Interpretations of Service Formation

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Abstract

Objectives: The research aimed to firstly identify and then explore what factors influence service participant interaction in the service formation process within the client-provider-manager network in community-based aged healthcare.

Methods: An exploratory inductive triadic study was undertaken with nine participants involving: clients with mild dementia, living in their own home; providers; and managers in the same service network. Inductive analysis was employed to discover the key interaction ideas and a literature review was then undertaken to identify related existing concepts. Based on the findings, a further study was undertaken in two separate locations with 29 individual semi-structured in-depth interviews. Inductive and deductive analysis was used to discover and describe the themes for the interaction concepts. The data was then stratified for each theme by respondent category and comparative analysis undertaken. Both studies used a phenomological approach, with participants purposively recruited.

Results: Study A identified four concepts: Client Orientation, Client Involvement, Provider Empowerment, and Client Empowerment. Study B pinpointed 18 shared themes for these concepts, but found that the meaning ascribed to each theme differed between the participant categories. Client comments were found to be positional; provider comments, relational; and manager comments, normative. This divergence in how service network participants perceive the formation of a service explicitly reflects each participant's place and role in the network.

Conclusions: The differences in meaning highlight that there is divergence in how service network participants perceive that a service is created. These findings reveal specific insights which offer service providers and managers information that can be used to actively enlist clients in the service creation process. It also offers information that could be used to assist in the areas of staff selection, training and assessment for high contact on-going services.

Key Words: Service Co-creation, Client Orientation, Provider Empowerment, Client Involvement, Client Empowerment

Introduction and Objectives

As a result of the significant growth in the number of people aged over 65 that is associated with the increase in life expectancy in westernised countries (United Nations Department of Economic and Social Affairs, 2005), public healthcare services have been confronted with

rising health care costs for older people. In response, public systems have introduced community delivered services which assist older people to be holistically supported in their own homes, thereby achieving a reduction in more costly hospital and residential aged care admissions (Holland & Harris, 2007). Moreover, the literature shows significant reductions in the cost of care when a service improves, with the dynamics of poor service often involving wasted effort, repetition, and misuse of skilled employees (Kenagy et al., 1999). Understanding healthcare quality has therefore become a critical area for healthcare services, as it is a means to achieving improved health outcomes (O'Connor et al., 1994).

The measurement of quality in the public sector has been influenced by the traditional concept of healthcare relationships which has been based on three primary assumptions: the system is the gatekeeper for socially supported services; the ideal client[1] is compliant and self-reliant; and the professional is the expert (Thorne et al., 2000). As a result, the definition and management of healthcare quality in this sector has been the responsibility of the service provider, and public healthcare services have been largely introspective in defining and assessing quality, focusing mainly on the provider components (Bell, 2004), and using client satisfaction as a proxy for the client's assessment of service quality (Turris, 2005). Yet a healthcare service requires a significant contribution from the client, the service provider and the service manager, with the inaugural quality assurance work of Donabedian (1980) highlighting the importance of the interpersonal process in the delivery of healthcare. Donabedian (1980) argued that the interpersonal component was the vehicle by which the technical care was implemented and on which its success depended. Healthcare services are fundamentally reliant on interactions between people, and Kenagy et al (1999) pointed out that interactions with clients have remarkably strong effects on clinical outcomes, functional status and even psychological measures of health. Additionally, Andaleeb (2001) reported that a client's perception of the quality of their healthcare service had a greater influence on their behaviour than other factors such as access and cost.

Method Study A

To locate the factors which influence the behaviours and interactions of the participants of a high involvement, high contact and ongoing community-based aged healthcare service, an exploratory triadic qualitative study and subsequent literature review were undertaken in

[1] The health literature largely refers to its clients as patients. This article uses the term "client".

early 2008 (Gill et al., 2011). The subjects for this study were the service manager, three direct service providers and five clients in the same service chain in the southern Sydney area in Australia. All five clients were of Anglo-Saxon origin and had mild to moderate dementia, were aged over 80 and were interviewed in their own home. In recognition of their potential vulnerability, recruitment of these participants was undertaken with the support of the organisation's research manager, and locally with the assistance of the area manager to ensure their ability and willingness to participate. The research proposal was reviewed and approved by the ethics committees of both the researchers' academic institution and the service organisation. A protocol was established to manage any potential adverse consequences or issues that might arise. To facilitate exploration of the concepts, it was necessary to deal with the cognitive and memory impediments of dementia which can affect a person's ability to engage with abstract concepts. Accordingly, in each client interview, some time was spent prior to the commencement of the interview getting to know the respondent and discussing their life experience, so that subsequent questions could focus on their active personal experience and emotions. For example, in every home there were photographs displayed and these were used as a means of connecting with the participant and their earlier life. Because of the special needs of the clients, interviews were conducted with a number of rest pauses.

The interviews were audio-taped and the convergent interview technique (Dick, 1990) was used to answer the question: what are the things that influence and support the interactions of the service participants? The interviews averaged 60 minutes, and each tape was electronically sent immediately following the interview to an independent transcriber who produced a verbatim transcript. The researcher audited each transcript, checking it against the original recording for accuracy. An evolving structured data analysis process was adopted and after the first two interviews, probe questions were used to converge on developing ideas. Any doubtful or ambiguous issues were followed up and the interviewee was asked for a summary of the key points they had covered in their interview. Observational notes about the interaction of each participant with the researcher and the interview process were made immediately after the interview, particularly for the clients because of their cognitive impairment, and these were built into each transcript. Reflective notes were also produced to describe the researcher's participation, reactions and experiences, and special attention was paid to reading the client responses carefully and interpreting them. The data were sequentially constructed, drawing on all of these sources and new ideas were explored with a

view to confirming/disconfirming their replication and looking for evidence of saturation. On completion of the interviews, the coding and categorisation of the data, the emergent themes within and then across each of the three participant groups were identified through inductive analysis (Pope et al., 2000). Four key ideas emerged from the data: how the service is focused on the client; how the care worker is empowered to provide the service; how the client actively contributes to the service; and how the client is empowered to actively participate in the service.

Client focus was firstly identified in the organisation's charter which centred on holistically improving the lives of older people, and was then repeatedly evident in the interviews with the service manager, each of the care workers and the clients and, consequently, can be depicted as influencing the quality of the service that was created. The manager highlighted the importance of the careful selection of the care workers *"finding the right staff … team players … good listeners … respectful of the needs of the elderly"*, her allocation of care workers *"ensuring there is a good relationship between a care worker and each of their clients … making sure the clients needs are being met … ideal is for care worker to work co-operatively and comfortably with the client"*, her interactions with the care workers *"providing advice and encouragement … ensuring care worker continuity and support … making sure staff have the skills and knowledge required to help their clients"* as well as the availability of physical resources that she controlled *"ensure necessary equipment and aids are in stock … keep up to date with best available aids"*. Moreover, the client focus was reinforced by all three care workers who spoke of the need to, *"listen and understand what the client is saying … work out what it is that you can best do to help them"* (P1)[2], *"relate to the client … respect the client"* (P2), *"meet the individual needs of each client … get to know them as a person"* (P3). Clients explained that it was important for their care worker to *"relate to people individually"* (C1) through the organisation demonstrating that it *"Values its clients ... the personal touch"* (C3).

Client contribution was highlighted in the interviews as both care workers and clients spoke of the need to *"work together"* (C2 & P1) and *"sharing information"* (C3 & P2). The manager explained how *"engaging them is an important part of meeting their need"*. Care workers spoke of *"encourage each client to express their needs"* (P1), *"tell them what you*

[2] The first component of the code is is the participant category code (M=manager, P=provider and C=client); and the second is the number in order of interview for that participant category.

think you need to do … ask them what they think? … ask them to help you do whatever it is you decide together" (P2), *"gain their confidence … ask what can I do for you? …two-way communication is very important"* (P3). Clients spoke of *"feel like they really wanted to know what I thought"* (C1), *"they like you to help them"* (C2), *"prepared to chat and listen to me"* (C3), there being *"agreement on what's to be done"* (C4), *"they ask me what needs to be done today"* (C5). Client involvement can therefore be identified as shaping the co-production of the service and its quality.

The three care worker interviews provided evidence of service provider empowerment through *"being able to deal with situations that arise"* (P1 & P3), *"really understanding what it is like to have dementia … what it means to the client who has it"* (P1) and *"knowing when to call in the manager"* (P2). They highlighted the importance of being empowered to perform their job *"we have to analyse what is happening with each client and take action if necessary … such as call my manager"* (P1), *"sort out problems as they arise"* (P2), *"we may have to check something out with the family that relates to our client's safety"* (P3). The manager indicated how *"it (service provider empowerment) forms a foundation ... they certainly need to be problem solvers"*. The clients explained that where there was a problem *"They (the manager and their care worker) know what to do ... they anticipate ... they fix it"* (C1), and *"(empowerment of the care worker) it's necessary, important, you know"* (C2). As a result, service provider empowerment can be seen to impact on the service that is created and its quality.

Care workers related the importance of being empowered *"Because the whole relationship depends on, you know, getting along with them and them being able to be empowered by us and make decisions and make choices"* (P3) and *"because we're client focussed ... it's one of the top things I think you do ... give them information and choices ... it empowers them really"* (P1). The manager indicated that *"knowledge is very important ... give them* (the client) *the information, then I think that helps in the relationship and the building of the service"*. All clients interviewed talked about the fact that the care worker *"answers my questions", "explains things to me"* and *"respects my ideas"*; and client empowerment could be seen with *"Lets me run the show"* (C1), *"I know X really wants me to ask her questions … tell her things"* (C2), *"They encourage me to take care of myself"* (C3), *"they treat me as an equal"* (C4), *"I can stay here with their help"* (C5). The co-production of the service is therefore influenced in part by how the client is empowered in its creation and delivery.

The literature examination identified four concepts that aligned with these ideas: client orientation, which impacts on the client's assessment of the performance of an organisation (Brady & Cronin, 2001); employee empowerment which is influenced by the organisation's service orientation, thereby impacting on the client's perceptions of the quality of their service (Schneider et al., 1998); client involvement which influences the client's perceptions of the benefits of the service they receive (Kinard & Capella, 2006); and client empowerment which enables the client's involvement in their service (Loukanova et al., 2007).

Literature Review

In the services literature, Solomon et al. (1985) first highlighted that a service encounter was a human interaction; and Czepiel (1990) maintained that services research should include the perspectives of all those involved in the creation of the service. Accordingly, if a service encounter is based on the interactive process between the client and the service provider (Grönroos, 2001), then the current measurement and assessment of perceived service quality through the client has largely ignored the interactive process that must occur in the production and consumption of the service. On this basis, Svensson (2002) proposed that overall service quality might ultimately be dependent on the interaction that occurs between all the participants of a service network. Svensson (2003) argued that interactive service quality was dependent on the provider and client perspectives of the interaction that occurred during the production, distribution and consumption of the service; and subsequently offered a mechanism whereby this could be measured (Svensson, 2004), and Svensson (2006) highlighted that a service and therefore its quality is produced through the behaviours and interactions of the service providers, service recipients and service enablers. Further, Vargo and Lusch (2008b) proposed that a service, to be effective, must be inherently client oriented, with employees empowered in their role of creating value as the organisation's source of knowledge and innovation. They depict value as always being uniquely and phenomenologically determined by the beneficiary, and contend that all direct service providers should be empowered in their role of value-creation, as they are the organisation's main source of innovation, knowledge and value. Service managers are also portrayed as having a key role in the service that is created through supporting their employees and facilitating integration of the organisation's resources (Vargo & Lusch, 2008b). Further, the quality of the interaction between the participants of a service network is essential to service

co-creation, with Fyrberg and Jüriado (2009) emphasising the need for research on the interaction processes of network participants and the resultant co-creation of value.

High-contact service provider success is a direct result of their flexibility, their tolerance for ambiguity, their ability to monitor and change their behaviour during the service encounter and their empathy for the client, which can be best achieved through client orientation (Heskett, 1986). In the services literature, client orientation has largely been studied as a component of the market orientation construct (Hajjat, 2002), yet many researchers have emphasised client orientation in their work (Deshpande et al., 1993), with Naver and Slater (1990) suggesting it might play the greatest role. Client oriented behaviours of frontline staff has been described as the activity by which relationships are developed and continued (Crosby et al., 1990; Dunlap et al., 1988) and through it, the resulting consultative and reciprocal dialogue provides the basis for the exchange of cues and information that each party needs to learn from each other, form expectations, co-ordinate plans, and resolve conflict (Williams, 1998). Furthermore, Brady and Cronin (2001) argued that client orientation influenced the consumer's evaluation of organisational performance and ultimately their outcome behaviours. They identified that perceptions of being client orientated were directly related to client evaluations of service performance, and indirectly related to service quality and outcome behaviours, as well as client satisfaction and service value. They concluded that the interactions with clients largely determine consumers' perceptions of their service experience. Hajjat (2002) found that client orientation was a first order construct and Macintosh (2007) highlighted that having capable, empowered and motivated client oriented frontline employees was important to the viability of a service organisation.

Daniel and Darby (1997) in their healthcare setting study, conceptualised client orientation as the ability of the service provider to adjust their service in response to the circumstances of the client, and Brown et al (2002) defined client orientation as an employee's tendency to meet client needs. Rafaeli et al (2008) claimed that client orientation is achieved by employees behaving in a way which supports client goals. A client orientation enables the organisation to create superior value for its clients because their needs are better understood (Narver & Slater, 1990); this implies that clients should be the priority of an organisation. Rindfleisch & Moorman (2003) defined client orientation as the beliefs and behaviours which show that the interests of the client are a priority, and indicated that it results in the

continuous creation of exceptional client value; with the later being achieved by a climate which promotes service improvement. Dean (2007) further developed the definition, where perceived client orientation is described as the extent to which clients believed that the service provider was committed to understanding and meeting their needs; and pointed out that client focus is actioned through a dedication to one's clients. Furthermore, commitment implies a pledge of relational continuity between partners (Dwyer et al., 1987) and the desire to maintain a valued relationship (Moorman et al., 1992). Homburg et al (2002) found that the pursuit of a service-oriented business strategy would create "benefit bundles" that make up the service offerings. In addition, Korunka et al (2007) pointed out that there has been limited research in both the private and public sectors on client orientation; and that it is portrayed as a component of corporate culture which will increase client benefit. In summary, client orientation sets the scene for the interaction that occurs between frontline staff and the client, as well as the interaction between service managers and their staff.

Empowerment is defined by Gibson (1991) as "a social process of recognising, promoting, and enhancing people's abilities to meet their own needs, solve their own problems and mobilise the necessary resources to feel in control of their own lives" (page 359); and Martin-Crawford (1999) noted that empowerment for one party can be central to empowering the other party. Empowerment cannot occur without the service climate's support, and the work of Strong (2006) indicates that there is an association between an organisation's customer focus strategies and employee empowerment, along with customised responsiveness, professional competence and team motivation. In addition, Crane-Ross et al (2006) highlight that service empowerment is dependent on the existence of a collaborative relationship between the service provider and the client.

There is a wealth of health sector literature that focuses on client empowerment, largely located in the mental health and disabilities area. Empowerment is identified as a motivational construct that impacts on outcomes (Baker et al., 2007). A systematic review of this literature by Loukanova et al (2007) identified empowerment as an ongoing process that not only relates to client skills but also to factors relating to the healthcare system. They defined empowerment as a continuous partnership which enabled clients to become more responsible for and involved in their treatment and healthcare. They proposed that client knowledge, health literacy, initiative and service access were empowerment antecedents; supported by information sharing, communication, choice, and shared decision making; and

these in turn impact on health status, satisfaction, self-efficacy and adherence. Geiger & Prothero (2007) point out that empowerment is directly related to how relationships between individual stakeholders develop, with the making of informed decisions requiring knowledge which is acquired through the availability and provision of information and the existence of genuine choice; all of which play an important role in the process of empowerment in the service relationship. Shankar et al (2006) emphasise that power creates both producers and consumers through the exchange of knowledge. In addition, the rise in chronic illness in older people has resulted in an increasing emphasis on client empowerment, specifically for them to manage their condition on a daily basis, and Michie et al (2003) refer to this as the client taking control of their illness; this can only be achieved through initiative taking. In summary, empowerment is both reciprocal and relational.

The services literature has focused on empowerment within the organisational context. This research has shown that employee empowerment is a component of service orientation (Kandampully & Solnet, 2005) and also that there is a link between service orientation and client perceptions of service quality (Schneider, et al., 1998). Empowering organisations provide employees with greater access to resources and information (Spreitzer, 1996); information builds knowledge, and McEwan and Sackett (1996) point out that where employees have a high level of control over the creation of their work, that they are empowered by their knowledge and skills. Furthermore, an empowering organisation allows employees to participate as partners, thereby facilitating initiative taking, and giving them the authority to make strategic decisions (Garfield, 1993). Honold (1997) highlighted that employee empowerment is used to describe both the individual and the organisational components, and that it is the service managers who create a work environment where employees have the choice of being empowered. Blanchard et al (2000) identified that empowerment bestows the freedom to make choices and therefore take action, which carries with it the responsibility for the outcomes achieved.

Client involvement in the service creation process has been recognised in the services literature for some time (Bateson, 2002; Bendapudi & Leone, 2003; Prahalad & Ramaswamy, 2004), with service co-creation receiving renewed consideration in the context of Service Dominant Logic (Vargo & Lusch, 2004). This logic depicts interaction as being the key influencer of the resultant service and its quality, and Vargo and Lusch (2008a), on the basis that service value creation is interactional, proposed that irrespective of the type of service,

the client is always a co-creator of value through their participation in the creation of the service. Importantly, service value cannot be created or delivered unilaterally; it always involves the contribution of the client within a relational context (Lengnick-Hall, 1995). In the health services sector, the terms "involvement" and "participation" are used interchangeably (Cahill, 1998) and much of the work reported is on client participation. Lammers and Happell (2003) point out that there is a clear need to develop mechanisms to support client involvement and to influence the attitudes of health professionals to more highly value a client's perspective. Client involvement is affected by both client and provider behaviour, and opinions concerning client involvement, as well as factors in the service delivery environment (Arnetz et al., 2008). Eldh et al (2006) found that conditions for client participation included being informed based on individual needs; being regarded as an individual and treated with respect; having knowledge; making decisions based on one's knowledge and needs; and participating in planning one's care. Entwistle et al (2008) established that involvement has a relational dimension, as it is a result of the subjective perceptions of engagement and affinity, as well as having action and information exchange dimensions. In addition, Clark and Clark (2007) point out that long term service relationships are more highly dependent in their nature, and that the clients will adjust their expectations and therefore their assessment of the quality of the service they receive, because of their relationship experience.

Health professionals are increasingly encouraged to involve clients in treatment decisions and Say and Thomson (2003) highlight that involvement of the client is essential to the client experience. Edwards and Elwyn (2006) focused on client involvement and found that it was the process of involvement that delivered benefits to clients and also influenced the service outcomes. Research indicates that individuals perceive greater benefits from service providers requiring high levels of client involvement (Kinard & Capella, 2006) and point out that to customise a service, the client must be willing to exchange specific information with the service provider, which in turn allows the provider to understand the client and their needs. Information sharing is a prerequisite to shared decision making, along with its influence on the client's level of confidence (Edwards & Elwyn, 2006). Furthermore, engagement in the decision making process relates to consumer confidence (Edwards & Elwyn, 2006) which is the primary relational benefit influencing relational response behaviours (Zaichkowsky, 1985). Kinard & Capella (2006) measured client involvement using a modified version of Zaichkowsky's Personal Involvement Inventory (Zaichkowsky,

1994) and found that clients perceive greater benefits when engaged in a relationship with a high contact customised service. Teichert & Rost (2003) measured the effects of trust and involvement on client retention and found that involvement plays a major role in explaining trust creation and client retention. Moreover, Trachtenberg et al (2005) found that trust is a key predictor of the client's involvement in their health care; this is supported by the work of Edwards and Elwyn (2006) which highlights the importance of clients trusting the information and advice of their doctor. In summary, the involvement of the client determines their contribution to the service which occurs through their interactions with their health service provider.

Method Study B

Building on the findings of Study A and a subsequent literature review, Study B sought to identify and then describe the key themes associated with the four concepts that were found in Study A to influence participant interaction for an ongoing community-based aged healthcare service. Two discrete deductive, qualitative sub-studies were undertaken, with participants purposively recruited through the same organisation, but in different geographical locations. The recruitment process used in Study A was replicated, and all the clients who were interviewed had dementia.

Informed by the literature, initially four themes were proposed for Client Orientation (commitment, benefit, priority and service improvement), three themes for Provider Empowerment (knowledge, initiative and choice), four themes for Client Involvement (confidence, trust, engagement and information exchange related) and three themes for Client Empowerment (knowledge, initiative and choice). Focusing on the four concepts and the proposed themes, general and specific interview questions were developed along with a free response question. During November 2008, in-depth interviews were conducted with a total of 12 respondents; one service manager (female), six care workers (all female) and five clients (three female and two male) in the same service network in the northern Sydney area in Australia. All participants were of Anglo-Saxon origin and interviews were audio-taped, with each manager and provider interview averaging 45 minutes' duration and client interviews averaging 60 minutes. Based on the findings of this work, the interview questions were further developed and additional institutional ethics approval obtained. In October 2009, the second sub-study was conducted with participants purposively sourced from the same organisation but in a location outside of Sydney which was semi-rural, of mixed socio-

economic profile and of Anglo-Saxon origin. A total of 17 in-depth interviews of similar length were conducted with participants belonging to two separate service networks: the first consisted of the manager (female), three providers (female) and six clients (four female and two male); and the second consisted of the manager (male), two providers (female) and four clients (three female and one male).

The same analytical approach was used for each sub-study, with organisation of the data beginning with the management of coded computer files for both the transcripts and the audio-recordings. Participants are reported as a three part code: study code, service category code and participant numerical code[3]. Thematic analysis of the data employed a deductive manual content approach (Miles & Huberman, 1994; Spencer et al., 2004), with both studies relying on systematic processes common to Grounded Theory: concurrent data collection and analysis, which facilitated constant comparison of data for checking theory development; purposeful sampling; exploring all atypical cases; memo writing; and member verification. The interview was recorded, with each tape being electronically sent immediately following the interview to an independent transcriber who produced a verbatim transcript. The researcher audited each transcript, checking it against the original recording for accuracy. Concurrently, analysis focused on the general interview questions and the final free response question, to inductively discover and then illustrate new emerging themes. The template analytic technique (Crabtree & Miller, 1999) was then used, and deductive codes from the code book were applied to the complete raw data set, to label meaningful units of text. Researcher comments were also attached to those units of data, and a separate file for each theme was gradually constructed, resulting in an integrated verbatim data set, to which the assigned the codes and comments were transferred. Memos, derived from the field notes, were used to reduce the data and then again in the verification and conclusion process, with coded data highlighted, linked and gradually combined, ultimately resulting in a table summarising the themes. A comparison of the meaning each participant group applied to each theme was then possible. A verification process was adopted for drawing conclusions, which involved the development of preliminary conclusions and then testing each of them by revisiting the data and identifying the evidence that supported or disproved each respective conclusion. Cases where the conclusion did not hold were further examined to evaluate what

[3] The first component of the code is the sub-study number (I or II) the second is the participant category code (M=manager, P=provider and C=client); and the third is the number in order of interview for that participant category.

was different about them and what it indicated. The result of the verification process established that the refined conclusions held in most cases.

Findings Study B

For all three respondent categories, explicit differences in the meaning ascribed to the themes of Client Orientation, Client Involvement, Provider Empowerment and Client Empowerment were identified from both the observational notes and the data analysis. Examination of the experiential content of the general questions and free response question established two additional themes for Client Orientation: Value and Focus. Analysis revealed that clients experienced valuing through a positive personal and responsive encounter with their service; providers outlined that valuing could be achieved through ensuring their client was at the centre of the service they provided; and managers indicated that valuing was experienced through the provider developing the service to meet individual needs of their client. Focus was experienced by clients when their provider responded obligingly in delivering their service; providers indicated that a client focus could be achieved through their shaping of the service; and managers suggested that a client focus was achieved through their selecting the right staff to provide the service.

Two additional themes were also identified for Client Involvement: Relationship and Participation. Analysis showed that clients desired a friendly relationship with their provider; providers indicated the importance of their developing a connection with the client; and managers spoke of the need for there to be consistency in the client's provider. Clients revealed that their participation was influenced by being able to personally interact with their provider; providers related that gaining a client's participation required allowing time for a connection to evolve between them; and managers focused on the importance of the provider actively finding a connection with the client. Subsequent definitions and descriptions were developed for each of those four new themes, and these were added to the template for use in sub-study II.

Despite the mutuality and interdependency that existed between the three respondent categories, differences became apparent early on in the analysis; manager comments tended to be normative in character "*we have to ensure*" (IM1); client comments highlighted the reliant nature of their service relationship "*look after us*" (IC4); and provider comments indicated the dissonance they experienced with the different expectations placed on them

firstly by their manager, "*act in a professional manner*" (IP5), and secondly by their client, "*view you like a member of their family*" (IP5). Almost all the clients interviewed presented as "passive" recipients of the service they were receiving, were keen to tell how they had come to rely on the service, how they could not do without it, and many expressly related how it was the service that made it possible for them to stay in their own home. These findings were also mirrored in the second sub-study.

The results of sub-study II reinforced the themes identified in the first sub-study, along with the differences in the perspectives of the three respondent categories. Analysis of the general questions and free response question uncovered no further themes. Comparative examination of the collapsed data of both studies highlighted consistent discrete trends in the responses for each participant category. Accordingly, the data for each theme was subsequently stratified by respondent category and further analysis was then possible. Overall manager responses focused on performance and organisational standards, reflecting their bigger picture managerial and reporting responsibilities. The manager data evidenced a focus on ensuring that the organisation's service objectives and reporting processes were implemented, this can be seen in the selected manager quote for the concept Client Orientation and the theme Improvement: "*You've always got the surveys and the paperwork that shows that you're trying to make some improvement* (IIM1)." The stratified analysis of provider responses found that they were relational, reflecting the provider agency and direct client involvement roles, for instance the selected provider quote for the same concept and theme is: "*By giving quality care, we're always trying to improve what we do as our main priority is the client and making sure they're happy* (IIP5)." The stratified analysis of the responses of the clients reflected their dependence on the service which was evident through their experiential and appreciative focused responses when talking about their service; this can be seen for the same concept and theme in the quote "*Well, they keep checking what I need, and if they say they're going to do something, they do it* (IIC6)".

A meaning was then assigned for each respondent group for each theme to depict the differences in the perspectives between the three groups of service participant for the same theme (Appendix A). To illustrate these differences, the meaning associated with the manager quote for the theme Improvement is one that is related to evidence; the meaning assigned to the provider quote is associated with practice; and the meaning assigned to the client is about service provision.

Discussion

This is the first investigation that identifies and links the four concepts Client Orientation, Client Involvement, Provider Empowerment and Client Empowerment in the context of service formation, and then pinpoints the abstract themes relating to each of them. It is based on the co-creation premise of Service-Dominant Logic, the application of which depicts the composition of a community-based aged healthcare service as the result of the combined contribution of the client, the provider and the manager. Considerable attention was paid to selecting the organisation in which to conduct this work, so as to ensure that the organisation had a strong client-centered approach to service provision and one where it was feasible to conduct the work in different geographic locations, thereby addressing the issue of validity. The research sought to explain how an intensive and ongoing service is created through the contribution of all three participants who play a role in forming the service due to their inter-dependencies. It also aimed to discover the meaning each participant category ascribed to the identified abstract themes.

Based on the significance of participant interaction in the creation of a service (Donabedian, 1980; Fyrberg & Jüriado, 2009), it is proposed that understanding the influencers of the interactive process for members of a service network offers a means to comprehending how a service and ultimately its interactional quality are formed. It is suggested that this work makes a theoretical contribution to services research, an extensively studied field with a number of conceptual service quality models which endeavor to explain the concept of perceived service quality (Svensson, 2002). Most recently, the depiction of perceived service quality as a multi-dimensional hierarchical concept has gained support, with interaction confirmed as a primary dimension (Dagger et al., 2007). However, these models fail to offer an explanation of what shapes the dimension of interaction, as they focus purely on the client perspective. Notably, Gounaris et al (2003) point out that there has been little work undertaken which identifies the antecedents of service quality, and in their banking sector study, they report that service quality is a function of both client and organisation specific antecedents, which they present as industry specific.

In relation to understanding the formation of a community based aged healthcare service, a number of observations relating to the participant categories were recorded during the conduct of the interviews, and to some extent these can potentially be explained by the

participant's relative position in the service network. Many of the clients appeared to be reticent to "opening up", and took great care to ensure that they spoke highly of the service and their provider. Their vulnerability was clearly apparent as they related how they relied heavily on the service to keep them in their own home and how it prevented them being moved into residential care, something which they dreaded. The providers expressed concerns about their participation, and these concerns were identified as relating to the possibility that it was they who were being assessed. They recounted their need to take care so that their responses would not negatively impact on their position, though longer term employees offered information more openly than those who had been with the organisation for a shorter period. The managers behaved as though they too were under a microscope, and made every effort to sprout the "language of the organisation", becoming concerned if they couldn't remember the right organisational phrase. As a consequence, the researcher gave continual and ongoing assurances about the nature, confidentiality and purpose of the research to all participants. In addition, both providers and managers offered unprompted comment that the questions that were asked in the interview concerned issues they had not consciously considered, but indicated that they felt all were important in executing their roles.

Sherratt et al (2007) asserted that reduced mental capacity could not justify excluding people from participating in research, and they indicated that obtaining an understanding of people with dementia could best be achieved through the use of qualitative methods. Yet despite the increasing incidence of dementia that is associated with the aging of the population (AccessEconomics, 2009), to the knowledge of the authors only one previous study has been identified that has explored the service provision perceptions of people with dementia (Aggarwal et al., 2003). Hubbard et al (2003) have highlighted that, in the area of dementia services research, proxy perceptions and observations of carers have been considered more valid than those of people with dementia. People with dementia are one of the most excluded groups from services research (Hellstrom et al., 2007), and their exclusion appears to be in contravention of the principles of the Declaration of Helsinki (The World Medical Association, 2008). Hellstrom et al (2007) argue that the issue is not, should people with dementia be included in research, but how best can they be included. There is increasing research evidence that the views of people with dementia can be accessed and that this is essential to understanding the service experience (Wilkinson, 2002). This research offers an approach to conducting research with clients, who have mild to moderate dementia.

The findings provide some new insights into the area of service orientation as they put forward an explanation of what shapes the dimension of interaction, thereby offering some clues to services research. More specifically, to ensure the creation of a quality community-based aged health care service, this investigation indicates that: first a service should be oriented to the client through specifically addressing the commitment, benefits, priorities, improvement, worth and focus of the service; second, client involvement should be facilitated through paying specific attention to informing, confidence building, engaging, trust building, relationship building, and gaining the active participation of the client; and third, the creation of a responsive service can be achieved by ensuring that the provider is empowered with the requisite knowledge, and they are able to take initiative and exercise choice in executing their role; and through empowering the client by sharing knowledge with them, and facilitating their taking initiative and being able to make choices. The results of this work demonstrate that the components that make up a high involvement, high contact, ongoing service's orientation could easily be measured, and this information then used to improve the quality of the service that is provided. Moreover, it is suggested that the results could assist with the quest to uncover the antecedents of service quality.

Whilst this research identified the emergence of main themes that recurred across all three participant categories, comparative analysis of the data identified that the meaning ascribed to each theme differed between the categories. Overall, the meaning assigned by clients and providers can be encapsulated by the direct exchange which occurs between them and their personal interface; and that of managers, through their overall service results perspective which they view as being achieved through, in particular, the performance of their staff. It is proposed that these results can also be considered in the context of role theory which suggests that service participant interaction will be determined by the respective roles which the participants adopt (Broderick, 1998). Applying this theory to the participant differences that have been identified in this work, it is suggested that these differences explicitly reflect each participant's position and role in the service network. This finding raises the question as to what influence adopted role differences, within the same service participant category, can have on the process of service co-creation.

Limitations

There are a number of limitations associated with this work. Due to the triadic structure of the research which required, for each study, that the participants of the three groups be in the

same service network, the sample size in each of the three groups was small. Further, the research was conducted in the same organisation, and all of the client participants had some dementia, such that their responses might not be fully representative of clients with good cognition. In addition, the results are confined to Anglophones, due to the exclusion of people unable to speak English. The authors invite discussion of the limitations of this work as well as the possibilities it creates for future academic research.

Further Research

As this work has been undertaken in service networks in the same organisation, it is essential that further investigation be undertaken for similar service networks in different organisations. More broadening of this work is also required to establish the extent of the transferability of the four concepts and their associated themes for clients with full cognition, for other types of high contact, high involvement and ongoing services, and for clients of other cultural backgrounds. Lastly, statistical analysis through quantitative research should also be conducted.

Managerial Implications

As service quality is influenced by the interactions and relationships which form between the participants of a service network, the findings offer healthcare managers information that could be used to inform:

- the health service policy and planning process;
- the definition of position statements for high contact, high involvement, ongoing services;
- the development of recruitment and selection criteria;
- the selection of service managers and front-line staff, with a strong service orientation and the ability to maximise a client's involvement in their service
- the area of staff training, specifically to improve the interaction of managers with their service provision staff, and service provision staff with their clients.

Achieving a workforce with the capacity to involve clients in the creation of their service should facilitate the translation of the organisation's service orientation objectives at the direct service provision interface.

Furthermore, this work offers an approach that healthcare managers could utilise to conduct research with clients with dementia, in order to understand their views as service participants. The resulting information could then being employed to improve the quality of the services they provide for people with dementia.

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APPENDIX A

Table A: Meaning Associated with Each Client Orientation Theme

Client Orientation: Commitment - Service promises made to the client		
Category	*Derived Meaning*	*Data Extract*
Manager	Reactive	"If there's issues that are expressed or complaints or concerns raised, then the organisation would attempt to do something about that and to change it (IIM1)."
Provider	Responsive	"Making sure everything's done right and on time and communication. That's a huge one with the clients. You know, that the communication lines are always open (IIP3)."
Client	Receipt	"I think just by remembering things that I like and how I like things and always making me feel it's a pleasure to do anything for me; however tiresome it may be, they never show it (IIC7)."
Client Orientation: Benefit - Client expressed needs are responded to directly and flexibly		
Category	*Derived Meaning*	*Data Extract*
Manager	Evidence	"A clear documentation trail that shows that there is a positive result there at the end, that we are getting outcomes (IM1)."
Provider	Adaptation	"The actual tailoring of the care plan in the first place to make sure that it actually suits the person. Because everyone's needs are so different (11P4)."
Client	Desire	"Caring gentle people and they know your wishes and they do their best to keep you at home (IC2)."
Client Orientation: Priorities - Service to the client takes precedence		
Category	*Derived Meaning*	*Data Extract*
Manager	Equate	"The majority of the front line staff's time is spent on client needs and addressing client needs (IIM2)."
Provider	Distill	"It's their priorities. And that's how, I think, you can see it, in that the service is focused on what the client's priorities are, not the organisation priorities (IP6)."
Client	Accommodate	"They do anything that I want them to do. They always tell me when they're coming. They ring up and tell me if they are delayed - they're good**.** You can rely on them (IIC3)."
Client Orientation: Improvement - Service is reviewed with input from the client		
Category	*Derived Meaning*	*Data Extract*
Manager	Proof	"You've always got the surveys and the paperwork that shows that you're trying to make some improvement (IIM1)."
Provider	Practice	"By giving quality care, we're always trying to improve what we do as our main priority is the client and making sure they're happy (IIP5)."
Client	Provision	"Well, they keep checking what I need, and if they say they're going to do something, they do it (IIC6)."
Client Orientation: Worth - The client is made to feel important		
Category	*Derived Meaning*	*Data Extract*
Manager	Develop	"Some form of survey or documentation … where the client's needs are investigated, and out of that should come their care being tailored to them and you can provide something that clients are actually wanting (IM1)."
Provider	Deliver	"We value them as a person and a client. We treat them with respect and dignity. We listen to them (IIP2)."
Client	Caring	"It's the personal touch. The way they treat me. They treat me with respect. We can sit and laugh (IIC9)."
Client Orientation: Focus - The service is tailored and personalised		
Category	*Derived Meaning*	*Data Extract*
Manager	Fit	"It's looking for front line workers that actually listen to clients and then be willing to adapt their processes to what they have heard (IIM2)."
Provider	Shape	"Everyone has different needs. You've just got to try and focus on them and provide the care that they need (IIP3)."
Client	Customise	"The way they care for you, they're just there for you. I think the girls are lovely and you feel comfortable with them (IIC8)."

Table B: Meaning Associated with Each Client Involvement Theme

Client Involvement: Information - Two-way communication with the client about their service		
Category	*Derived Meaning*	*Data Extract*
Manager	Reconnaissance	"To provide a good service, you have to really understand where a client's coming from, what's important to them and they appreciate some information around what the service can provide (IIM1)."
Provider	Exchange	"All those things that we do to assess actually involves communication, we need to tell them what we can do and we need to find out as much as we can about them to provide the best service that we can (IP4)."
Client	Telling	"They know what you like and what you don't like. How would they know if you didn't tell them? (IIC1)."
Client Involvement: Confidence - The client feels they are able to participate and self-determine		
Category	*Derived Meaning*	*Data Extract*
Manager	Integrate	"The aim would be to actually incorporate confidence building into the care that we do. So whether it is just getting them back into their community when they've been isolated, or to do more exercise or go for a walk (IIM2)."
Provider	Affect	"It's like you've given them their life back. They've done this thing themselves. You do get better results, they not only try and want to do that - whatever it is - but they also want to branch out into other areas as well (IIP3)."
Client	Independence	"Well, it makes you feel that you're needed and you've got a quality of life, that you can make a contribution and not be a total responsibility to the other people (IIC6)."
Client Involvement: Engagement - The client is interested and connected with their service		
Category	*Derived Meaning*	*Data Extract*
Manager	Provision	"If an organisation's not willing to be flexible in the way they provide that service, then a client can lose interest fairly quickly as well and if we don't really understand what their interests are, or what's important to them, then we're just giving them a superficial service, really (IIM1)."
Provider	Personalise	"So if you're tapping into what they like, trying to encourage them to do the things that they like and finding ways to do that they become the one who's sort of leading the way (IIP5)."
Client	Contribute	"My mind is active enough to realise that they are helping us to want us to help ourselves. They might say could you do so and so? I say, Oh, yes. That would be nice you know (IIC4)."
Client Involvement: Trust - The service participants depend on and confide in each other		
Category	*Derived Meaning*	*Data Extract*
Manager	Protective	"We take people and we put them in the homes of people who are vulnerable and we have to ensure as far as possible that we can trust those workers, and they act at all times in a way that is positive for the client (IM1)."
Provider	Connecting	"If you haven't got trust, you haven't got anything, you're not going to have a relationship with the client and be able to work with them and they wont want the service (IIP1)."
Client	Reliance	"I know that if I want something done, and they come, they'll do it for me. You know, I trust them completely. They wouldn't come back if I didn't have any trust in them (IC5)."
Client Involvement: Relationship - There is good rapport between the client and service provider		
Category	*Derived Meaning*	*Data Extract*
Manager	Consistency	"Face-to-face relationship, being reliable, having the careworkers turn up on time, if you don't keep that up then people start to lose faith and to lose confidence in the service (IIM2)."
Provider	Association	"You get involved, but it can be quite hard if they pass away. So you have to feel and care and get upset (IIP2)."
Client	Manner	"There's none of my loving care ladies ever been a grumpy lot. They've always been so happy and relaxed. You know, they're pleased to do things for you. If they didn't treat you with respect, you know, you wouldn't be bothered with them (IIC1)."

Client Involvement: Participation – Good interaction between the client and service provider		
Category	*Derived Meaning*	*Data Extract*
Manager	Solution	"So finding those keys to connecting with people. That's what, I guess, participation's all about. Because when you find that key to connect with somebody, that's when they open up to you or they start to participate (IIM2)."
Provider	Timing	"You have to form the tie and not force things. You just ask them and involve them and get input from them (IIP4)."
Client	Interplay	"We'll sit down and have a talk for a while, and when I can I try and help. I feel we are a good team (IIC5)."

Table 1C: Meaning Associated with Each Provider Empowerment Theme

Provider Empowerment: Knowledge - The provider comprehends the situation and possibilities		
Category	*Derived Meaning*	*Data Extract*
Manager	Base	"It forms a foundation so they understand well this is a disease that they must work around to understand the needs of the client (IM1)."
Provider	Facilitator	"Knowledge plays a huge part in empowering me because without it it's quite difficult to work with people with dementia (IP2)."
Client	Guide	"They've got to have the knowledge to know what to do or how to help me. So they've got to have some sort of training (IIC4)."
Provider Empowerment: Initiative - The provider can act resourcefully		
Category	*Derived Meaning*	*Data Extract*
Manager	Requirement	"If you've got a careworker that's got good intuitive skills and is able to take the initiative and they're empowered to be able to take the initiative, then you've really set up a really good model to provide good customer service (IM1)."
Provider	Solution	"Because we do it every day, you know. We make decisions on the spur of the moment, that has to be done, and we're, you know, quite entitled to do that so long as we report what we've done (IIP5)."
Client	Function	"They'd have to be able to take control and do something if it was necessary (IIC8)."
Provider Empowerment: Choice - The provider is able to determine options		
Category	*Derived Meaning*	*Data Extract*
Manager	Possibilities	"It's just going to limit the potential of what the service could become. So without choices, you're really not realising your potential (IIM2)."
Provider	Performance	"You're out there on your own and there will be choices that you have to make, but hopefully by what you've been taught and the experience you've obtained in the job, you know, that will help you make the right choices (IIP4)."
Client	Commodity	"They have to be able to choose to help me with the things that I need done (IIC3)."

Table 1D: Meaning Associated with Each Client Empowerment Theme

Client Empowerment: Knowledge - The client comprehends the situation and possibilities		
Category	*Derived Meaning*	*Data Extract*
Manager	Scope	"If they haven't got the knowledge about the service, what can be done for them, what can't be done for them, what they can ask for, what they can expect, then they don't know what's available to them (IIM1)."
Provider	Assurance	"Well, they feel like they're making the decisions and you're not making them for them. So they haven't lost all their independence (IIP2)."
Client	Enlighten	"It's important for them to give me information as it gives me an idea of what is going on so I can make their job easier (IC3)."

Client Empowerment: Initiative - The client can act resourcefully		
Category	*Meaning*	*Data Extract*
Manager	Receptive	"If clients express an idea or a preference for something then we need to be able to act on it to help satisfy their needs (IIM1)."
Provider	Ownership	"If they can initiate something, it becomes theirs. If they own it, they're keen to see it through. They've got a goal. They've got something to live for, you know (IIP3)."
Client	Autonomy	"You're in control of your own life and I like to be in control of my life. It is very important that I am able to do things for myself (IIC7)."
Client Empowerment: Choice - The client is able to determine options		
Category	*Derived Meaning*	*Data Extract*
Manager	Operation	"We're about choice, really, because it's providing them more choice to have our service than by not having it (IIM2)."
Provider	Motivator	"Giving them choice makes them keener to do the things - everything becomes their decision and they're in charge again (IIP3)."
Client	Sovereignty	"I like to be able to think that I can still decide I do it because I want to do it and I think I'm still pretty independent (IIC2)."