Perspectives

A personal reflection on co-creation in public health: a dream partly realised

Adrian Bauman[a,b]

[a] Prevention Research Collaboration, Charles Perkins Centre, University of Sydney, NSW, Australia
[b] Corresponding author: adrian.bauman@sydney.edu.au

Article history

Key points

- The term 'co-creation' points to the perennial challenge in health promotion to understand context and increase local engagement to solve complex, community-wide health problems
- The current schism between co-creation as 'process' and policy makers' need for health outcomes remains a barrier to serious recognition and funding agencies
- Long-term, multiyear funding schemes are required to generate evidence that comprehensive co-creation makes an eventual difference in sustainable health improvement

Abstract

This personal reflection considers the challenges in co-creation in public health over time. The concept of 'co-creation' has existed in community health promotion practice for decades, and points to the perennial challenge to understand context and increase local engagement to solve complex community-wide health problems. While co-creation has become a 'fashionable term' in health promotion, the challenge is that it remains a niche set of processes described in prevention programs. The schism between co-creation as 'process' and policy makers' need for health outcomes remains a barrier to widespread recognition and support. To fully realise the co-creation 'dream', we need a process of more committed co-production using democratised approaches to community engagement. This must be supported by long-term funding to mainstream the process and to demonstrate whether comprehensive co-creation makes an eventual difference in sustainable health outcome improvement.

The popularity of 'co-creation' in the public health and health promotion discourse

This paper is a personal reflection based on 30 years of academic work in health promotion, often in government or community-based partnerships. Although I have had an academic career in health promotion and program evaluation, these reflections are drawn from my field research experience in considering the challenges and barriers to co-creation.

My PhD in the 1980s was in patient education and capacity-building through self-management training, skills development and empowerment for people with chronic conditions. Over the ensuing decades, this area moved forwards through the development and dissemination of the concepts underpinning health literacy[1] and patient-centred care.[2] The evidence for co-creation in improving patient experiences, clinical pathways and improving the quality and functioning of health services is now well recognised.[3,4]

By contrast to clinical contexts, this paper is focused on public health and community settings for co-creation. This term implies research and programmatic engagement in partnerships with end-users, stakeholders and the community.[5,6] The rationale for co-creation is to address 'wicked' problems

(those complex problems with many interdependent factors) and foster sustainable solutions within communities.

The concept of 'co-creation' has existed since well before the 1986 *Ottawa Charter for Health Promotion.*[7] It has been described diversely as 'community engagement' and 'community-based participatory research'. The term 'co-creation' points to the perennial challenge in health promotion to understand context and increase local engagement to solve complex, community-wide health problems.

Co-creation is rapidly becoming a fashionable term in health promotion, but mostly earlier concepts and values. Medline was searched for publications with the keyword "co-create or cocreat*" and 336 published papers were identified in the period up to November 2021, of which 96% were published since 2010. A search of keywords related to the cognate and antecedent concepts of 'community participation, community engagement or community based participat*' for the same period located 30 156 papers, of which 25% were published before 2000, 24% in the 2000s and only 51% since 2010. These studies indicated that the aims of community development were to reduce disparities (inequalities) in access to services and community programs[8,9], to value community perceptions of health and to consider the power imbalance inherent in such work. Most of the paradigm shift that included democratising the idea of co-creation permeated community health promotion for decades before the term became fashionable around 2010.

Co-creation includes partnerships between community members and researchers, however, it is substantially broader[10], and can include government policy makers, nongovernment organisations, professional groups, primary health practitioners and other agencies. These multiple intersections illustrate the complexity of co-creation in the real world. Further, there are various stages where this crossover can occur. Initial co-planning can occur through consultation and co-development of realistic strategies with communities. Program implementation, delivery and evaluation are also potentially shared tasks. Following the program, co-interpretation and feedback to multiple interested parties may reflect on a program's success or otherwise. For academics, co-creation research findings are destined for publication, different to the policy maker focus (priority-based implementation) or the community goals (meeting local needs or achieving local community change).

The limits of co-creation in prevention: rhetoric or evidence?

The public health challenge for co-creation is that it remains a niche set of processes described in prevention programs. The challenges to co-creation in routine practice are suggested in Table 1, many of which result from incongruence in values between the diverse actors engaged in implementing prevention programs. Policy makers are driven by time-bound government priorities, focus on top-down driven problems and are

Table 1. Rhetoric versus reality: a personal perspective on challenges in co-creation in primary prevention programs

Co-creation (CoC) principles and underpinning values	Real-world perspectives on feasibility and widescale adoption
Power-sharing relationships, partnerships and engagement are central to CoC	Vested entrenched interests exist[3] It is difficult to redistribute power relations between policy makers, across different sectors, and between researchers and community[11] Joint ownership is rare[10,12]
Need trust and mutual respect for CoC	It takes time to develop relationships with community stakeholders[5]
Resources for CoC projects	CoC consumes substantial resources, personnel time and funding
Mutually shared benefits as a core value underpinning CoC	Researchers lack incentives for co-creation studies due to dominant academic values There are limited incentives for policy makers These challenges make shared benefits difficult to discern in many situations
Value of creating better evidence of health promotion or prevention effects	Different needs: technical and affordable programs (policy maker), scientific best evidence (researcher), which are inconsistent with community needs for democratic participation"[13] in co-shared community programs
'Policy impatience' and lack of implementation methods	Usually, timeframes are too short Types of evidence of success (outcomes) not discussed in CoC projects
Bibliometric analysis shows increasing CoC published	Case studies and published papers may reflect 'windows' of opportune circumstances for CoC, or describe conceptual models, theoretical analyses
Paradigm shift needed to institutionalise the CoC process	Possible "radical action needed to create a systems approach to community intervention"[10] requires long-term programs starting with community co-creation, ending with health improvements being demonstrated

informed by evidence of effectiveness in ameliorating problems. My impressions have been that policy makers tend to dominate discussions around government priorities, researchers insist on optimal (rather than pragmatic) research methods, and communities often have needs not directly related to specific health or disease prevention priority issues. These disparate objectives lead to power imbalances and contribute to potential disconnects between the aspirations of co-creation and its implementation across the prevention and health promotion systems. It may be difficult to generalise co-creation principles from published case studies, as they often have unique or local features, reducing their implementation potential across the prevention system.

There are exceptions where co-creation practice has become normative or even mandatory. Many First Nations projects require community consultation and engagement. This is now accepted as a prerequisite by policy makers and researchers alike, for example, as described by Bailey et al[14] and Gwynne et al.[15]

Finally, it may be that the independent effects of co-creation on definitive health outcomes are difficult to demonstrate. Several systematic reviews exist, but focus on studies of concepts and principles[3], methods and tools used in co-creation, or the (successful) effects of patient education. One review suggested that co-creation has "rarely (been) tested for effectiveness against intended outcomes"[16] but did demonstrate small effect sizes for health-promoting behaviours and self-efficacy.

What is needed is 'productive' co-production, using democratised approaches to community engagement.[13] However, researcher/community partnerships could improve on their currently politicised and polarised positions on co-creation. The academic funding criteria for researchers don't value co-creation studies.[13] A paradigm shift will only occur when these opposing perspectives are reconciled. Reporting of more practical examples of co-creation's effects are needed. The processes and nature of co-creation should be defined at the outset and clear goals must be established for either indicators of community change or health outcomes or both, but accountable change needs to ultimately be measured, even after several years of programmatic partnership.[17]

Conclusion

Co-creation is grounded in the history of community engagement and empowerment in health promotion, which has produced more than 65 case studies and frameworks over several decades.[18] It has proved difficult to generalise lessons from such diverse and local case studies across the primary prevention field. The current schism between co-creation as 'process' and policy makers' need for health outcomes remains a barrier to serious recognition and to funding agencies. Many working in the field suggest that co-creation

should be confined to understanding and improving processes in diverse community contexts. However, to mainstream this process, long-term, multiyear funding schemes are needed to generate sufficient evidence that comprehensive co-creation makes an eventual difference in sustainable health improvement. Evidence-generation would require researchers to extend beyond the usual methods for complex program evaluation[19], but also to extend beyond realist approaches alone[20] with an understanding of the need for flexible but rigorous adaptations to program evaluation, cognisant of local contexts.[21] Another decade of the status quo in community-based co-creation case studies will continue to polarise policy makers without providing any links to subsequent improved health, *a sine qua non* for sustained funding in the prevention system.

Peer review and provenance

Externally peer reviewed, not commissioned.

Competing interests

None declared.

Author contributions

AB, the sole author, conceptualised the piece, conducted a literature search, wrote, revised, and took responsibility for its content.

References

1. Nutbeam D. Health literacy as a public health goal: A challenge for contemporary health education and communication strategies into the 21st century. Health Prom Int. 2000;15(3):259–67.

2. Bauman AE, Fardy HJ, Harris PG. Getting it right: why bother with patient-centred care? Med J Aust. 2003;179(5):253–6.

3. Greenhalgh T, Jackson C, Shaw S, Janamian T. Achieving research impact through co-creation in community-based health services: literature review and case study. Milbank Q. 2016;94(2):392–429.

4. Goodyear-Smith F, Jackson C, Greenhalgh T. Co-design and implementation research: challenges and solutions for ethics committees. BMC Med Ethics. 2015;16:78.

5. Oliver K, Cairney P. The dos and don'ts of influencing policy: a systematic review of advice to academics. Palgrave Commun. 2019;5(1):1–11.

6. Darlington E, Masson J. What does co-creation mean? An attempt at definition informed by the perspectives of school health promoters in France. Health Education Journal. 2021.

7. World Health Organization. The 1st international conference on health promotion, Ottawa, 1986. The Ottawa charter for health promotion. Geneva: WHO; 1986 [cited 2022 May 25]. Available from: www.who.int/teams/health-promotion/enhanced-wellbeing/first-global-conference

8. Wallerstein NB, Duran B. Using community-based participatory research to address health disparities. Health Promot Pract. 2006;7(3):312–23.

9. Israel BA, Schulz AJ, Parker EA, Becker AB. Community-based participatory research: policy recommendations for promoting a partnership approach in health research. Educ Health. 2001;14(2):182–97.

10. Tembo D, Hickey G, Montenegro C, Chandler D, Nelson E, Porter K, et al. Effective engagement and involvement with community stakeholders in the co-production of global health research. BMJ. 2021;372:n178.

11. Voorberg WH, Bekkers VJJM, Tummers LG. A systematic review of co-creation and co-production: embarking on the social innovation journey. Public Management Review. 2015;17(9):1333–57.

12. Tembo D, Morrow E, Worswick L, Lennard D. Is co-production just a pipe dream for applied health research commissioning? An exploratory literature review. Front. Sociol. 2019;4:50.

13. Williams O, Sarre S, Papoulias SC, Knowles S, Robert G, Beresford P, et al. Lost in the shadows: reflections on the dark side of co-production. Health Res Policy Syst. 2020;18(1).

14. Bailey S, Kalucy D, Nixon J, Williamson A, Wright D, Newman J, et al. Establishing an enduring co-production platform in Aboriginal health. Public Health Res Pract. 2022:32(2):e3222212.

15. Gwynne K, Rambaldini B, Christie V, Meharg D, Gwynn JD, Dimitropoulos Y, et al. Applying collective impact in Aboriginal health services and research: three case studies tell an important story. Public Health Res Pract. 2022;32(2):e3222215.

16. Halvorsrud K, Kucharska J, Adlington K, Rudell K, Brown Hajdukova E, Nazroo J, et al. Identifying evidence of effectiveness in the co-creation of research: a systematic review and meta-analysis of the international healthcare literature. J Public Health (Oxf). 2021;43(1):197–208.

17. Oliver K, Kothari A, Mays N. The dark side of coproduction: do the costs outweigh the benefits for health research? Health Res Policy and Syst. 2019;17(1):33.

18. Greenhalgh T, Hinton L, Finlay T, Macfarlane A, Fahy N, Clyde B, et al. Frameworks for supporting patient and public involvement in research: systematic review and co-design pilot. Health Expect. 2019;22(4):785–801.

19. Craig P, Dieppe P, Macintyre S, Michie S, Nazareth I, Petticrew M. Developing and evaluating complex interventions: the new Medical Research Council guidance. BMJ. 2008;337:a1655.

20. Marchal B, Van Belle S, Van Olmen J, Hoerée T, Kegels G. Is realist evaluation keeping its promise? A review of published empirical studies in the field of health systems research. Evaluation. 2012;18(2):192–212.

21. Ogilvie D, Bauman A, Foley L, Guell C, Humphreys D, Panter J. Making sense of the evidence in population health intervention research: building a dry stone wall. BMJ Global Health. 2020;5(12):e004017.

.