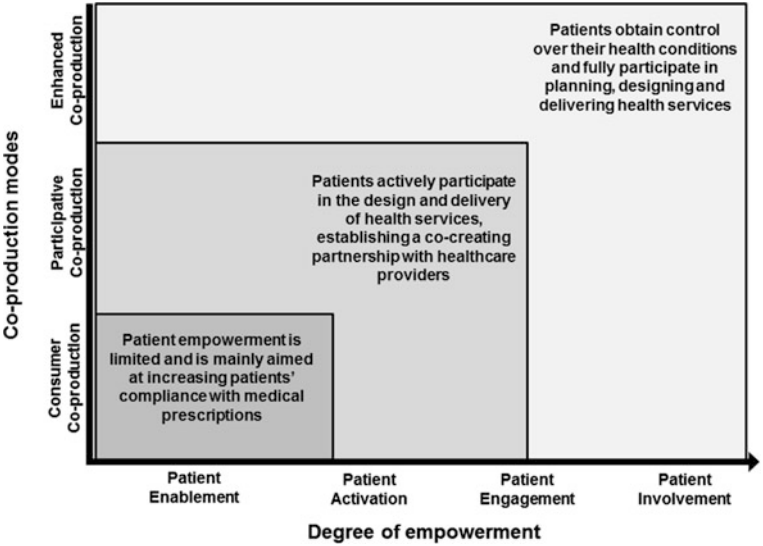


Fig. 2.2 Co-production modes and levels of patient empowerment. *Source* Author’s elaboration

Figure 2.2 depicts the co-production modes suggested by Osborne and Strokosch (2013), pointing out a relationship between each of them and the levels of patient empowerment. While a limited degree of patient empowerment is consistent with consumer co-production, enhanced co-production requires an expert patient to be realized.

2.3 A Re-design of the Patient-Provider Relationship

It is interesting to point out that health services’ co-production basically involves a reconfiguration of the roles of patients and healthcare providers during the medical encounter, recognizing them as partners. In an attempt to systematize the consequences of co-production on the patient-provider relationship, the theoretical framework proposed by Bovaird (2007) could be exploited. Going more into details, a diversified range of professional-user relationships could be identified, which are disentangled by taking into consideration the way regular providers and consumer producers—both individually and collectively—perform the activities of service co-planning, co-design and co-delivery. Table 2.2 illustrates the different shades of co-producing relationship between the providers and the users, in light of their specific role in a generic service delivery system.

The columns of Table 2.2 show the distribution of responsibilities between the professionals and the users with regard to the planning and/or the design of services. Alternatively, the rows depict the allocation of functions between the

Table 2.2 Co-production styles and users-providers relationship

		Service design and planning		
		Providers as sole service designers and planners	Providers and users as service co-planners and co-designers	Users as sole service designers and planners
Service delivery	Providers as sole service deliverers	<i>Traditional service provision:</i> Professionals as sole value creators in the service delivery system	<i>Service co-planning and co-design:</i> Users participate in planning and designing services, which are delivered by traditional providers	<i>Professional delivery of user-led services:</i> Users plan and design services, which are delivered by traditional providers
	Providers and users as service co-deliverers	<i>Service co-delivery:</i> Professionals as sole planner and designer of services and engagement of users as co-deliverers	<i>Full co-production:</i> Establishment of a co-creating partnership between the users and the providers	<i>Co-delivery of user-led services:</i> Users plan and design services, which are delivered in partnership by users and traditional providers
	Users as sole service deliverers	<i>User delivery of provider-led services:</i> Professionals as sole planner and designer of services and engagement of users as co-deliverers	<i>Co-design of user-led services:</i> Users participate in planning and designing services and perform as the sole deliverer of services	<i>Self-organized provision:</i> Users as sole value creators in the service delivery system

Source Author's adaptation from Bovaird (2007)

providers and the users concerning the delivery of services. Crossing the rows and the columns, 9 different approaches to service co-production could be identified.

When the planning, design and delivery of services are exclusively led by ordinary providers, a traditional approach to service provision occurs. Users are understood as mere consumers of value, which is solely created by providers. Therefore, the users are not involved in service provision, sticking to a relieving logic. In several circumstances, the users could be engaged in planning services, assuming a limited role in delivering them. In other words, the traditional service provision could be contaminated with the involvement of users in planning and designing services, in order to make the latter more compliant with the perceived needs of the population served. On the other hand, the users could be involved in

delivering services, while planning activities continue to be controlled by regular providers. In this case, the users co-deliver services which are designed by professionals, with the purpose of complementing the efforts of providing organizations and improving their responsiveness.

Also, users could be engaged as the sole providers of professionally designed services, thus performing as key partners of providing institutions in the process of value creation, even though they are not assigned with a relevant role in planning the attributes of the service delivery system. Besides, users could perform as sole deliverers of co-planned services: in this specific circumstance, the users and the providers collaborate in defining the characteristics of services, whose implementation is exclusively ascribed to the former. Lastly, users could perform as co-deliverers of services which are planned without the contribution of regular providers, performing as the most important driver of value creation in the service delivery system. In all of these cases, only a shade of service co-production is caught. In fact, the users and the providers variously collaborate to plan, design and deliver the service, but they do not share the same responsibilities to contribute in the proper functioning of the service delivery system. From this point of view, full co-production is only realized when regular providers and users are simultaneously engaged in co-planning, co-designing, and co-delivering services, performing as peers in the process of value co-creation.

The taxonomy suggested by Bovaird (2007) could be adapted in the attempt to apply it to the healthcare delivery system, as depicted in Table 2.3. In fact, the patients and the healthcare professionals could variously cooperate for the purpose of health services' design and delivery, realizing the different co-production styles briefly presented above.

Traditional service provision echoes the biomedical model, which assigns to patients a limited role in co-producing health services and conceives the healthcare providers as the main value creators during the medical encounter (Lewis, 2009). Sticking to a traditional service provision, patient empowerment is neglected; in fact, the attention is focused on the disease, as well as on the relieving ability of healthcare professionals.

In several cases, patients are enabled to participate in the delivery of care, even though the healthcare professionals maintain the control over health decision making. In this circumstance, the process of empowerment is aimed at improving the ability of the patients to comply with the clinical prescriptions of healthcare professionals and to stick to the requirements of the health treatment, thus performing as active co-deliverers of care (Delamater, 2006). Also, it is possible that the healthcare professionals support and encourage the patients to be the sole deliverers of health services which are professionally planned and designed. That is to say, the patients may act as self-carers of their own health conditions, developing the skills and the competencies to cope with their health-related problems according to the prescriptions of healthcare professionals (Inouye, Flannelly, & Flannelly, 2001).

The patients could be involved as co-planners and co-designers of health services, partnering with the healthcare professionals to define and deliver an appropriate health treatments. On the one hand, the healthcare professionals could

Table 2.3 Co-production styles and patients-providers relationship in healthcare

		Health service design and planning		
		Providers as sole service designers and planners	Providers and users as service co-planners and co-designers	Users as sole service designers and planners
Health service delivery	Providers as sole service deliverers	<i>Traditional service provision:</i> Healthcare professionals stick to the biomedical model, focusing on the illness rather than on patients' health needs	<i>Service co-planning and co-design:</i> Healthcare professionals involve users in shared decision making, but maintain their control over healthcare delivery	<i>Professional delivery of patient-led services:</i> Patients are the main drivers of health decisions, while healthcare professionals perform as the sole deliverer of care
	Providers and users as service co-deliverers	<i>Service co-delivery:</i> Healthcare professionals control health decision making and involve patients in delivering health services	<i>Full co-production:</i> Establishment of a partnership between the patients and the providers to plan, design and deliver health services	<i>Co-delivery of patient-led services:</i> Patients control health decision making and partner with healthcare professionals to deliver health services
	Users as sole service deliverers	<i>Patient delivery of provider-led services:</i> Healthcare Professionals plan and design health services, which are delivered by patients through self-care	<i>Co-design of patient-delivered services:</i> Patients are involved in shared decision making and are engaged in self-managing health services	<i>Self-organized provision:</i> Patients self-organize healthcare provision and do not establish a co-creating partnership with the healthcare providers

Source Author's elaboration

perform as the sole deliverer of co-planned and co-designed services: this is possible when the patients are allowed to participate in shared decision making, concurring in planning health treatments (Frosch & Kaplan, 1999; Hargraves, LeBlanc, Shah, & Montori, 2016). On the other hand, the patients could be engaged as the main deliverers of co-planned health treatments, being encouraged to be autonomous in protecting and promoting their well-being (Kennedy et al., 2013), even though relying on the support of the healthcare professionals (Veroff, Marr, & Wennberg, 2013).

In rare cases, the patients could perform as the sole planners and designers of health services, which could be either co-delivered or delivered by healthcare professionals. In the former case, the healthcare professionals strive for promoting patients' independence (Hughes, 2003); in the latter case, the healthcare providers support the patients' self-management of care, being involved in the delivery of person-centered care (Eaton, Roberts, & Turner, 2015).

As previously emphasized, all these situations concern a particular shade of health services co-production. Indeed, full health services co-production is only realized when the patients and the healthcare professionals fully collaborate in co-planning, co-designing and co-delivering health treatments, establishing a therapeutic alliance which is aimed to the protection and the promotion of psycho-physical well-being (Palumbo, 2016; Clark, 2015). Obviously, the implementation of such a co-creating partnership requires a twofold process of empowerment, which should concern both the patients and the healthcare professionals.

2.4 The Effects of Patient Empowerment on Health Outcomes

A “*zest for patient empowerment*” has risen in the last few years (Raina & Thawani, 2016, p. 1). In fact, patient empowerment has been depicted as a crucial tool to increase the effectiveness and the sustainability of the healthcare service system (Adinolfi, Starace, & Palumbo, 2016). Patient empowerment has been attached to different categories of patients and various health conditions. Among others, scholars have stressed the role of patient empowerment in improving the access to care of disadvantaged populations (Lubetkin, Lu, & Gold, 2010). In fact, patient empowerment shrinks the barriers to patient activation and increases the patients' commitment to health protection and promotion, thus leading to a better use of health services available. Similarly, patient empowerment has been pointed out as an important strategy to deal with rare diseases (Aymé, Kole, & Groft, 2008). In this specific circumstance, the process of empowerment allows to awaken the sleeping resources of patients, who are encouraged to participate—both individually and collectively—in co-designing and co-delivering appropriate health services.

Also, patient empowerment has been claimed to be especially fitting with the treatment of long-term conditions (Greenhalgh, 2009). Actually, people who live with one or more chronic conditions may strongly benefit from patient empowerment initiatives. In particular, the engagement of chronic patients in healthcare delivery allows the access to more personalized and timely care, which in turn contributes in increasing the appropriateness of care (Fotaki, 2011). It is worth noting that the importance of patient empowerment has been claimed beyond chronic and rare conditions, representing the underpinning of patient-centeredness in the healthcare service system also when acute diseases are concerned (de Boer, Delnoij, & Rademakers, 2013).

Two different interpretations of patient empowerment have been suggested in order to examine its consequences on health outcomes. On the one hand, patient empowerment has been dealt with as a risk factor (Simmons, Wolever, Bechard, & Snyderman, 2014): it involves the development of the individual knowledge, confidence and skills to cope with the disease and to protect the individual well-being. From this point of view, the disempowerment of patients may produce several side effects on health outcomes, preventing the patients to participate in the provision of care and to perform as value co-creators during the medical encounter. On the other hand, patient empowerment has been understood as an outcome of enhanced patient-provider relationships (McAllister, Dunn, Payne, Davies, & Todd, 2012), which pave the way for a greater willingness to activate and use the patients' sleeping resources in order to enhance the functioning of the healthcare delivery system. Regardless of the interpretation embraced, a link between patient empowerment and health outcomes could be figured out (Palumbo, 2016). However, the scientific literature is not consistent in discussing the direction and the intensity of such a relationship (Michie, Miles, & Weinman, 2003).

Therefore, it is not surprising that the relation between patient empowerment and health outcomes has been argued to be complex and dynamic. In general terms, since it involves a long-term partnership between the patients and the members of the healthcare service system at both the operative and the strategic levels, patient empowerment establishes a bridge for the achievement of more responsive and effective care, which is crucial to achieve increased health outcomes (Laurance et al., 2014). Echoing these considerations, a co-creating relationship between the patients and the providers of care has been found to be related with higher rates of compliance and therapeutic adherence, resulting in better recovery and enhanced health outcomes (Skolasky, Mackenzie, Wegener, & Riley, 2011). Similarly, Hibbard and Greene (2013) pointed out a positive link between patient empowerment and better healthcare experiences, with empowered patients being more willing to participate in the provision of care and to perform as active value co-creators. Of course, the more the patients are able and willing to be involved in the provision of care, the higher their retention rates and their attendance to health services in order to cope with impaired health conditions, and, consequently, the better the health outcomes achievable (Alegria et al., 2008).

Also, empowered patients have been found to show greater use of preventive health services and to be more likely to follow healthy behaviors, which are significant predictors of better health outcomes (Greene, Hibbard, Sacks, Overton, & Parrotta, 2015). What is even more interesting is that the effects of patient empowerment on the ability of the patients to perform as value co-creators and service co-producers have been argued to be enduring, paving the way for the establishment of a long-term collaborative partnership between the patients and the healthcare providers (Hibbard, Greene, Shi, Mittler, & Scanlon, 2015). In fact, patient empowerment entails: better patient-provider communications, increased patients' satisfaction and greater compliance with medical prescriptions, which are

key to produce patient engagement and to enhance health outcomes (Powers & Bendall, 2004).

Interestingly, patient empowerment has been related to a more appropriate access to care. Empowered patients living with one or more chronic conditions have been found to be less likely to use health services and to be more effective in following medical prescriptions, thus reporting better health outcomes as compared with those who were not involved in co-planning and co-delivering health services (Remmers et al., 2009). Confirming the role of patient empowerment in producing a more appropriate access to care, Mitchell et al. (2013) reported that hospitalized patients who were not involved in patient empowerment initiatives were more likely to use hospital services within 30 days after discharge. This was especially true for emergency services, emphasizing that lower health outcomes are associated with poorer levels of patient activation. In spite of these findings, scholars are not consistent in depicting a positive relationship between patient empowerment and health outcomes when hospitalized patients are concerned (Arnetz et al., 2010). In particular, the hostility of the hospital setting could be argued to prevent the effectiveness of patient empowerment initiatives, producing apprehension and disengagement.

The relationship between patient empowerment and health outcomes is mediated by different variables, which could amplify or reduce the impacts of interventions intended to enable and involve the patients in the provision of health services. First of all, patient empowerment is strictly related to the ability of the patients to access, understand and use health information (Smith, Pandit, Rush, Wolf, & Simon, 2015). Moreover, the lack of reliable and significant health information within the healthcare service system could negatively affect the ability of the patients to participate in the provision of care and to perform as value co-creators (Annarumma & Palumbo, 2016). Information and communication technologies represent a fundamental tool to enhance the access of patients to timely and reliable health information, thus performing as an essential catalyst to patient empowerment initiatives (Samoocha, Bruinvels, Elbers, Anema, & van der Beek, 2010). Beyond fostering the patients' access to health information, digital tools are able to create a social arena which encourage the establishment of co-creating relationships between the patients and the healthcare professionals, facilitating the mutual exchange of information (Bartlett & Coulson, 2011).

Both health outcomes and patients' satisfaction rely on the establishment of a trusted and friendly patient-provider relationship. At the same time, it is worth noting that patient empowerment and other similar initiatives aimed at supporting the patients' autonomy in the healthcare environment have been found to produce trust and satisfaction among the patients, which in turn contributes in improving the experience of care (Lee & Lin, 2010). On the one hand, trust is fostered by the increased control of patients over the process of health service design and delivery and, on the other hand, by the continuous support of patients' activation by the side of healthcare professionals (Ouschan, Sweeney, & Johnson, 2006).

The importance of trust and reliable patient-provider communication is particularly relevant when disadvantaged patients are concerned, since they are more

likely to escape patient empowerment initiatives (Maly, Stein, Umezawa, Leake, & Anglin, 2008). From this point of view, it could be maintained that, if patient empowerment initiatives are not supported by the establishment of more direct and friendly relationships between the patients and the healthcare professionals, their effects on health outcomes turn out to be constrained (Street et al., 2009). On the opposite, the commitment of healthcare professionals to provide the patients with tailored communication tools in order to promote their involvement in health service co-production is expected to pave the way for a more appropriate use of health services and, as a consequence, for better health outcomes (Trummer, Mueller, Nowak, Stidl, & Pelikan, 2006).

Last but not least, the relationship between patient empowerment and health outcomes is mediated by the disease-specific knowledge of patients. In fact, scholars have emphasized that patient activation is associated with an increased ability of patients to develop an adequate understanding of their health condition, as well as with a higher awareness of the implications of the disease on psycho-physical well-being (Hendriks & Rademakers, 2014). Disease-related knowledge leads to greater patients' ability to self-manage their health conditions, which is related to the achievement of better health outcomes (Camerini, Schulz, & Nakamoto, 2012). Ultimately, patient empowerment initiatives assist the patients in developing both health-related skills and increased self-efficacy, which underpin self-management of care and concur in improving the individual well-being (Shah & Siegel, 2015).

Figure 2.3 summarizes the relationship which links patient empowerment and health outcomes. The scientific literature is consistent in discussing the positive effects of patient empowerment programmes on health outcomes (Altshuler et al., 2016). However, in most of the cases the variables which mediate the relationship between patient empowerment and health outcomes have been overlooked. There is a strong need for shedding light on these mediating variables, in order to push forward the knowledge about the consequences of patient empowerment initiatives.

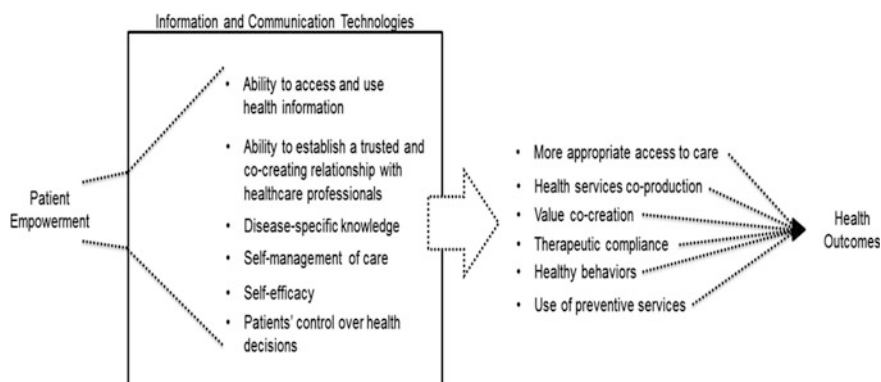


Fig. 2.3 The relationship linking patient empowerment and health outcomes. *Source* Author's elaboration

The greater awareness of the mediating variables between patient empowerment interventions and health outcomes could bring to the design of more effective and tailored patient empowerment interventions, improving the involvement of patients in the delivery of care.

Patient empowerment implies the activation of the patients' sleeping resources. Such a process of activation concerns the ability of the patients to access, understand, process and use health information, their willingness to establish a co-creating partnership with the healthcare professionals, the development of disease-specific knowledge and the proficiency in self-managing health conditions. Information and communication technologies create a digital arena which allows to strengthen the link between patient empowerment initiatives and health outcomes, disintermediating the relationship between the patients and the healthcare providers. Hence, information and communication technologies may foster the patients' ability to perform as value co-creators in the healthcare service system.

2.5 Patient Empowerment: A Requisite for Sustainability

Inadequate patient empowerment has been discussed as an important determinant of inefficient management of impaired health conditions (Angelmar & Berman, 2007). In particular, patient disempowerment is associated with inadequate ability to detect and cope with health problems, limited involvement in co-planning and co-designing health treatments, poor willingness to participate in the delivery of care, low compliance with medication prescriptions and higher risks of inappropriate access to care (Palumbo, Annarumma, Adinolfi, & Musella, 2016). From this point of view, it could be pointed out that patient disempowerment is associated with higher healthcare costs. Therefore, if patient empowerment is not included among the strategic priorities of the healthcare service system, significant risks of unsustainability are expected to emerge.

These considerations seem to be supported by the findings of several studies which examine the implications of the adoption of a patient-centered approach to care during the medical encounter. Among others, Stewart et al. (2000) suggested that the establishment of a common ground between the patients and the healthcare providers contributes in increasing the efficiency of care, by reducing diagnostic tests, referrals and inappropriate use of health services. In a similar way, lower health-related charges have been attached to the implementation of a patient-centered approach to care (Bertakis & Azari, 2011). In addition, patient-centered communication styles have been found to be associated with fewer diagnostic testing expenditures, even though they are likely to produce increased visit length (Epstein et al., 2005).

Since time is one of the most critical and scarce resources in the healthcare environment, scholars have questioned whether patient involvement is always possible when designing and delivering health services (Jones et al., 2004). In fact, it is possible that the healthcare professionals overlook the role played by patient

empowerment in their everyday practices, since they lack adequate time to meet the special information and health needs of their patients. Nonetheless, it is interesting to note that the initiatives aimed at promoting patient empowerment have been generally found to be cost effective, merging two conflicting purposes: the enhancement of health outcomes and the containment of costs associated with the provision of care (Richardson et al., 2008). As anticipated, this is possible by enabling the sleeping resources of the patients and activating them for the purposes of health protection and promotion.

Empowered patients perceive greater self-efficacy in dealing with their health-related conditions and are likely to report a lower use of emergency and hospital services (Shively et al., 2013), thus contributing to significant cost savings (Lorig et al., 2001). Hence, it is not surprising that a recent study aimed at investigating the costs incurred by patients facing different diseases—such as diabetes, hyperlipidemia, hypertension and asthma—reported that those living with higher levels of patient activation were consistent in producing lower healthcare costs as compared with their disempowered counterparts (Hibbard, Greene, & Overton, 2013). A more appropriate access to care and healthier life-styles have been argued to perform as the most important determinants of reduced costs for empowered patients (Greene & Hibbard, 2012). Also, patient empowerment has been claimed to enhance the ability and the willingness of patients to take a proactive role in the healthcare service system, partnering the providers of care in co-producing health services and co-creating value (Tzeng et al., 2015).

Since it merges the opportunity to reduce health costs and to increase health outcomes (Goozner, 2016), patient empowerment could be depicted as a requisite for increased sustainability of the healthcare service system (Angelmar & Berman, 2007). A wide-ranging analysis should be performed to appreciate the impact of patient empowerment initiatives on the functioning of the healthcare system, taking into considerations both the cost savings associated with the engagement of patients in the provision of care and the additional costs which are required to enable patients (Entwistle, Sowden, & Watt, 1998). Embracing such perspective, Groessl and Cronan (2000) claimed that the cost savings which are associated with patient empowerment are able to outweigh the costs of planning and implementing patient empowerment initiatives. Drawing on these arguments, greater attention should be paid to the role of patient empowerment in strengthening the sustainability of the healthcare service system, a hot topic in most of Western Countries' health reform.

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