Meaningful Engagement or Co-Production, or Both?

Mobilisation authentique, coproduction, ou les deux?

COMMENTARY

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ABSTRACT

The COVID-19 pandemic magnified the cracks in healthcare performance. Dysfunctionalities and exhaustion appeared, but so did resilience and innovation. Examination of these cracks offers opportunities for learning and potential for new developments just as in the Japanese art of kintsugi, *which is about building new objects from pieces of broken ceramic and mending the cracks. Engagement and partnership activities came under strain in Canada, as well – a pioneer in the field.*

Some were put on hold; others proved resilient and contributed to surmounting the challenges of the pandemic. Applying their Engagement-Capable Environments Framework, Kuluski and colleagues (2024) studied kintsugi in partnership activities in Canada during the pandemic. The resulting case studies exemplify the factors facilitating engagement and partnership during crisis. Through a lens of co-production that we see as a precondition for understanding and improving healthcare during a crisis and beyond, we challenge the results of the study, hoping to open new perspectives and advance engagement and partnership.

RÉSUMÉ

La pandémie de COVID-19 a amplifié les failles dans les soins de santé. On a observé des dysfonctionnements et de l'épuisement, mais aussi de la résilience et de l'innovation. L'examen de ces failles peut apporter des connaissances et des innovations, à la manière du kintsugi, *art japonais consistant à façonner une nouvelle poterie à partir des éclats et des fissures d'un objet cassé. Les activités de mobilisation et de partenariat ont été fragilisées au Canada, pourtant pionnier en la matière. Certaines activités ont été suspendues, mais d'autres ont perduré et contribué à surmonter les défis de la pandémie. En appliquant leur cadre d'environnement propice à la participation, Kuluski et son équipe (2024) ont étudié le kintsugi dans les activités de partenariat au Canada menées pendant la pandémie. Les études de cas obtenues illustrent des facteurs facilitant la mobilisation et le partenariat en situation de crise. Dans une optique de coproduction, condition préalable selon nous pour comprendre et améliorer les soins de santé pendant une crise et dans d'autres contextes, nous remettons en question les résultats de l'étude dans l'espoir d'ouvrir de nouvelles perspectives et de faire avancer la mobilisation et le partenariat.*

Key Takeaways

- The language of engagement and co-production connects with different epistemologies. By using both, we can enhance our shared efforts to improve how healthcare service is created and experienced.
- The descriptive language used also depends on the perspective of the user: observer, participant, policy maker, researcher or assessor?
- Using multiple languages to understand the amazingly human work of helping and supporting one another in the pursuit of better health can also invite inquiry into the limits and benefits of any one epistemology.

Introduction: Applying the Art of *Kintsugi*

The COVID-19 pandemic made visible the cracks in the organization and the performance of healthcare systems around the world. Fragile and vulnerable things often crack first. Engagement and partnership activities were among such vulnerable innovations in healthcare that cracked. Many were put on hold because they were considered less crucial. Others, however, rapidly got back up on their feet again, demonstrated resilience and agility and made new and critical contributions to health during the pandemic. Learning from these cracks for the future reminds us of the Japanese art of *kintsugi* (Wikipedia 2024). The kintsugi master carefully examines the crack lines of broken ceramics, then gilds them and finally recreates objects of stunning beauty.

Many consider Canada the world leader in patient involvement. The Montreal model (Pomey et al. 2015) is famous for good

reasons. It has inspired colleagues around the world to develop partnerships between patients and healthcare professionals, policy makers and researchers. To hear from such a mature player what facilitated and inhibited these activities during the disruption of the COVID-19 pandemic holds important messages for others.

The Canadian frame is ambitious. Meaningful engagement, as Kuluski et al. (2024) define it, should involve all stakeholders from patients to policy makers and happen everywhere in clinical care and on the organizational and the policy levels. It means proactively co-producing a health system where power is shared. This takes time and resources and requires will, understanding and a culture shift valuing the expertise from lived and professional experience.

The authors propose a framework for what it takes to implement system-wide partnership. This Engagement-Capable Environments Framework (Baker et al. 2016; Kuluski et al. 2024) includes leadership support and strategic focus, engagement of staff to involve patients and enlisting and preparation of patients so they can act as partners. Stakeholders can self-assess the presence of these facilitators in their organizational setting with a self-assessment tool recently published by Healthcare Excellence Canada (HEC n.d.).

After the pandemic, the authors studied examples of kintsugi in their system. Patients and care partners, leaders of quality improvement and patient involvement and senior managers participated in in-depth interviews that were summarized as case studies. These include hospitals, community services, health authorities, regional quality improvement agencies and coordination agencies, a knowledge centre for patient and public engagement and a community of practice for patient experience and partnership.

The results of the study are five core themes that are exemplified with short vignettes from the case studies: "(1) strong connections between organizational leaders and patient and family partners; (2) maturation of context, including entrenched philosophy of PFCC [patient and family-centred care]; (3) giving patient and care partners the space to lead, build and sustain relationships; (4) willing partnerships through meaningful activities; and (5) creating new mechanisms for engagement" (Kuluski et al. 2024: 16). These echo Bannear's suggestion that we need to "design for the conditions that enable the emergence of many solutions" (Bannear 2023).

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Through the Lens of Co-Production

We come to this commentary with a lens of co-production of healthcare service that we have been living with and developing. The lens of healthcare service co-production has helped us see that, like other services, making a healthcare service involves two parties: one who is an expert in the lived reality of the person whose health it is and one who has studied the multiple types of knowledge and applications of it as others with similar situations have seen or experienced. These two parties work interdependently to *make the service*. Each party has access to supportive resources – information that they bring to the task. Their interaction is key to the logic of service making. Since it is common to refer to people by the name of the role they are playing such as "patient" or "professional," this has sometimes obscured the truth that both people are "kin" to one another and that, as people, they are working together.

We have come to see that work systems as well as policies can make it easier or harder to do that shared work by the way we frame,

assess and improve. So, we have come to understand that co-production is a logical precondition – not just a priority – for how we understand and improve a healthcare service. This logic is a fundamental enabler of the practice of meaningful engagement that Kuluski et al. (2024) present. Furthermore, we have come to understand that this frame carries multiple knowledge systems, which are created with different methods. The biology of the condition, the experience of having it and the design of interventions that work and that help minimize the undesired burdens of the condition and its treatment are all different streams of knowledge. The architecture of the systems of co-production offers the opportunity to explore ways by which structures can contribute to the design and the performance of the parties as the work is done.

Our Questions

These *ways of seeing* have made us curious as we approached the article by Kuluski et al. (2024), and it is from those ways and habits that our questions and reflections have emerged:

1. **How would a patient and a clinician working together view meaningful engagement in designing and delivering a healthcare service?**

"Meaningful engagement" for two parties actively working together is not a matter of ticking a box or of applying some measure of "engagement meaningfulness." The core work of co-creating service invites attention to that work – not the strength of one or more attributes of their interaction. Meaningful engagement, trust, mutual respect, willingness to be vulnerable, shared power, integrity and mutual accountability are all illustrative of attributes seen in good co-production.

2. **What is the model behind the reasoning of enabling factors and environments?**

Bannear (2023) identifies the shared voices of intent, experience, capability and design that together create an ecosystem for change and improvement. According to Uhl-Bien and Arena (2017: 12), enabling factors for such an ecosystem include "space" in time, human interaction, generative exploration and inquiry, some boundary setting and "local rules of interaction" (Hazy 2012), active community building, the use of data to learn from the work and the exploration of information from the experience of others. Southcentral Foundation's Nuka System of Care, based in Anchorage, Alaska, may serve as an example of meaningful engagement and kinship in a community. Through native customer ownership and relationships, the Nuka System of Care evolved from a centrally managed, bureaucratic system to an integrated, high-performing and comprehensive healthcare service (Gottlieb 2013). April Kyle and Doug Eby describe the journey in a podcast in the "The Power of Coproduction" series (Kaplan et al. 2019).

3. **Might co-production invite a more explicit understanding of the relevant "action" and its interconnection with "relationship"?**

The work of healthcare service making involves both relationship and action. Meaningful engagement offers an important invitation to authentic, helpful relationships. The case in Box 1 may illustrate the development of a co-produced decision, care plan and action.

Box 1. An example of meaningful engagement

A 70-year-old man was told he had borderline vascular hypertension. He was offered treatment, but declined. A while later, he decided to obtain a method for recording his own blood pressure. He began to see the data that confirmed borderline hypertension. On the next visit with his primary care professional, he told the physician that he agreed with the doctor's earlier assertion. The doctor asked if he wanted treatment. He said that he wanted to lose weight, reduce the alcohol he was drinking and exercise more in addition to getting a very low dose of an established antihypertensive medication. He lost about 20 pounds, reduced the number of glasses of wine with meals, and started regularly walking regularly. His blood pressure moved into the normal range. The action required agreement between the professional and the patient. Data helped the patient share the doctor's opinion. The patient actively co-designed the intervention. The relationship between the professional and the patient was based on trust and data. Both were proud of the result.

4. What is required for an epistemology for the work of co-production and engagement in healthcare?

A sociologist (engagement) and an economist (co-production) describe this work differently. In healthcare, we borrow their terms, which can be confusing. Developing an epistemology for healthcare might help advance both.

So, enabling co-production, or "engagement," as Kuluski et al. (2024: 10) call it, requires at least two parties who develop a clear sense that both are "kin" to each other and who cultivate an open spirit for the use of multiple knowledge systems to make it work and put in unceasing efforts to challenge our individual and organizational habits that have often made this hard to accomplish. We hope that our questions will stimulate further curiosity and understanding about meaningful actions and relationships in healthcare.

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