Value co-creating activities in micro-level healthcare
- A qualitative study of value co-creation in dental care

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Abstract
This research paper explores the value co-creating activities from a micro-level healthcare perspective by investigating value co-creation in dental clinics. Previous research on the subject of co-creation of value has directed its focus to higher-level healthcare with advanced illnesses, chronic diseases and complicated processes with many interactions. This research paper expands the theoretical research and provides valuable practical insight for dental clinics by adding a perspective where there is a low level of interaction. Through interviews with dentists and a focus group discussion with patients it is concluded that the co-creating activities of: cooperating, colearning, collating information, integrating networks, providing options, and designing environments, are present on the micro-level healthcare. Furthermore, contrary to existing literature, it is concluded that the co-creation is commonly instigated by the dentist rather than the patient, and that the value co-creation can also be active on a psychological level, and not solely through physical interactions and activities.

Keywords: Value co-creation, healthcare, dental care, service-dominant logic, service marketing, value co-creating activities
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1. Introduction

Healthcare is one of the most basic sectors of a functioning society and its importance is growing (United Nations, 2015). The population of the world is ageing, the United Nations (2015) projects that by 2030, the number of people aged 60 years or older will grow by 56%. Therefore, the United Nations (2015) call it one of the most significant changes to society in the 21st century. Along with the general population increase, the demand on functioning healthcare will increase. Reports are showing symptoms of this already. The World Health Organization (WHO) predicts a global shortage of 12.9 million healthcare workers in the coming decades (Campbell et al., 2013).

To cope with the new situation, healthcare operators are increasingly looking at ideas originating from the field of marketing and there has been an increase in healthcare research using a marketing perspective (e.g. McColl-Kennedy et al., 2012; Osei-Frimpong & Owasu-Frimpong, 2017; Tartaglione et al., 2017). This has resulted in patient-centred care (Weber, 2017), a concept based on the customer centricity of marketing transferred to a healthcare context. The specific perspective used in much of this literature is based on the service-dominant logic developed by Vargo and Lusch (2004), particularly focusing on the concept of value co-creation. The service-dominant logic perspective not only focuses on material resources, but also on the immaterial resources, such as the relationship with the customer. Therefore, a customer must be an active participant in the co-creation process as the customer is the end-user.

McColl-Kennedy et al. (2012) and Sweeney et al. (2015) use the concepts from service-dominant logic to identify different activities of value co-creation taking place in the interaction between the provider of healthcare and the patient. The findings from both of these studies emphasise the importance of integrating the network in which the care is taking place. This materialises by making sure the interaction with different divisions of the care provider is seamless as well as involving the network of the patient, such as friends and family, in the process. Managing the integration of this network can in the end have a positive effect on the quality of life perceived by the patient. This view of the service network is mirrored by Akaka and Vargo (2015). From their research of service ecosystems where it is concluded that value is not created solely by the customer or by the company, but by a whole group of actors (Akaka and Vargo, 2015).
What these studies tell us is that the healthcare sector should focus their operations on co-creating value together with the patients, and that an important way of doing this is by making sure the service network is well integrated. There are however limitations to the studies, as Tartaglione et al., (2017), McColl-Kennedy et al., (2012) and Sweeney et al. (2015) all share a macro-level object of study i.e. big hospitals and advanced illnesses requiring a multitude of different operations and interactions. This means that the objects of study allow for big service networks, and integration of many processes. No studies however, have been devoted to micro-level of healthcare where the service networks are more limited. In these cases, where value cannot be co-created through integration of the networks, there is a lack of research on where it can be created instead. It is reasonable to assume that the value perceived by the patient is different in treatments of more standardised character that take place over a limited period of time with few interactions than it is in the advanced cases present in the current research literature. For this reason, it is of theoretical interest to see if co-creating activities on the micro-level of healthcare can be identified.

One instance that exemplifies what is meant by micro-level of healthcare in this research paper, is dental care. The operations taking place in dental clinics are generally standardised and are often completed through a single interaction. With this in mind, dental care is a good point of investigation to identify possible value co-creating activities. Furthermore, Maarse (2006) concluded that there is an increase of private healthcare establishments in Europe. This increase in turn leads to higher competition in the market of healthcare. Therefore, understanding the activities of value co-creation at the micro-level of healthcare is of practical value for healthcare organisation operating in this market.

Based on the research gap identified above, the purpose of this research paper is to expand the literature on value creation in healthcare by identifying value co-creating activities within healthcare establishments with limited service networks. The purpose will be achieved by answering the following question:

“What value co-creating activities exist in dental healthcare?”
2. Theoretical background

The following section reviews the literature with regards to the concepts of the co-creation of value, activities that co-create value from a healthcare perspective, obstacles to the co-creation of value process and practice styles of customer value co-creation from a healthcare perspective. From the literature a theoretical model for the co-creation of value has been formulated.

2.1 Creation of value

The creation of value has traditionally been seen as the strategic positioning of an organisation in the value chain by offering the right products and services (Ramirez, 1999). According to Ramirez (1999) value is created through the co-production of multiple actors, with and for each actor involved. Prahalad and Ramaswamy (2004) note however that the creation of value is becoming less and less product- and company-driven, but rather based on the experience that customers encounter. Involving customers in the creation process of a product or service (i.e. co-creation) will become an important competitive strategy for organisations (Prahalad & Ramaswamy, 2004). Co-creation is therefore becoming more consciously and increasingly used by organisations to offer better products and services tailored to the needs of the customer.

2.1.1 Co-creation of value and the Service-Dominant Logic

Vargo and Lusch (2004) have done extensive research focused on the customer at the centre of the value creation, and as a result they have developed the service-dominant logic. The service-dominant logic perspective, in contrast to the goods dominant logic, not only focuses on material resources, but also emphasises the immaterial resources, such as the relationship and interactions with the customer. Thus, according to the service-dominant logic, organisations should not only focus on the product, but rather include all activities that might provide value for the customer (Vargo & Lusch, 2004). Therefore, a customer must be an active participant in the co-creation process as the customer is the end-user.

In a follow-up study Vargo and Lusch (2008) provide several points of views in which they argue that the service around a service or product is a common denominator in the process of the co-creation of value. When an organisation applies the co-creation of value in the creation process of a product or service, the customer must be seen as a partner (Vargo & Lusch, 2008). Organisational processes such as innovation, production and marketing must be coordinated.
Thus, the organisation is not only seen as a producer of a product or service but also as a facilitator, supporter, organiser, structurer and co-developer (Vargo & Lusch, 2004; Vargo & Lusch 2008).

Both Grönroos (2008) and Payne et al. (2008) carried out follow-up research into the dominant logic developed by Vargo and Lusch (2004). Grönroos (2008) concludes that when an organisation incorporates the service-dominant logic in its process, it is possible for them to involve customers more in the organisational processes that generate value. Thus, an organisation can expand or change their market offerings on the basis of the customer's experience (Grönroos, 2008). Payne et al. (2008) also state that through co-creation, organisations can create better value propositions by determining what a customer's requirements for a service or product are when it is consumed.

2.1.2 Co-creation of value in the public sector

Above, a description of co-creation of value has been provided. Nevertheless, there is no mention of a sector in which an organisation must be operating with regards to the applicability of co-creation of value to different sectors. However, Voorberg (2017) argues that there is a difference between the co-creation of value in the private and public sector. Organisations in the private sector are challenged to produce products or services more efficiently. Thus, customers are defined as possible co-producers who undertake specific activities in the production chain (Voorberg, 2017). In addition, customers in the private sector are an important source of product and service innovation, in which research has shown that co-creation not only influences customer satisfaction and loyalty, but also may help to gain a competitive advantage (Voorberg, 2017).

In the public sector, citizens are the customers. Voorberg (2017) argues that co-creation mobilises every citizen to become an active participant in the co-creation process. Participation of customers (i.e. citizens) is considered as a necessary condition for the co-creation of value in an organisation (e.g. healthcare organisations) in the public sector (Voorberg, 2017). This is because it is the customer that makes use of the service and ultimately assess the organisation on the service that they provide (Voorberg, 2017). In addition, Voorberg (2017) states that it is therefore important to take into account a number of factors that influence co-creation among
citizens, thereby distinguishing between organisational- and civic-factors, which are necessary in order for co-creation in a public organisation to succeed (see table 1).

<table>
<thead>
<tr>
<th>Organisational factors</th>
<th>Civic factors</th>
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</thead>
<tbody>
<tr>
<td>Compatibility of public organisations to enable citizens to participate.</td>
<td>Willingness to participate as a citizen in the process of co-creation.</td>
</tr>
<tr>
<td>The attitude of employees (officials) in the public sector to involve citizens as a valuable partner in the organisational process.</td>
<td>Awareness of the citizen about the ability and the possibility of the actual influence of the service.</td>
</tr>
<tr>
<td>Suppressing the risk-averse culture among organisations in the public sector.</td>
<td>The presence of social capital (shared value and norms) to create long lasting relationships between the public organisation and the citizen.</td>
</tr>
<tr>
<td>Providing citizens with clear incentives for the co-creation and co-production of value</td>
<td>Resolving and handling the risk-averse attitude of patients/customers/citizens towards co-creation initiatives.</td>
</tr>
</tbody>
</table>

Table 1: Organisational- vs civic-factors (Voorberg, 2017)

2.2 Co-creation of value in healthcare

McColl-Kennedy et al. (2012) researched the concept of co-creation of value from a healthcare perspective. Their article defined the co-creation of value as follows: "benefit realized from integration of resources through activities and interactions with collaborators in the customer’s service network" (McColl-Kennedy et al., 2012, p. 375). Their results have built upon existing theories such as the service-dominant logic of Vargo and Lusch (2004) and the Consumer Culture Theory of Arnould and Thompson (2005). From the existing theories, customers are seen from an economic, cultural and social point of view and as an active-participant in the creation process of a product or service. McColl-Kennedy et al. (2012) state that patients can contribute to their own value creation by undertaking activities in the management of their own health. The conclusion from their research is that patients in the co-creation of value process can be distinguished by the degree of interaction and the number of activities. The more initiative a patient shows to involve other individuals in his or her treatment process as well as the activities a patient undertakes themselves, the higher the willingness to co-create (McColl-Kennedy et al., 2012). Similar reasoning is provided in a study by Grönroos and Voima (2013). In their study on “Critical service logic: making sense of value creation and co-creation”, the authors develop a model explaining the value creation process (Grönroos & Voima, 2013, p. 141). According to Grönroos and Voima (2013), all value is created by the customer through
usage of the product, and value can only be co-created when the customer invites the producer into the creation process and engage in a dialogue (i.e. interactions and activities). This particular research is aimed at investigating what kind of activities and interactions can co-create value within a micro-level healthcare (i.e. dental care) perspective. In order to answer this question, it is necessary to look at the individual patient and in particular at the degree to which this individual patient wants and is willing to co-create value.

A prerequisite for co-creation of value is that there is cooperation between the organisation and its customers (Prahalad & Ramaswamy, 2004). Vargo and Lusch (2004) conclude in the service-dominant logic that there must be a relationship between the organisation and the customer and the customer is central to the process. Without co-operation of the customer, co-creation is impossible. For the customer, participation in co-creation has the advantage that products and/or services are tailored to his or her wishes and needs and are able to meet their expectations. For organisations, it has the advantage that they can better respond to the needs and desires of the customer.

McColl-Kennedy et al. (2012) have done research into the co-creation of value in healthcare. Based on their research, they have developed a typology in which activities and interactions around the perception of the patient are defined with respect to co-creating value (McColl-Kennedy et al., 2012). Their research shows that there is a positive effect on the perceived quality of life when the patient in a hospital experiences a medium- or high-level of co-creation of value (McColl-Kennedy et al., 2012). In addition, it has been shown that there is a positive relationship between the efforts of activities in the own treatment process of the patient, the quality of life and satisfaction with the service that has been provided by the hospital (Sweeney et al., 2015).

2.2.1 Co-creation of value activities in healthcare

According to McColl-Kennedy et al. (2012, p. 378) there are eight co-creation of value activities that patients can engage in themselves, which are explained here below:

- **Cooperating**, which is accepting information and adhering to the treatment.
- **Collating information**, which is the sorting and compiling of the information that the patient receives on a daily basis.
• *Combining complementary therapies*, which is the use of supplementary medicine e.g., exercising, keeping a diet, doing yoga or meditation.

• *Colearning*, which is actively searching and sharing information from other sources about the treatment process or general experiences.

• *Changing ways of doing things*, which is managing long-term adjustments such as changes in the financial position by e.g. working part-time instead of full-time after going back to work.

• *Connecting*, which is building and maintaining relationships in order to e.g. keep feeling connected to friends and family.

• *Co-production*, which is assisting with the redesign of treatment programs and restructuring the medical team.

• *Cerebral activities*, which is actively keeping hope, having a positive attitude, showing your emotions and accepting the situation in which you are in as a patient.

### 2.2.2 Healthcare workers’ obstacles to the co-creation of value process

According to a study by Longtin, et al. (2010), there are certain obstacles that prevent the patient in the participation of the co-creation of value process. One of those obstacles is the lack of acceptance of the new role of healthcare workers. From their research, Longtin, et al. (2010, p. 55) state that this is due to “healthcare workers’ beliefs, attitude, and behaviour”. Furthermore, refusal of healthcare workers to abandon their traditional role and to delegate power to their patients was identified as one of the main obstacles. In addition, in a study by Henderson (2003) it was identified that nurses are unwilling to share their decision-making power and exercise almost absolute power and control over patients. This is due to nurses considering patients to be unable to make decisions. This is in line with doctors as well, as they are more reluctant with regards to encouraging the participation of patients as they either refuse to delegate-power and control, or are afraid to lose their identity (Longtin, et al., 2010). Moreover, the lack of time is also a factor for limiting the input by patients in healthcare.

### 2.2.3 Practice styles of customer value co-creation in healthcare

According to McColl-Kennedy et al. (2012) the degree of interaction between the patient, the practitioner and other individuals depends on the number and type of individuals involved in a patient's treatment process. This can be of a low level, a medium level or a high level (McColl-Kennedy et al., 2012). A *low level* of activities is the involvement of a doctor and other medical
staff. A *medium level* of activities is the involvement of a doctor, other medical staff and making the treatment process open to immediate family. A *high level* of activities is the involvement of a doctor, other medical staff, friends and family and other patients in the same treatment process. From their research McColl-Kennedy et al. (2012, p. 380) identified five practice styles of customer value co-creation. The characteristics of each style are explained here below:

- **Team management** is characterised by the high level of activities that the patient undertakes and the high level of interaction with caregivers, other organisations, family, friends and other patients (McColl-Kennedy et al., 2012). Patients in the style of team management coordinate the team around their hospital care themselves and openly communicate about their treatment process to both family and friends as well as caregivers. This style gives the patient a high degree of control and is associated with designing their own treatment program together with doctors.

- **Insular controlling** is characterised by the high level of activities that the patient undertakes and a low level of interactions with other individuals (McColl-Kennedy et al., 2012). The interactions seem superficial as patients are self-centred, have few emotions and prefer to be alone and do not want to share their problems and feelings with others. They limit themselves to the amount of details they provide and keep their emotions under control. These patients do however have a wide range of activities such as gathering information, learning together, combining complementary therapies. In addition, patients remain positive about their own treatment process yet see their role as controlling from a distance and find that recovery only lies within themselves (McColl-Kennedy et al., 2012).

- **Partnering** is characterised by the medium level of activities that the patient undertakes and the average number of interactions with care providers of a healthcare organisation, other organisations, family, friends and other patients (McColl-Kennedy et al., 2012). The collaboration is mainly with doctors and a limited number of healthcare providers. Patients in this style see their role as a partner in their own treatment process. They are involved in collecting information, combining therapies with mainly doctors and want to remain positive about their treatment process. In addition, the patient is involved in the composition of their medical team and accept when they aren’t able to do something no longer or on a temporary basis (McColl-Kennedy et al., 2012).
• **Pragmatic adapting** is characterised by the low level of activities that the patient undertakes and the high level of interaction with care providers of the healthcare organisation, other organisations, family, friends and other patients (McColl-Kennedy et al., 2012). Patients in this style see their role primarily as adapting to their changed circumstances and an important activity for these patients is changing and being adaptive (McColl-Kennedy et al., 2012). Patients in this style do not hide themselves and are not ashamed of who they have become.

• **Passive compliance** is characterised by the low level of activities that a patient undertakes and the low level of interaction (McColl-Kennedy et al., 2012, p. 379-381). The interactions mainly take place with the doctor and the patient follows their orders. This style is characterised by the acceptance of the diagnosis and the patient does not tend to ask the doctor questions. The patients see themselves as the one who must comply with what the doctor wants. However, the patient does not take the initiative to search for more information, do exercises or make adjustments to their diet.

### 2.3 Theoretical framework

Applying the theories and previous research presented above to the purpose of this research paper we can conclude that according to McColl-Kennedy et al. (2012) co-creation of value can be established through activities and interactions between the patient and the dental clinic. This is supported by Grönroos and Voima (2013), who state that value is co-created when the customer invites the organisation into the joint sphere and involve in a dialogue (i.e. interactions and activities).

Furthermore, the literature also shows that the higher the level of interaction from dental clinics the greater the chance of high involvement from the customer in the value co-creation process (McColl-Kennedy et al., 2012). In addition, depending on the practice style of the patient when co-creating value, the number of required interactions with the dental clinic in order to achieve successful value co-creation differs (McColl-Kennedy et al., 2012). Thus, when dental clinics take into account the expectations of the patient it can lead to a more successful co-creation of value. The literature presented above is summarized in the theoretical framework of figure 1.
Figure 1: Theoretical framework for the co-creation of value
3. Method

In this section, the research design based on interviews with dentists and focus groups with patients, will be presented together with a description of the selection of respondents, and a critical view of the research design. This is followed by ethical considerations, operationalisation of theory, and lastly, the processing of acquired data.

3.1 Research design

Following the purpose of this research paper, to identify and analyse value co-creating activities within healthcare establishments with limited service networks, a qualitative approach was adopted. This approach has been used on most of the literature on the subject (e.g. McColl-Kennedy et al., 2012; Sweeney et al., 2015). Qualitative methods are also often used when the research question involves investigating the experiences of an individual (Ghauri & Grønhaug, 2010). This makes it relevant to this research paper as the perspective on value co-creation is rooted in individual experiences (Vargo & Lusch, 2004).

As mentioned in the introduction to this section, this research paper makes use of both interviews and focus groups. The reason behind this was based upon the different types of respondents. As the question revolves around co-creation of value, and as such around interaction between dentist and patient, both actors were investigated. For the dentists, interviews were chosen as the appropriate method as they are experts within their area, and for the patients the focus group format was used as the possibility of discussion was deemed valuable (Bryman & Bell, 2011). The choice of method is supported by the methodological approach by McColl-Kennedy et al. (2012) which successfully uses interviews and focus groups to fulfil a similar purpose.

The interview form was semi-structured, allowing the respondents to talk freely around a set of themes (presented in table 2). The semi-structured interview allows for flexibility and is centred on the understanding and experience of the respondent (Bryman & Bell, 2011). The interviews were made either at the clinic or in the home of the dentist, both for reasons of planning and convenience as well as making sure the setting was familiar to the respondent.

The other part of the data gathering was accomplished through focus groups with patients. Focus groups are generally used in situations where the researchers judge that the dynamics of
a group discussion will benefit the outcome of the interview (Bryman & Bell, 2011). Furthermore, they are deemed a good option in situations where the researcher is interested in finding the topics or subjects the respondent find important in relation to the main subject (Bryman & Bell, 2011). Lastly, it is also valuable as a way of researching how individuals construct meaning around a concept (Bryman & Bell, 2011). In the context of this research paper these are all factors that will benefit the quality of the data. As the research question focuses on a subject of research with which the patients have limited interaction there is an inherent risk that they might have difficulties with answering direct questions. With this in mind, the dynamics of a group discussion where the respondents may reason together to find their answer is judged to be of value.

3.2 Selection
Two dentists were interviewed to represent the healthcare provider of this research. The role of the dentists that were selected for the interviews had to be what is called general practitioners, meaning they are not operating as specialists within the clinic. The reasoning for this follows from the problem statement the purpose of the research is to identify the co-creating activities on the micro-level of healthcare where the interactions are limited, and treatments are specialised. This means that the more specialised the respondent is, the closer this study is to the research that has already been done. Furthermore, it was ensured that both a dentist in the private sector and the public sector was interviewed. The purpose of this research paper is not to identify between the private- and public dental clinics. Instead the reason for including both is to make sure the results presented are not only representing one of the perspectives.

The focus group was made up of six participants. Smaller groups are recommended in cases where the participants have a high degree of involvement in the topics (Bryman & Bell, 2011), which was deemed the case. The main selection criteria for the participants of the focus groups was to be a regular patient at either a private or a public dentist, and the construction of the group made sure that both perspectives were represented. Diversifying the selection based on age, gender, and occupation was not a goal in itself. There are two reasons for this. Firstly, the purpose of the research is to identify co-creating activities within the micro-level healthcare. The ambition however, is not to provide an exhaustive presentation of every existing activity to generalise to the population. Rather it is to provide a valuable perspective to the research
that has already been done. Secondly, the research done by McColl-Kennedy et al. (2012) does not draw any conclusions between the identified activities and the characteristics of the respondents. Based on this, this will not be the aim of this research. Following the above presented criteria, the focus group was constructed by accessible respondents from the authors’ network.

3.3 Critique of the method

The methods of semi-structured interviews and focus groups are, from the researcher’s point of view, similar (Bryman & Bell, 2011). Thus, the critique against methods are also similar. In literature on business research (e.g. Saunders et al., 2016; Bryman & Bell, 2011), this critique is focused around a couple of different factors.

Firstly, the question of reliability based on a lack of standardisation within the format. This is particularly important to keep in mind in the context of this research paper, where time constraints together with the time-consuming nature of interviewing and transcribing, means the number of respondents is low. The reliability criterion is concerned with the question of if the results can be repeated (Bryman & Bell, 2011). A low number of respondents means the answers provided are more individually connected, and as such, more prone to variation depending on the individual characteristics of the respondents. In the case of the dentists interviewed this research paper, it is therefore important to keep in mind things such as how long they have been working, educational background and roles within the clinic. These are all factors that might affect their views on value and consequently on co-creation. The same applies to the respondents taking part in the focus group. Secondly, the method is vulnerable to different kinds of biases, mainly on the side of the interviewer (Saunders et al., 2016; Bryman & Bell, 2011). This can be based on tone of voice and choice of wording during the interviews. It should also be noted that the interviews were exclusively focused on the dentists and not on the management of the clinics. This means that the involvement in the creation of value propositions might vary between dentists depending on the size of the clinic and whether it is public or private. This is particularly important to keep in mind in this research paper where the sample size is small both on the side of the dentist and the patient. It is therefore important to stress that the aim is not to generalise toward the population but to explore what co-creating activities might be present.
3.4 Ethical consideration

According to Bryman and Bell (2011, p. 128) there are four main questions concerning the ethical consideration to consider when doing business research:

1. Is there harm to participant?
2. Is there a lack of informed consent?
3. Is there an invasion of privacy?
4. Is deception involved?

It was made sure that all participants had a clear image of the research to be done and what their role in it would be. This was done by presenting the purpose of the research and explaining how their answers would be used in subsequent analysis. To maximise the well-being of the respondents, careful care was taken to ensure the meetings fit with the respondents’ schedule and took place in a space that they were comfortable with. As this paper concerns healthcare, the third point is particularly important. Because of this, the respondents of the research have been anonymised. Furthermore, the recordings of the interviews and focus group was deleted after they had been transcribed, making sure that only anonymised records of the conversations exist.

3.5 Operationalisation of theory

The purpose of the research paper is to identify what co-creating activities can be found on a micro-level of the healthcare sector. With this background, the questions used in the interviews and the focus group are based on the study by McColl-Kennedy et al. (2012), and the terminology used for the activities will therefore be the same.

The interview guide is centred on three main themes: the respondents background and operations, views on value, and co-creating activities. In the first theme, the question focuses on basic facts on the respondents and their work. The second theme gets into the process of creating value; how do they perceive value and how do they experience customers’ perception of value and so on. The last theme builds on the views on value from the second theme and goes into the value co-creating activities that are being undertaken. E.g., how are they interacting with patients and how are they trying to integrate the different value perceptions.
This is where the biggest part of the interviews and discussion were focused in order to fulfil the stated purpose of the research paper.

In table 2 the themes and the main questions are presented. It should be noted here that the nature of semi-structured interviews means follow up questions will vary between respondents. It is also worth pointing out, as mentioned above, that the question for the third theme of co-creating activities is dependent on the answers given in the second theme. Nevertheless, the main interview outline is presented below.

<table>
<thead>
<tr>
<th><strong>Theme</strong></th>
<th><strong>Questions</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The respondents personal background and current operation</strong></td>
<td>How long have you been working as a dentist?</td>
</tr>
<tr>
<td></td>
<td>What is your education?</td>
</tr>
<tr>
<td></td>
<td>Describe your place of work</td>
</tr>
<tr>
<td></td>
<td>- Public or private?</td>
</tr>
<tr>
<td></td>
<td>- Size?</td>
</tr>
<tr>
<td></td>
<td>- Divisions?</td>
</tr>
<tr>
<td></td>
<td>What is your role?</td>
</tr>
<tr>
<td><strong>Views on value</strong></td>
<td>What is your view on the value you are offering your patients?</td>
</tr>
<tr>
<td></td>
<td>How do you create your value proposal?</td>
</tr>
<tr>
<td></td>
<td>What is your perception of what the patient finds valuable?</td>
</tr>
<tr>
<td><strong>Value co-creating activities</strong></td>
<td>Can you see any possibilities to involve the patient in creating value?</td>
</tr>
<tr>
<td></td>
<td>Can you give examples of how the hospital deals with the wishes and needs of patients?</td>
</tr>
<tr>
<td></td>
<td>How are patients approached when providing information?</td>
</tr>
</tbody>
</table>
How are patients involved in improvements in their treatment process?

What kind of influence does the patient have in the treatment process?

Can you mention examples of times when the patient would like to take control of his own treatment process?

What is your opinion regarding the participation of patient’s network (i.e. friends, family, other organisations and other patients)?

What kind of activities would create value for the organisation as well as the patients?

Table 2: Interview outline

For the focus groups, the same themes were used, but the questioning was less organised to let the participants engage in discussion and speak more freely around the topic. A summary of the guide for the focus group is presented in table 3. Again, it should be noted that the questions in the table were the outline of the discussion, but the participants’ answers and subsequent discussions are what decides the direction.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>The respondents personal background with dental care</td>
<td>Could you tell us a bit about your relationship to the dental care?</td>
</tr>
<tr>
<td></td>
<td>- How often do you go?</td>
</tr>
<tr>
<td></td>
<td>- Private or public? Why?</td>
</tr>
<tr>
<td>Views on value</td>
<td>What are your expectations when going to the dentist?</td>
</tr>
<tr>
<td></td>
<td>Do you like going to the dentist?</td>
</tr>
<tr>
<td></td>
<td>- Why/Why not?</td>
</tr>
</tbody>
</table>
What is important to you when visiting the dentist?

<table>
<thead>
<tr>
<th>Value co-creating activities</th>
<th>Can you tell us about your interaction with the dentist?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>How involved are you in the process?</td>
</tr>
<tr>
<td></td>
<td>- In what ways?</td>
</tr>
<tr>
<td></td>
<td>What is your commitment in relation to your dental clinic/care?</td>
</tr>
<tr>
<td></td>
<td>Are you undertaking any activities related to your dental care?</td>
</tr>
</tbody>
</table>

Table 3: Focus group guide

3.6 Data collection and processing

How the data was collected is presented below, starting with the dentist interview followed by the patient focus group are presented. Finally, how the data was processed is presented.

3.6.1 Interviews

Two interviews were conducted with dentists. The first one took place in a small private clinic. The dentist that was interviewed is the only dentist working in the clinic. Apart from the general dental operations, her responsibility also includes keeping contact with material suppliers. The second dentist that was interviewed worked as a general practitioner in a public clinic (Folktandvården), that employs approximately ten dentists. The second interview took place in the home of the dentist. The interviews lasted 35-40 minutes and was recorded and transcribed (Appendix 1 and Appendix 2).

3.6.2 Focus group

One focus group was conducted, containing six participants. The characteristics of the members are presented in table 4. The focus group interview took place at the Ekonomikum building in the university of Uppsala and lasted approximately 45 minutes. The discussion was recorded and transcribed (Appendix 3).
### 3.6.3 Data processing

The data acquired through the interviews and focus groups was managed through the three steps for analysing qualitative data developed by Miles and Huberman (1994). The first step of this process is data reduction. In this step, the transcriptions were reduced by removing answers not deemed valuable and simplifying the answers that were to be used. The second step is data display. Here the reduced data is being connected to the themes identified in the operationalisation of the theory. The data was then coded and categorised in connection to the theory. The respondents’ answers were compared by analysing similarities and differences. The second step is what makes up the result and analysis part of the research paper. Finally, the third step is conclusion drawing, where the data is used to present the conclusions of the research.

<table>
<thead>
<tr>
<th>Participant</th>
<th>Gender</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Male</td>
<td>23</td>
</tr>
<tr>
<td>B</td>
<td>Female</td>
<td>24</td>
</tr>
<tr>
<td>C</td>
<td>Female</td>
<td>23</td>
</tr>
<tr>
<td>D</td>
<td>Male</td>
<td>27</td>
</tr>
<tr>
<td>E</td>
<td>Male</td>
<td>25</td>
</tr>
<tr>
<td>F</td>
<td>Male</td>
<td>27</td>
</tr>
</tbody>
</table>

*Table 4: Focus group participants*
4. Results
In the following section the empirical data collected will be presented. The structure will follow the themes presented in the operationalisation of the theory in the previous section. The result from the dentist interviews will be presented first and the focus group will follow thereafter.

4.1 Dentists
In the presentation of the results below, Dentist A is working in a private clinic where she is the only dentist. Her role includes the dental work as a general practitioner, meaning she performs actions such as regular check-ups and examinations as well as treating cavities and extracting teeth. Her responsibilities also include administrative task such as ordering supplies and medications and having contact with labs producing prosthetics. Dentist B is working at a public clinic (as a general practitioner). In total, the clinic (Folktandvården) employs approximately ten dentists and offers both basic and specialised treatments. Dentist B is not responsible for overall administrative tasks of the clinic, and the administrative tasks she is performing is in relation to the care of the patient.

4.1.1 Views on value
Regarding the views on value, a few different perspectives were brought forward. Dentist A mentioned that the dominating factor for the patients is money and that the costs are their main concerns. On the topic of how patients perceive value, Dentist B also mentioned money and talked about time as being very important, both in terms of finding a suitable time for the patient’s appointment and then making sure that the time allotted for the appointment is enough to satisfy the customer.

Their own views on value were similar and centred around making the patient feel safe. Dentist A described how her knowledge of different languages allowed her to provide a degree of safety to the patient that could not be achieved through the use of a translator. Dentist B explained that it is important to listen carefully to the patient and making sure that they feel that they are being heard. Both dentists mentioned how this degree of safety for the patient is particularly important within the dental care as many patients are scared of visiting the dentist. Dentist A said that in her experience as much as 90% of her patients exhibit some degree of anxiety before the visit and stated that “nobody is happy to come here”. With this background, both respondents mentioned using a psychological approach to provide value. Dentist A says
she will use “psychological talk” to make the patient feel safe, and Dentist B explained that her education focused on using a psychological approach to the dentist-patient interaction.

4.1.2 Value co-creating activities

On the subject of activities that can be seen to co-create value between patient and dentist, both dentists shared an approach for including the patient in the treatment process. When the patient suffered from a particular condition that can be treated in different ways, the dentists explained that they will prepare different options for the patient to choose from. Generally, these options are separated by price, with the most expensive option being the most long-term, aesthetically beautiful and holistic solution. The other options will lack some of these benefits and instead come at a lower price. It is then up to the patient to choose which option suits their situation the best. Dentist B expressed it as follows:

“[…] you do an examination you tell the patients what you find and then what are the solutions to fix the problem. Sometimes, patients want to fix it right now. Even when they have the money and want to fix the problem correctly, let’s do something that fixes it for now. Other patients want to go with the cheapest solution and other patients want to go with the most expensive solution.” - Dentist B

Another point of co-creation of value is the aspect of planning and time managing. Dentist B explained that in the public sector where she is active, the time book is not managed solely by her, and the managers of the time books are generally keen on getting as many patients done as possible during the day. Dentist B however, makes sure to keep some control over her time book in order to tailor the appointments to the needs of the specific patient.

A more two-way interaction of value co-creation was brought up by both respondents and concerned the use of information sharing. Firstly, the dentists make sure that they are providing the patient with necessary information about the process and treatment, as well as showing them how to prevent certain issues from developing by brushing, flossing, and giving them advice on what products to use. Secondly, they explained that there are cases where the patient will have done their own research on different treatment processes. In these cases, both dentists stated that they were open towards accepting and investigating this information, even if it was seldom something new to them. Another area with direct involvement of the patient was
mentioned by Dentist A and concerned the physical space of the clinic. The rooms were equipped with speaker systems and an in-ceiling screen and the patient could then decide what music they wanted to hear, or what they wanted to look at.

The respondents also talked about how they worked with the network in order to provide a better experience for the patient. Dentist B, that is working within Folk tandvården, explained the process of sending a patient to a specialist at the hospital:

“At the moment at the clinic that I am working at there are a few dentists that are specialised in certain areas of care. The patients really appreciate that when they are able to stay at the same clinic. When you send a patient to another dentist, they might come in and introduce him or herself to the patient and the patient really appreciate when they know who they are going to meet next time. If there are more severe issues with the patient and I want a specialist at a hospital to look at I can send them to the emergency room. I will call the hospital that there is a patient coming in.” - Dentist B

In the case of the much smaller clinic of Dentist A, a similar process was also in place:

“[…] I tell them this is complicated and it needs a specialist to deal with it. I can fix it for now so you won’t feel pain but for better treatment you should go to a specialist. And then I send a remiss [referral] to the hospital. […] When I send the remiss I include the details of the patient and then it’s the hospital that contacts the patient to set up a time. So when I send the remiss, the issue is not in my hands anymore. It’s all up to the hospital.” - Dentist A

In addition, both respondents mentioned cases where it is useful to include the network of the patient i.e. friends and family. Generally, this happens when the patient is a child or if the patient suffers from a disease such as Alzheimer’s or dementia. They would also recommend patients that are anxious about their visit to bring someone with them to help them stay calm. Dentist A explained how this could be beneficial both for the clinic and for the patient:

“sometimes it is good to involve the family. It helps the patient, but it also increases our patients because when a friend comes with a patient they are usually more calm because they have some support and security and then if the other person sees the patient was happy and we solved his problems, maybe he would be interested to come and check his own teeth at our
clinic. So it is valuable for us in a business sense but also for the patient on a psychological side.” - Dentist A

4.2 Patients
In the presentation of the results below the focus group consisted of six participants. Of the six participants two were female and four were male. All of the participants have gone to the dentist prior to the focus group. However, a majority of the participants are going to a private dental clinic in favour of a public dental clinic. This is due to several factors such as; the relationship with the dentist, convenience, time and quality. This can be seen in the participants’ statements below:

“[…] I did go to Folk tandvården but the dentist clinic changed to a private clinic and I wanted to go to the same clinic. Thus, I stayed at the dentist.” - Participant A

“I have been to both a private- and to a public dental clinic as well. […] When I turned eighteen I went to a private dental clinic as I don’t feel that there are public possibilities for me.” - Participant C

“Yes, I also go to a private dental clinic […] when you want to go to a public dental clinic the waiting time can be more than three months.” - Participant D

“I’ve been to both. However, the last time I was in a public dental clinic was when I was five-eight years old. Because the system for dental care is not so good […] it is better to go to a private dental clinic.” - Participant E

The participants in the focus group also stated that they visit their dental clinic once or twice per year in order to get a check-up on the health of their teeth. Meaning that the patients experience a low level of interactions with the dental clinic. This is shown in the participants’ statements below:

“Maybe once a year for a general check-up of my teeth for about twenty minutes.”

- Participant A
“[…] I don’t go to the dentist that often” - Participant B

“I have some hygiene (scale) issues for which I go to the dentist about two or three times a year.” - Participant C

4.2.1 Views on value

From the focus group several views on value with regards to dental clinics emerged. One value that emerged is the importance of having a relationship with their dentist. According to the participants they want and find it important to build a relationship with their dentist as they visit the dental clinic on an annual basis. This is shown in the following statements from the participants:

“Yes, for me it is important as you go to the dentist on an annual basis, no matter what. So, you are as a patient building a relationship with dentist.” - Participant F

“You are building a relationship with your dentist.” - Participant C

“[…] however, I think it important in order to build a relationship and trust with the dentist as well.” - Participant B

Another value that became apparent during the focus group is trust. The participants stated that as they are paying for the treatment they expect to build up a degree of trust with the dentists. Furthermore, the participants trust their dentists as the dentist is perceived as being an expert in his or her respective field and knows what he or she is doing. This is exemplified by the following statements:

“As I am paying for something I am expecting them to be there and build up a trust and it shouldn’t matter if it is a different dentist all the time they still work for the same organisation.” - Participant B

“Usually, I think that they are the experts, so I’ll just listen to them. If they say we have to fix this I just say let’s do this. I trust that they are giving me the best option.” - Participant A
“But usually you don’t know so much about what you need and how it works so you just trust the dentist completely.” - Participant C

“And I think that also depends on the trust. If you need to fix something immediately but you don’t have the money. If you have built a trust with the dentist you can say, fix this for me and I will pay you in the future.” - Participant E

Time is according to the participants of the focus group also an important value. One participant e.g. stated that if they would go to a public dental clinic they would have to wait for more than three months. Furthermore, one participant stated that he wants to go to the dental clinic as little and as quick as possible. This can be seen in the participants’ statements below:

“[…] when you want to go to a public dental clinic the waiting time can be more than three months. Since I just go for emergency situations I go to a private dental clinic.” - Participant D

“Yes, yes, yes, you know, it is not fun to go to the dentist. You want to do it as few times as possible and you want it to be as quick as possible.” - Participant F

Costs was another value that became apparent during the focus group. The participants stated that going to the dentist the value is mostly with regards to the costs. Furthermore, one participant expressed that she is more concerned about the price and quality of the visit than going to the same dentist. This is shown in the participants’ statements below:

“So for me the going to the dentist the value is mostly about the money, like how much you are going to pay.” - Participant B

“To some extent it [money] is important.” - Participant A

“I am more concerned about the price and the quality than going to the same dentist.” - Participant C

The last value that emerged during the focus group was the quality of the treatments. One participant stated that it is better to go to a private dental clinic instead of a public dental clinic.
As mentioned previously, one participant expressed that she is more concerned about the price and quality of the visit than going to the same dentist. This shows from the participants’ statements below:

“Thus, it is better to go to a private dental clinic. Since the quality and they usually treat you better for the money and quality than public dental clinics.” - Participant E

“I am more concerned about the price and the quality than going to the same dentist.”
- Participant C

4.2.2 Value co-creating activities
According to the participants of the focus group, the time that the dentist makes available to talk to the patient is an activity that is valued. By having this kind of interaction between the dentist and patient does not only build a relationship but also trust. As mentioned earlier, building a relationship and trust with the dentist are values that the participants find important when going to a dental clinic. Following quotes exemplify this point:

“I also think it is important that the dentist make the time available, so you don’t feel stressed, especially when you go to a private dentist. Now, they don’t always have the time or aren’t listening for a full 100%, however, I think it important in order to build a relationship and trust with the dentist as well.” - Participant B

“Also, when you are feeling pain you might think your pain is unique. Even though the dentist might already know what is wrong, you as a patient still wants to explain all the details. For me as a customer I think that is important.” - Participant C

“I also like that when they are showing you what they are doing, and this is how your teeth look like and see it on the x-rays. By doing so, you are developing more of a trust with the dentist.” - Participant B

“Yes, and be aware of your medical history.” - Participant E
According to the participants of the focus group, bringing family members and friends is another co-creation value activity. The participants go to their dentist with family members such as their mother, father and grandmother. In addition, one participant pointed out that one of her friends brings her boyfriend as she has anxiety when she has to go to the dentist. This is shown in the participants statements below:

“No, not specifically during the appointment. Sometimes, I am there with my mother or grandmother as it is a family dentist. We even schedule it after each other so we can all go on the same day and together.” - Participant C

“I also go to the dentist with my mother.” - Participant D

“Me too or with my father.” - Participant E

“I have a friend that has really big anxiety going to the dentist, so she has to take a pill before and her boyfriend always has to go with her.” - Participant B

Within the focus group the participants also pointed out that one co-creation activity is the prevention of something bad happening to your teeth. One of the participants stated e.g. that by going to the dentist he will avoid problems with his teeth and thus more expensive treatments in the future. A similar statement was made by another participant. The participant stated that it is good to go the dentist in order to prevent more expensive visits. The prevention of avoiding problems with the participants teeth also ties in to the costs value that the participants mentioned above. This can be seen in the following statements:

“The problem afterwards may be pricier, so it is better to go regularly to avoid that.”

- Participant E

“[…] So it is good to go to the dentist in order to prevent having a more expensive visit in the future.” - Participant B

“I also think that the value is in the prevention of something bad. It’s more about having the insurance that you are actually fine and healthy.” - Participant F
5. Analysis

Much of scientific literature on the co-creation of value is based on the active patient (i.e. customer) (Vargo & Lusch, 2008), however, it is unclear whether the individual patient is willing and able to fulfil this role. This research focused on co-creation of value with patients and dental practices, to subsequently identify value co-creating activities within healthcare establishments with limited service networks. The central research question of the paper is; “What value co-creating activities exist in dental healthcare?”

The findings show that co-creation of value does occur between patients and the dental clinic. Despite the fact that this particular research is aimed at healthcare organisation that have fewer possibilities for this than, e.g., a hospital that does have the potential to do this because of the long-term relationship that patients with more advanced conditions have with the hospital (McColl-Kennedy et al., 2012). The findings from the focus group with patients also showed that not every patient has a need to co-create value. However, it is worthy to mention that many of the patients who are actively involved in the co-creation process expect that the dental clinic facilitates them in the co-creation of value process. The findings show that patients are satisfied with the level of co-creation of value with the dental clinic. One reason for this is that most of the patients have a great loyalty to their dental clinic and accept it if the dentist can offer less than they were expecting. In addition, patients find that the dental clinic has the right qualifications and knowledge to make and implement the right choices in their treatment process. Patients have different needs in terms of co-creation of value, varying from showing the practice style 'passive compliance' to the practice style 'team management' (McColl-Kennedy et al., 2012). From the results with regards to the dental clinics it can be concluded that their behaviour affects the level of co-creation of value. The dentists indicate that it is important that patients take control of their treatment process. However, in practice, no care is handed over by the dental clinic. Furthermore, dental care clinics expect that patients are not very active in the treatment process and find that they usually exhibit passive behaviour.

Based on the research by McColl-Kennedy et al. (2012) the value co-creating activities in the healthcare can be separated based on the level of interaction they have. In the context of dental care, the number of interactions between patient and dentist is inherently low. This can be seen in the attitude of the patients where they are stating that the dental care works as a method of prevention. Going to the dentist is not necessarily something they do because something is
wrong with them, but rather they do it to make sure that everything is right. This leads us to
the first identified co-creating activity. From the result, it is clear that the dentists are making
sure they are educating the patient is how to best take care of their teeth. On the patients’ side,
they are working actively with following these instructions. This type of interaction shows that
the activity identified as cooperating by McColl-Kennedy et al. (2012) is present in the dental
practice as well. In the case of dental care, the activity of cooperating is closely linked to
another co-creating activity identified by McColl-Kennedy et al. (2012), i.e. collating
information described as managing basic everyday activities.

Another co-creating activity that is identified by McColl-Kennedy et al. (2012) and present in
dental care is that of colearning. The dentists are seeing patients performing their own research
and consult this together with their dentist. This was however not something that was widely
spread among the participants of the focus group. The reason for this might be that the research
provided by the patients concerns more serious treatments, and as such, is not a part of the
focus group participants experiences as those focused on the standardised activities. This
indicates that there is a relationship between the level of interaction and co-creation of value.
This is further strengthened by the interviews with the dentists and the creation of different
treatment options. This is also something that is only done for more serious and advanced
treatments and therefore not something a patient will experience during a regular check-up.
The activity of providing the patient with different treatment is nevertheless a good example
of a value co-creating activity. It is however, not represented in any of the activities identified
by McColl-Kennedy et al. (2012). The reason for this is that that research is focused solely on
the activities undertaken by the patient to co-create value, whereas this research paper also
explores the perspective of the dentist in the co-creation process.

The different treatment options are not the only example of the value co-creation being
instigated by the dentist rather than the patient. The interviews also show that the dental clinics
can be designed in a way that enables the patient to have some control over the environment
by selecting music or be able to watch something on a television. These are instances where
the value co-creation does not follow the theory on co-creation by Grönroos and Voima (2013).
Grönroos and Voima (2013) concludes that value can only be co-created when the user
(patient) invites the producer (dentist) into the value-creating process. However, the result of
this research shows that in the context of dental care, the producer can be the facilitator and
instigator of co-creation of value.
Looking at the customer co-creation practice styles that are presented by McColl-Kennedy et al. (2012), this research shows some resemblance to the style of team management. This style is characterised by managing the team around the treatment and integrating the network, both on the dentist side and the patient side. The result of this research indicates that this is, to some extent, present in dental care. However, it is something that is mainly done by the dentist rather than the patient. The dentist is working to make the transitions between different divisions as smooth as possible for the patient as well as actively including the patient’s network in cases where it is deemed needed. Nevertheless, it is a co-creating activity, not least as shown by the dentist explaining that including the patient’s network is beneficial to all actors.

The practice style that is most applicable to the patients in the dental care is what McColl-Kennedy et al. (2012) call passive compliance. The role of the patient practicing passive compliance is to simply comply with the advice and instructions from the doctor. The main activities undertaken by the patient practicing passive compliance are cooperating and collating information, two activities which can be identified in this research. Furthermore, passive compliance is the practice style characterised by the lowest level of interaction. As seen from the answers by the patients, dental care is something that takes place regularly but seldom, and therefore the level interaction is inherently low. This means that adopting a different practice style might not be possible in the context of dental care. Finally, the relative indifference of the patients towards dental care, viewing it as something that just needs to be done, resembles the low effects on quality of life that McColl-Kennedy et al. (2012) identify for passive compliance.

5.1 Revision theoretical framework for the co-creation of value

Based on the results and the discussion presented here above, a revision to the theoretical framework is presented in figure 2 below.

The five practice styles from McColl-Kennedy et al. (2012) is extended and a sixth style is added as “Facilitator”. The facilitator is characterised by two new activities identified from this research as “Option providing” and “Designing of environment”. Moreover, “Integration of networks” is identified as a co-creation of value activity within the practice style of team management, occurring on the side of the dental clinic.
From a patient perspective the identified practice style is passive compliance and the co-creation of value activities are identified as cooperating, collating information and colearning as defined by McColl-Kennedy et al. (2012).

Figure 2: Revised theoretical framework for the co-creation of value
6. Conclusion and discussion

Based on the results and the analysis of the research paper, this section provides a discussion and subsequent conclusions. Following this, a critical discussion is of the limitations is presented and finally suggestions for future research is provided.

6.1 Conclusion

The purpose of this research paper is to expand the literature on value creation in healthcare by identifying value co-creating activities within healthcare establishments with limited service networks. The research question that was asked stated: “What value co-creating activities exist in dental healthcare?”

Following the empirical study presented in this paper, the following conclusion can be drawn. The value co-creating activities that can be identified from the patient’s perspective are cooperating, colearning, and collating information. From the dentist’s perspective the activities are integrating the networks, providing options, and designing environment. Thus, it can be concluded that prior research with regards to the co-creation of value in the healthcare sector is partly applicable to the micro-level of dental healthcare.

Furthermore, a couple of other things have surfaced during the research process. The co-creating activities within the dental care is mostly instigated by the dentist rather than the patient. This serves as a valuable theoretical contribution to the research of co-creation of value activities where the patient has been the focus of study. There are also practical implications to this, e.g., providing dental clinics with an understanding of how to form their co-creation of value activities to include the patients. It can also be concluded that co-creation of value can exist in sectors where the level of interaction is low. Whilst the interaction with the dentist happens once or twice a year, patients consider it an important control function in preventing health issues from occurring. As such, the dentist is always present as the co-creator by providing the patient with a sense of safety. This leads to the final conclusion; that the co-creation of value can also be active on a psychological level, and not solely through physical interactions and activities.

6.2 Limitations

Even though this research paper has been carefully prepared and has achieved its aim, there are limitations and shortcomings. First of all, the research has been conducted in ten weeks.
Therefore, due to time limit, the research that has been conducted is only a small size of the actual population that go to the dentist and only a small size of dental clinics available. Thus, in order to generalise the results for a larger portion of the population, the research should have involved more participants. Secondly, another consequence of a small sample size is that the results cannot be considered exhaustive. As such, the value co-creation activities that are identified through this research might not be the only instances of value co-creation between dentists and patients. Lastly, the results showed that dental care is perceived to be different to hospital care as dental care is done as an act of prevention whereas a visit to the hospital generally happens when something is already wrong. Thus, the results are less comparable to the theoretical background from a patient’s point of view, and the result of this research should not be considered true for all instances of micro-level healthcare.

6.3 Future research

For future research, it is suggested that more focus is directed to exploring the different types of healthcare establishment from different levels of interaction. The result of this research indicates that there are both similarities and differences depending on what type of healthcare is examined. Furthermore, the results of this paper indicate that there is a fundamental difference between dental care and other parts of the healthcare sector, in the sense that dental care is about prevention of health issues and other healthcare is not. It would therefore be of interest for future research to look at co-creation of value activities within the more basic levels of healthcare such as primary care. Finally, the results in this research paper suggest that co-creation of value activities within healthcare can be instigated in large part by the dentist. Directing more attention to investigating co-creation of value activities from the point of view of the doctor would therefore be a valuable contribution to the research field.
7. Bibliography


8. Appendices

8.1 Appendix 1. Transcript Interview Dentist A

INTERVIEWER: Can you describe the organisation here? What is your position?

DENTIST A: I’m the clinic chef. And basically, we are only me and my assistant who is at the same time also the secretary. So basically, I manage everything. Patient calls, they come in, I examine them. Everything that is related to dental care, I’m responsible for. Everything that is on… I have to take care also and check every time what materials we have, what we need to order, and stuff like that. And yeah, that’s basically my job. So, like, I have to take care also, some people has a free card, and some people have like personal issues, they don’t have money, and they go to the kommun (municipality) or the socialen (social welfare) for help, so I have to build up also the plan for them that suits also their pocket money. And their social status as well.

INTERVIEWER: How do you work together with the kommun or socialen?

DENTIST A: I usually if people really have bad teeth and they cannot afford to fix them so usually they come and I examine them, I take pictures, four pictures usually for every patient, and then I build up a plan. Usually I build up more than one because there is always more than one solution so I take like basically two or three. One is expansive, one less and one is like the basic. Then I give it to the patients, and they go with it to socialen or the kommun, I don’t know exactly, everyone depends on his case, if they are asyl (asylum seeker) if they are not asyl, if they are already registered here. Usually it’s immigrants that go to ask help. I haven’t seen yet a Swedish person asking the kommun for help.

INTERVIEWER: Do you have a lot of immigrants coming to your clinic?

DENTIST A: Yes, especially because I speak Arabic. They prefer to come here even if they have to drive three or four hours.

INTERVIEWER: So, these plans that you are giving them, with the different prices, that is decided then on what they can get from the kommun?
DENTIST A: No that’s basically… For example: There is a bad tooth that need extraction, so I extract it. Okay, after that, what? Something needs to be put there. So, I start with the plan. Implants is the highest thing which costs almost 30 000 crowns. And then that’s the highest option. And then we move on to a bridge, which is basically, I have to slipa (grind?) two teeth, and then connect them with a bridge with which I fulfil this extracted tooth. That is the second option which costs less, it’s around 13 000 crowns. And then there is the most basic thing which is like a small tooth that they can take out and put back in which is like a prosthesis. And that’s the basic. And then it all depends on their many and what socialen accepts to pay for them. And we are talking mostly about immigrants. But it’s the same thing I do also with Swedish people. Not all of them can afford to pay the best solution. And some of them don’t even care that they’re missing a tooth, they just don’t want to have pain and that’s it.

INTERVIEWER: How does it work with insurance in these cases? Do you see a lot of patients without insurance?

DENTIST A: Everybody has insurance from Försäkringskassan, but is works like this basically: First up to 3000 crowns you have to pay it yourself, and after that… Our prices here is a bit higher than normal prices, so usually after 3000, Försäkringkassan start to pay 35% and then 50% after 10 000 and then 85% after 15 000. But these rules are changing all the time so if you want the exact number it is better if you google it.

INTERVIEWER: So, when you have these plans with different costs, is it then just up to the preference of the patient to decide?

DENTIST A: Exactly. But I have to inform them of all the options and then they have to choose one. So, I explain the benefits of every step, if you do this you’ll have this benefit, and if you do that you will have this benefit.

INTERVIEWER: So, this gives the patient some control over their treatment process, are there any other ways in which you include the patients?

DENTIST A: Usually, the most troubled persons who are the ones who do not check themselves regularly. The people who check themselves every six months or at least once a year, they don’t have such a trouble. Because we can detect even the smallest cavity. And then
they never get to pay too much because fixing the cavity is a very small amount, compared to other treatments. So, if you do the basic checks every half year or every year the no one will get to these bigger issues.

INTERVIEWER: So, there is a part where the patient can control their treatment process by keeping checking their teeth and brushing properly and flossing etcetera?

DENTIST A: Yes of course. Although, I’m not the type of dentist that bothers her patients a lot. Myself, I hate to go to the dentist when he is just standing there saying “brush your teeth and floss and to that and to this!”. Come on, nobody does that. So, first of all, I check the situation. If it is good enough and he has a good hygiene, then I say nothing. But if I see that he has problems with the gums or a lot of caries because of lack of brushing or flossing then I say and I explain and say you have this problem because you do not do this and you do not to that and so on. And I also recommend them to buy things and I show them on small models how to do the right movements.

INTERVIEWER: The regular examination or check-in, is that the most common operation you have?

DENTIST A: Yes. Usually, people, most of them, and I don’t know why, especially older people, they come every six months and they follow the rules. But young people do not do that. But yes, basically every six months we invite them and they come here and we take new pictures and I confront with the old ones to see if something new happened.

INTERVIEWER: And if you are going in here every six months for the examination you are going to be fine?

DENTIST A: Yes, because even if something is starting to go wrong I can detect it from the beginning. And we are not allowed to fix every cavity. It has to be a certain volume so to say. If it is very small then we cannot fix it and we just watch it until the next visit and if it becomes bigger, then we fix it and if it is the same, then we leave it. Because sometimes we have active cavities and sometimes we have inactive cavities.

INTERVIEWER: What’s is the reason you are leaving them? Are they too small to fix?
DENTIST A: I don’t know, it is Försäkringskassan’s rules.

INTERVIEWER: So, there is actually a rule from the insurance that if it is small it shouldn’t be fixed?

DENTIST A: Yes, let me show you something that can explain. (DENTIST: brings a paper showing different types of cavities named D1, D2, and D3). This is part of some research from Försäkringskassan. So, for example, if it is D1 then I cannot fix it, I just need to follow up on it. If it is D2 it’s the same thing. Only if it gets in to the second layer of the tooth… So, the tooth has three layers, the enamel, the dentin and the nerves. So only if it gets to the second layer then we are allowed to fix it otherwise we only have to watch it. Unless, a patient wants to fix it. Maybe he doesn’t care [about insurance] because sometimes it’s on the frontal teeth and then it’s like a black point and aesthetically it’s not beautiful. So yes, sometimes we do fix that, depends on the patient.

INTERVIEWER: So, the patient is still allowed to go outside of the Försäkringskassan rule but won’t get any insurance money?

DENTIST A: Well, usually this is only done if it is on the frontal teeth and from the pictures you cannot see the depth of the cavity. So even Försäkringskassan won’t know how deep it is.

INTERVIEWER: So, the checking process, even if it’s a regular process, it not a continuing thing. I mean it’s a new examination every time. Do you have any kind of treatments that take place over a longer period of time? For example braces, I guess there is a longer process with more steps.

DENTIST A: We don’t do braces here. But there are like, if I’m doing prosthetics I should measure it like four times and each time I have to send the object to the lab and wait while they prepare it and get it back and sometimes it takes three four months until we finish one prosthetic for one patient.

INTERVIEWER: What is the patient’s role in this process?
DENTIST A: Unfortunately, it doesn’t depend on them. It depends on the time that… You know we are always fully booked all the time, so it depends on when they can come to the clinic and how long it takes for the lab to do what I need them to do and send it to me.

INTERVIEWER: So, there is a lab that are doing the prosthetics for you. Is that lab a part of your clinic or is it an independent company that are making those?

DENTIST A: Yes, it’s separate from us.

INTERVIEWER: What other actors exist in your process that aren’t a direct part of your operation?

DENTIST A: There is the company where I buy materials. There are two places because one of them include also medicines and stuff so it’s on the pharmacy side. And there are a lot of other sides for the normal basic material that doesn’t include medicines. But it is up to me to choose where I buy from. And then we have the lab, and that’s it.

INTERVIEWER: Are there cases where a patient could come in with a special type of condition where you would see that this requires treatments which you cannot provide?

DENTIST A: Yes, if I see that we have a very complicated case and the patient is in a lot of pain. Usually if I want to send a patient to the hospital it takes months until they have the time. What we do is first aid help. The first thing the dentist needs to do is to relief the pain of the patient, and then he [the patient] can think further about what to do next. But the first thing is to send the patient home with no pain. Sometimes I cannot do anything because they come with a swollen jaw and when it is like that sometimes they can’t even open their mouth and so I can’t do anything. Then I just give them antibiotics and wait until the next week when it has calmed down a bit.

INTERVIEWER: If there is a case where you feel like you have to send them to the hospital how does that work?

DENTIST A: I will inform them of course. But as I said, I will do something to relief the pain and I tell them this is complicated and it needs a specialist to deal with it. I can fix it for now
so you won’t feel pain but for better treatment you should go to a specialist. And then I send a remiss to the hospital.

INTERVIEWER: And how does the process of you sending a remiss for the patient work?

DENTIST A: I inform the hospital about the patient. I send them pictures and write what I see, what I have done, and what needs to be done and why I cannot do that and why it needs a specialist.

INTERVIEWER: And that is a communication between just you and the hospital?

DENTIST A: Yes, but when I send the remiss I include the details of the patient and then it’s the hospital that contacts the patient to set up a time. So, when I send the remiss, the issue is not in my hands anymore. It’s all up to the hospital. And of course, sometimes, but I haven’t met these cases yet, and I hope I won’t, but in some cases a patient need to be sent immediately to the hospital. Sometimes the swollen parts get so big that it blocks the respiratory system and they cannot breathe well so these issues need to be sent immediately to the hospital. But it hasn’t happened to me yet and I hope it won’t.

INTERVIEWER: How do you work with the privacy of patients?

DENTIST A: When you become a dentist, they make you take an oath and that means you cannot talk about patients. So ethically it is not good to do that and I think no dentist does.

INTERVIEWER: And how do you work to keep data of the patients secure when you are sharing it between actors like socialen or the hospital?

DENTIST A: Nowadays in Sweden there is a new law. Usually when I need to send a remiss or to talk to Landstinget I have to pass some information. But it is only between me and the other part and they also protect the privacy of the patient. But now there is a new law that says I cannot send any information on paper or by email or something. It has to be on a special program. We don’t have that yet but there will be a kind of intranet where the details can be shared among the actors.
INTERVIEWER: The research that has been done on hospitals from the marketing perspective talk about how the hospitals can have a connection not only with the patient but also with the network of the patient, meaning friends and family. Are you working on integrating this side of the network?

DENTIST A: One example would be children of course, but they usually don’t come here since they have free treatment at Folk tandvården.

INTERVIEWER: Apart from children, are there situations where you would involve someone around the patient?

DENTIST A: It happens. One example is where old people have Alzheimer or dementia. They won’t remember what I’m telling them, or even remember to come to the appointment. So, then I will talk to a wife or a son or a daughter and they will be with them. They always inform me before, and tell me the situation so I know how to act. Or sometimes there are patients who are really really afraid and they need like a special treatment and a special psychologic way of speaking. So yes, sometimes I need involvement of friends and family. It happens. And sometimes it is good to involve the family. It helps the patient but it also increases our patients because when a friend comes with a patient they are usually more calm because they have some support and security and then if the other person sees the patient was happy and we solved his problems, maybe he would be interested to come and check his own teeth at our clinic. So, it is valuable for us in a business sense but also for the patient on a psychological side.

INTERVIEWER: Is it common that people are afraid of dentist?

DENTIST A: Yes, most people. 90 % if not more. Nobody is happy to come here.

INTERVIEWER: Why do you think they aren’t happy?

DENTIST A: You know, it is uncomfortable, it’s noisy, sometimes it hurts a bit and it steals time from you so nobody wants to do that.

INTERVIEWER: How are you working on trying to make it into a more pleasant experience?
DENTIST A: We have a screen in the ceiling so the patient can watch that, or sometimes I’ll just put on some music to make it a more pleasant experience and to distract them a bit. Some patients ask to put their own music in their ears while I’m working and that is fine for me. Usually if the patient is afraid I will try to make it the most comfortable situation in the end for him.

INTERVIEWER: Do you find that it works? Are the patients more satisfied because of this?

DENTIST A: Yes, usually I succeed. Not 100% of the cases but 99%.

INTERVIEWER: What happens if you can’t treat them?

DENTIST A: Like last week, a very old lady came. She probably has some health problems and some mental problems, and her two assistants came with her but we couldn’t succeed in even making her sit on the chair. Even her assistants were trying to make her sit but she kept getting up and when they tried to make her sit she was biting them. And so, in these cases I say “okay this woman has bigger issues than her teeth” so I just leave it.

INTERVIEWER: One thing we talked about in the beginning was the different plans or treatment options. To what extent do the patient have an influence on the options? What reasons do you see for them choosing one option over the others?

DENTIST A: Mostly it depends on their economic situation. Not only though, some people do have money but they don’t like to spend it. Some people don’t think their teeth are that important. Every patient is different and some people don’t care if they are missing a tooth. They feel fine and they are comfortable and they don’t care.

INTERVIEWER: What your view on the value that you are providing your patients with?

DENTIST A: From my own point of view. The most important thing that they care about is money. This is the most common thing for all patients. Even if I tell them they should thing this thing and that and that and that, the first thing they ask is how much does it cost. That’s why then, I have to give them more options to make them see that this thing that is more expensive it has more benefits because of these reasons. Another option maybe is not as
aesthetical but it works for chewing and everything but not beautiful. The third is just to solve the pain but leave the situation as it is.

INTERVIEWER: Apart from money and financial value, what other types of offerings do you see attracts the patients?

DENTIST A: One thing is some patients are very afraid and the way they are being treated is very important to them. Another thing is me speaking Arabic which is a very big benefit. Nowadays we have a lot of Arabic immigrants who speak Arabic and they do prefer to have someone who speaks their language. Even if there is a translator it is not the same because the dentist who was here before, he didn’t speak Arabic but there were always translators available for these patients. But they always tell me that it is not the same. They couldn’t understand properly what the dentist wanted to do and what he was planning to do. So, it gives them a feeling of relief psychologically that the dentist speaks the language.

INTERVIEWER: How much contact and communication do you have with patient, outside of the clinic?

DENTIST A: None. If they are our patients who come here regularly, I decide if they have to come here every six months or once a year depending on the status of their mouth. Some people even come every three or four months, it depends. But yes, if they have regular visits we send them an invitation for examination every time they need to come. And we also have people who just won’t come here and they wait until the pain comes, and then they call us and we have emergency visits. What they don’t understand is that pain for this treatment will cost more because the cavity is bigger and the treatment needs more stuff so it costs more. And they also have to pay extra for emergency visit. So basically, they spend more money than just checking regularly. And nowadays Försäkringskassan is paying almost 600 for each patient to check himself every year. So basically, if you check yourself once a year the state pays 600 for you so you have to pay only around 200 to do that which isn’t a very big amount.

INTERVIEWER: Is the invitations sent out automatically or do you contact the patients personally.

DENTIST A: The system sends out the invitations.
INTERVIEWER: What opportunities do you see for the customers to create value?

DENTIST A: Some people come to me with their own research and they have googled their condition and wants to hear my advice on the treatment. And I will listen and sometimes I’ll tell them not to believe what they read. Or sometimes their information will be correct but it isn’t yet scientifically approved and I will explain to them why it can’t be done now. I haven’t had a patient showing me something I know nothing about but that seems good but if they came to me with good research and good sources I would be happy to investigate that and see if I can implement it.
8.2 Appendix 2. Transcript Interview Dentist B

INTERVIEWER: Where do you work and what is your position?

DENTIST B: I am working as dental practitioner at Folktandvården in Stockholm.

INTERVIEWER: Is that a public- or private dentist?

DENTIST B: It is a public dentist, Folktandvården.

INTERVIEWER: When you are studying to become a dentist how much focus is there on the interaction with patients or is it more technical?

DENTIST B: I’ve studied in Malmo and there was more a focus on the interaction with patients when comparing to other schools that offers a study to become a dentist. There is a lot of focus on the way you are as a dentist.

INTERVIEWER: a more phycological approach?

DENTIST B: Yes, during the first year of my studies we were actually filmed to see our interaction with the patients in order to help us interact better with the patient.

INTERVIEWER: Is there a set of patients that you know that come back to you specifically?

DENTIST B: It depends, I’ve been working at this clinic for the last year. Usually you meet the patient, you will have the examination of the patient and you make a therapy plan. Afterwards they come back if they don’t need anything. If there is technical aspect to the patients I will send them to a dentist that specialises in the technical aspect that they need. As there are so many dentists at the clinic where I am working it is quite often that you will get patients that have been to other dentists, because they don’t have a proper time slot that fits with the time of the patient. However, I worked at another Folktandvården clinic which was much smaller, and you always took care of your own patients.
INTERVIEWER: Are the patients more open to the treatment when they know you or not open when they don’t know you?

DENTIST B: I can see some kind of demographic differences when it comes down to the clinic where I am working at. At my clinic time is more valuable. If I don’t have a time that doesn’t fit with the patients’ schedule, the patient will just go to another dentist within the clinic. When I worked more in the North of Sweden, patients where more open to the time that the dentist have available as the patients have met me before and want to continue that relationship. But it depends on the patients.

INTERVIEWER: Furthermore, about the treatment process. The private dental care facility provides different treatment options to their patients. E.g. option one costs less and option three costs more. Is this also the case within the public clinic in which you are working?

DENTIST B: Yes, when you do an examination you tell the patients what you find and then what are the solutions to fix the problem. Sometimes, patients want to fix it right now. Even when they have the money and want to fix the problem correctly, let’s do something that fixes it for now. Other patients want to go with the cheapest solution and other patients want to go with the most expensive solution.

INTERVIEWER: How would you say, looking at the interaction with you and the patients, is a lot of interaction and information from only you or do you have a lot of interaction with the patients themselves?

DENTIST B: I try to have a lot of interaction with patients because if I tell them stuff they would not remember. If I ask them what they do and let them think about things they remember more, and they feel more participating in the treatment process instead of just sitting there. I have had a few patients that are afraid of going to the dentist. So, then we do a lot of talking and try to narrow it down to what they are afraid of and how to work around that.

INTERVIEWER: Do you ever have had patients do their own research and ask you for advice about what they have read?
DENTIST B: A lot of people have looked on google for information about their problems and what they need to do about it. Sometimes that is quite difficult when patients have a fixed idea about what they want and how much it is going to costs. Usually, if you look at the price lists what everything costs you always do more than what the patients thinks. You have to do an examination, maybe some x-rays and the patient hasn’t thought about that. I am sure that you are aware about the subsidies from the government depending on how much you contribute. A lot of patients have difficulty understanding that if you pay this much you don’t have to pay for that thing on the price lists. So, it is quite complicated to explain how the price lists works.

INTERVIEWER: Have you also experienced that patients might have allergies or other medical complications and already know what they have and been to the doctor and found a treatment process that might be better based on their needs? Having a more scientific bases instead of just googling.

DENTIST B: Some patients have. However, it is not that common. But we ask all our patients about their health and diseases and illnesses that effects the mouth. So, it depends on what you as a dentist are able to do and not able to do. A lot of patients who take medicine that effect their health they are quite well informed that they have to provide that information to their dentist when they come for an appointment.

INTERVIEWER: According to the private dentist when you have a cavity in your teeth there are three levels: D1, D2 and D3. But according to them you can only treat the D3 status as försäkringskassan doesn’t want the dentists to fix D1 and D2 is this also the case in Folk tandvården?

DENTIST B: Yes, when you are looking at an x-ray and you are trying to diagnose the different cavities. You can also see that the cavities aren’t growing. So, it is very difficult because when you meet the patients and it shows that they have a lot of new cavities compared to last year you can see it has grown quite fast. So those numbers don’t contain that much information, you need to have a lot more information as a dentist. There is a lot more to it than just the D1, D2 and D3.
INTERVIEWER: In the beginning you stated that patients are sometime sent to a specialist. How is the structure, your role and what are the other parts that you as a dentist are connected with?

DENTIST B: At the Folkandvården I am working as a general practitioner. We have patients from small children to really old individuals. Then they might need to have an implant or surgeries, then I will send them to a dentist that can provide that specialist care.

INTERVIEWER: That process of you sending patients to other dentist or places how does that work for the patient?

DENTIST B: At the moment at the clinic that I am working at there are a few dentists that are specialised in certain areas of care. The patients really appreciate that when they are able to stay at the same clinic. When you send a patient to another dentist, they might come in and introduce him or herself to the patient and the patient really appreciate when they know who they are going to meet next time. If there are more severe issues with the patient and I want a specialist at a hospital to look at I can send them to the emergency room. I will call the hospital that there is a patient coming in.

INTERVIEWER: How do you deal with the information as there is an issue of privacy. Do you share that directly with the hospital or does the patient bring the information along?

DENTIST B: When we send a patient to the emergency room at the hospital it is extremely rare. When the patient e.g. has an infection that has been spreading around through the neck the nurses and doctors know what to do at the hospital. If the patient goes to another Folkandvården they will use the same programs as we use and can look at the information that is available about the patient.

INTERVIEWER: How many dentists does your Folkandvården clinic employ?

DENTIST B: I think we have ten dentists, ten to twelve. However, not everyone is working fulltime. But I know it is around ten.
INTERVIEWER: We have now talked about the network from the Folktandvården point of view with specialist and hospitals and etc. Do you also work with a network from a patient’s perspective? Do you have contact with family e.g. and in what kind of cases would that happen?

DENTIST B: Well sometimes I have patients that are children, so you talk with parents. However, you also have patients that are quite old and come with their husband or wife as they might have dementia and aren’t able to make full informed decisions. So, in those cases you have direct contact with the patients and family members.

INTERVIEWER: Do you have specialised rooms where these kinds of patients can be treated to create value?

DENTIST B: Every room within the Folktandvården where I work are the same. However, we can either open or close the room if the patients want that. Especially within paediatrics they have more designed and special rooms that are child friendly compared to the regular rooms. But it really depends on the kind of Folktandvården clinics and where you are working.

INTERVIEWER: When a patient is really scared of the dentists can someone accompany the patient?

DENTIST B: Yes, that happens quite often when those kinds of patients what to bring someone along.

INTERVIEWER: Could you explain what patients in general expect or feel that the value is from a Folktandvården clinic versus a private clinic?

DENTIST B: The patients value the price, this is something they value as Folktandvården clinics are in general cheaper than private clinics. In addition, time is important as you are listening to their problems and not just treat time like in and out as quick as possible. So, I think it is the price and the that we take time for them and that we of course do a good job.

INTERVIEWER: How do you work in order to fulfil that values? Do you have a particular way of making sure that you create value for the patients?
DENTIST B: One thing that I do, as I am working at Folktandvården that is quite big, there are people that fill in my schedule, but I keep a close eye on my time book and tell them if the schedule will not work as the patients are so closely scheduled after each other. Or I don’t this type of patient a 08:00 or late in the afternoon as I need to take more time. So, I try to manage my own schedule as far as I can.

INTERVIEWER: How much communication do you have with the patients? Is it only during the visit or also outside of work?

DENTIST B: I can call my patients. E.g. when I do an examination and I see something and I need to discuss this with a colleague I can call the patient back when they are home to discuss options.

INTERVIEWER: Is this also for checking in on the patient if they do as what has been discussed during the visit or is it more administrative?

DENTIST B: I do not follow up if they are brushing their teeth. However, e.g. if I had a patient that had a big infection and I have done a treatment and I want to be sure if it hasn’t got worse I will sometimes call those patients in order to check if everything is okay.

INTERVIEWER: I think we have everything for now. Do you have any questions or something you want to comment on?

DENTIST B: One thing I would like to say that I and my colleagues think that is different from Folktandvården and the private clinics is that Folktandvården has a much harder schedule as we need to fill our time book every day. In the private clinics they are more able to work with their time and therefore take longer for examinations. You as a patient will pay more but you also get more time within the private clinic.

INTERVIEWER: So, you feel that as private clinics have more time available that they can spend on the patients, they thus create more value than a Folktandvården?

DENTIST B: I am not completely sure as they also need to make money. However, as they are charging more they can have longer times for the examinations. Nevertheless, if I need one full
hour for a patient I will take one hour as want to do a good job for the patient and it is my responsibility. You can’t really listen to your superiors’ when they want you to make more money for the Folktandvården.

INTERVIEWER: How much of your time is actually spend on dentistry and how much on administrative duties?

DENTIST B: I am not sure during a workday. However, it is quite a lot and I actually need more time than what I have now as there is a lot of consults. In addition, when you work with children who need braces e.g. then you e-mail back-and-forth with the orthodontist.

INTERVIEWER: Do you have any responsibility with the operational side of the clinic, price e.g. or a connection with försäkringskassan?

DENTIST B: No, nothing more than being a dentist that you call them sometimes to consult about the prices when looking at their little book of prices.

INTERVIEWER: You can’t give your opinion about pricing or point out that försäkringskassan can help the Folktandvården more as an organisation?

DENTIST B: You can, but it is kind of tricky. When you hear people talking about försäkringskassan it is such a big organisation and as they are affected by the country wide politics it is very difficult. But there are dentists that look into the price setting and you can e-mail them directly, but it is very hard to get something changed.

INTERVIEWER: The private clinic that we interviewed has a lot of patients that don’t speak Swedish or are asylum clinics. Is this also the case within the Folktandvården clinic where you have patients that want to be treated by dentists that speak their language to feel at ease?

DENTIST B: Well we have a translator if they don’t speak Swedish or English. We also have dentists that speak other languages. But there aren’t that kind of patients within our Folktandvården clinic. When I worked more up north there were more patients that were immigrants or asylum seekers.
8.3 Appendix 3. Transcript Focus Group

FACILITATOR: Have you been to the dentist before, and if so, was it a private or semi-public clinic?

PARTICIPANT A: Of course, I have been to the dentist before and I go to a private dentist in Stockholm?

FACILITATOR: Have you only been to a private dentist or also to Folktandvården e.g.?

PARTICIPANT A: I have been to Folktandvården before. However, I changed to a private dentist.

FACILITATOR: Was there a particular reason for going to a private dentist instead of Folktandvården?

PARTICIPANT A: The reason was that as I mentioned I did go to Folktandvården but the dentist clinic changed to a private clinic and I wanted to go to the same clinic. Thus, I stayed at the dentist.

PARTICIPANT B: I’ve been to both. When I lived in Paris, France, I went to a private dentist as well as when I was younger. However, currently as I have insurance that you receive each year from the government to go to the dentist, I go to Folktandvården as it is more convenient.

FACILITATOR: To elaborate on that a bit further. For you as a patient, the amount of money that you spent is also then of importance?

PARTICIPANT B: Uhm yes, but I don’t go to the dentist that often. Nevertheless, I feel like having this kind of insurance is helpful as going to the dentist can be expensive. So, I guess the money is something that is important for me.

PARTICIPANT C: I have been to both a private- and to a public dental clinic as well. However, in Italy there is a bit of a different system than in Sweden. Till the age of eighteen and when you have low income, you can go to the hospital and they have a dental department. When I
turned eighteen I went to a private dental clinic as I don’t feel that there are public possibilities for me. If you have some sort of insurance, you can always go to the private dental clinics.

FACILITATOR: If I understand correctly, depending on the age you either go to a public dental clinic at the hospital and the moment you turn eighteen you have to go to a private clinic.

PARTICIPANT D: Yes, I also go to a private dental clinic as in Turkey when you want to go to a public dental clinic the waiting time can be more than three months. Since I just go for emergency situations I go to a private dental clinic.

FACILITATOR: Did you only go for emergency situations or as well for general check-ups?

PARTICIPANT D: No, generally something happens to my teeth on a yearly basis. So, I will go to the dentist whenever something bad happens.

PARTICIPANT E: I’ve been to both. However, the last time I was in a public dental clinic was when I was five-eight years old. Because the system for dental care is not so good in Greece. Thus, it is better to go to a private dental clinic. Since the quality and they usually treat you better for the money and quality than public dental clinics.

FACILITATOR: PARTICIPANT A, as you mentioned you are going to a private dentist. Is the price of the treatments of importance to you?

PARTICIPANT A: To some extent it is important. Nevertheless, that is not the main reason for me. The availability and the close location of the dentists are more important to me than the price.

FACILITATOR: With regards to the time, how much time do you spend at the dentist? Do you go only once a year, twice a year?

PARTICIPANT A: Maybe once a year for a general check-up of my teeth for about twenty minutes.
FACILITATOR: To elaborate on that. You haven’t had bigger issues with your teeth when you went to the dentist?

PARTICIPANT A: I’ve had before about a couple of years ago. However, that was five years ago, since then nothing has happened.

FACILITATOR: Are you willing to elaborate on what you went through five years ago?

PARTICIPANT A: Yes, about five years ago I went to the dentist and I had a cavity which had to be fixed. In addition, they removed scale from my teeth which all in all took about one hour instead of twenty minutes. So, I first had a check-up and then I had another appointment a few days later to do the rest.

FACILITATOR: Did the dentist offer you any treatment options. E.g. one treatment option would be cheaper than another option?

PARTICIPANT A: No, the dentist told me we need to do this and that is what they did. I agreed with the dentist.

FACILITATOR: Has anyone else also had bigger issues with their teeth than just a general check-up on which they would like to elaborate. e.g. braces?

PARTICIPANT C: I have some hygiene (scale) issues for which I go to the dentist about two or three times a year. When I was younger I had braces which for a longer period. Braces in the private dental clinics are super expensive. However, in the public dental clinic it is almost for free as it is only about 200kr per visit.

FACILITATOR: Did you have to go to just the dentist or also an orthodontist?

PARTICIPANT C: No, the dentist in the private clinics I went to can do both. At the hospital they are more specialised dentist for children. So, if you would have bigger problems they would refer you to the private dental clinics.
PARTICIPANT D: I believe the difference between dentist and more specialised dentist such as orthodontist is that you generally go to a dentist for check-ups and if you need somewhat specialised you go to them. We have more family dentist where you, your mother, father and family will go to and that you trust.

PARTICIPANT E: I agree, it is whole generations go to the same dentist.

FACILITATOR: You always meet the same dentist when you visit the dental clinic?

PARTICIPANT D: Yes, that is correct. You go to the dental clinic where your family goes to.

PARTICIPANT C: You are building a relationship with your dentist.

FACILITATOR: Is that important for you as a patient going to the dental clinic and get the same dentist for every visit?

PARTICIPANT C: For my mother it is important, for me it doesn’t really care. I am more concerned about the price and the quality than going to the same dentist. Maybe you don’t want to change as it may be a family friend or upsetting for the dentist if I wouldn’t be coming to the clinic anymore.

FACILITATOR: Is this the same for you PARTICIPANT F or do you not agree?

PARTICIPANT F: Yes, for me it is important as you go to the dentist on an annual basis, no matter what. So, you are as a patient building a relationship with dentist.

FACILITATOR: Do you always meet the same dentist when you visit the dental clinic or do you also meet other dentists?

PARTICIPANT F: When I was a child I had the same dentist. However, as I have been moving around I have had different dentists.

FACILITATOR: PARTICIPANT B, you stated that you are going to Folkandvården as of now. Do you meet the same dentist during every visit or different dentists?
PARTICIPANT B: As I am moving around quite a lot I don’t have one dentist that I see on a regular basis.

FACILITATOR: Nevertheless, is it something that you find important?

PARTICIPANT B: Not really, every dentist knows what they are doing. I don’t really care, I just want them to do their job. I don’t really care who is looking at my teeth.

PARTICIPANT C: I care e.g. for the hygiene (scale). Probably, the one who is doing the hygiene (scale) is not the dentist. However, one can do it better than the other and then I will ask if that person that I like can do it.

FACILITATOR: Because you know that they deliver a better quality of a job?

PARTICIPANT C: Exactly, because there is one that I like and others that I am not satisfied about.

FACILITATOR: How do you feel like when you go the dentist? Did you ever had a bad experience and thus don’t want to go to the dentist?

PARTICIPANT E: It is like you are afraid of the dentist. There is that fear. Nevertheless, I understand it is just their work that you as a patient get hurt sometimes but it is better for your health.

PARTICIPANT C: E.g. the first time I went and received anaesthetic I was really afraid for the needles. It took the dentist half an hour to convince me to open my mouth. Now, even though I know it is more expensive, I wouldn’t change it as I know it is better when I don’t feel anything.

FACILITATOR: As you mentioned you received anaesthetics, did you go with family/friends/other to the dentists?
PARTICIPANT C: Yes, not specifically during the appointment. Sometimes, I am there with my mother or grandmother as it is a family dentist. We even schedule it after each other so we can all go on the same day and together.

PARTICIPANT D: I also go to the dentist with my mother.

PARTICIPANT FIVE: Me to or with my father.

PARTICIPANT B: I haven’t been to the dentist with my family since I was a child.

FACILITATOR: As you have mentioned; time, costs, hygiene, quality of the dentist, what is something that you haven’t mentioned that you feel is also important when you go to the dentist?

PARTICIPANT B: You want the dentist to listen to you as you are relying on the dentists their expertise as I don’t know anything about teeth and I cannot look at my own. Thus, you are really relying on them for the dentist to do their job, listen to you and as well as given you advice on cleaning habits e.g.

PARTICIPANT C: Exactly, because when you are on the chair you cannot complain as you can’t speak and trust them for 100%. I really like to ask them questions on what they are doing to think about something else and not just the pain.

PARTICIPANT B: I also like that when they are showing you what they are doing, and this is how your teeth look like and see it on the x-rays. By doing so, you are developing more of a trust with the dentist.

PARTICIPANT C: The ability of the assistant is also important as mine is not really customer friendly and I have said a few times that I might change dentist because of how she interacts with me. E.g., every time I call her I cannot come as I am abroad or not able to come that day and is then annoyed.

FACILITATOR: besides the dentist the interaction with the assistants or secretary is also of importance for you as a patient?
PARTICIPANT C: Yes, especially as they are in the room when the check-up takes place.

FACILITATOR: Is it more about the lack of knowledge or more about the interaction with the assistant?

PARTICIPANT C: No, not about the knowledge. I like to speak to them when the dentist is not in the room I want to have a nice conversation when I am laying there, and you aren’t able to go away.

PARTICIPANT B: I also think it is important that the dentist make the time available, so you don’t feel stressed, especially when you go to a private dentist. Now, they don’t always have the time or aren’t listening for a full 100%, however, I think it important in order to build a relationship and trust with the dentist as well.

PARTICIPANT C: Also, when you are feeling pain you might think your pain is unique. Even though the dentist might already know what is wrong, you as a patient still wants to explain all the details. For me as a customer I think that is important.

FACILITATOR: These examples are based on private dental clinics. Is this also possible within public dental clinics like e.g. Folkandvården?

PARTICIPANT B: I think so yes, you as a patient are still paying for it in order to go to the dentist. As I am paying for something I am expecting them to be there and build up a trust and is shouldn’t matter if it is a different dentist all the time they still work for the same organisation. Thus, they have to portray the same image and build this relationship with me.

PARTICIPANT E: Yes, and be aware of your medical history.

PARTICIPANT B: Exactly, it is important that they read up before they go into the meeting with me as a patient.

FACILITATOR: Do you agree with that PARTICIPANT D or do you have something to add?
PARTICIPANT D: I totally agree, I always went to the same dentist and they know me from my childhood, so I am not able to completely talk on this particular subject.
FACILITATOR: Do you have anything to add PARTICIPANT F?

PARTICIPANT F: It has been a while that I have been to the dentist. They send you this letter that it is time to go to the dentist and you will make an appointment. What I really find annoying is that they set the date and you as a patient adjust your schedule to this visit. When you arrive and have the check-up I sometimes have to come back in one week for another procedure. Thus, it would be nice if they could take care of everything in one session. It takes a lot of time out of my agenda.

PARTICIPANT E: It depends on the kind of treatment that you have. If you are removing a wisdom tooth you will have to go back to remove it all.

PARTICIPANT F: I understand, but still it would be nice if they could set aside a bit of extra time to do the basic stuff that they don’t do during a general check-up.

FACILITATOR: So, time is something you value?

PARTICIPANT F: Yes, yes, yes, you know, it is not fun to go to the dentist. You want to do it as few times as possible and you want it to be as quick as possible.

PARTICIPANT D: Yes, definitely.

FACILITATOR: So, it’s more a thing that has to be done just because it has to be done so to say?

PARTICIPANT SIX: Yes, basically.

FACILITATOR: When you go to the dentist, do you undertake any activities before [going to a dentist appointment]? Brushing your teeth extra or flossing, in a way that you might not do normally?

PARTICIPANT C: Yes, especially before the hygiene. Maybe a couple of weeks before that I remember I have the hygiene so maybe it’s better. But I brush my teeth like four times a day
anyway. But maybe the flossing. But at least I’m trying to, and I keep thinking about it that I might improve something. And especially I like to ask for advice when I’m there and then of course for the first weeks I remember to use the floss and everything etcetera, but then after a while you lose it and you don’t do that every day.

FACILITATOR: How about the rest of you?

PARTICIPANT A: Yes, I put in a little bit of extra effort before going to the dentists. You know I’ll floss extra and brush for a little bit longer. A bit better, more thorough. A little bit of extra effort.

PARTICIPANT B: I mean I always brush my teeth before going to the dentist appointment because I think it is nice [for the dentist] to look at a clean mouth. So yeah, but otherwise no real extra activities.

PARTICIPANT D: Nothing special for me. I just use some antibiotics because I have a heart problem, but that is special.

FACILITATOR: One thing that also came up when talking to dentists is different treatment options. They will provide you with different treatment options based on different costs. Have you experienced that?

PARTICIPANT A: What do you mean with options?

FACILITATOR: So, for example if you need to extract a tooth there are different ways to fill the whole so to say, and the dentist will then provide you with different options for that, with different costs and it’s up to the patient to decide what benefits they want and how much they are willing to pay.

PARTICIPANT A: Usually, I think that they are the experts so I’ll just listen to them. If they say we have to fix this I just say let’s do this. I trust that they are giving me the best option.

FACILITATOR: So you are willing to pay the price of the best option?
PARTICIPANT A: Yes. But I have never been offered different options.

PARTICIPANT B: I’m with you there, I haven’t really experienced being given different options.

PARTICIPANT C: And I think that they really have price transparency for different treatments and options. But for example for other doctors or for example orthopaedic, you can choose if you want to have this kind of treatment or the other one. They might not be stressed a lot on the price, because usually or like for us [in Italy] it is not really common to ask for a price to the doctor. But it’s more like, you can have those benefits if you this otherwise you can have the other benefits but you lose something of the other option. Then you might accept, you know you might think that one option might be cheaper. But like, that is different [from dentists] where the options are not as good. With the doctor they will usually provide you two good treatments where the benefits are different but equal. In the dentist maybe they will say you know, with this option you have to brush very carefully and the other not so much. But in the doctor it’s usually not a fixed price for the options that you can choose. But usually you don’t know so much about what you need and how it works so you just trust the dentist completely.

FACILITATOR: Do you feel that when you get these options you are participating in the treatment process? That you are getting an opportunity to affect the process?

PARTICIPANT C: Yes, but I think that this is only present in really, really big treatments for example if you have to rebuild maybe four or five of your teeth, I’ve never done it, but I know that now in this way you can have the package like, you need to have this set of treatment and this will be the final price of the whole thing, or you can do maybe something that you have to change every day, or the one that is moveable, or if you want them to stay so that you don’t have to change and something like that. So, for this you can have a more clear like feel at the beginning or you know, what would be the project behind it. But when it is a small treatment like half an hour or something small, I think that you don’t really have so many choices.

PARTICIPANT D: Maybe for a regular control you don’t need that much and you just look at the money and go for the cheaper ones but if it’s a specific treatment I think I become more price indifferent like I will go for the more expensive one, or the one that does the job better actually. Price is not that important actually. But for a regular control I just want it cheap.
PARTICIPANT E: I’m trying to see if I can remember if they have given me any options but I think most of the time it’s just that they tell me we have to do this, you know fix it or remove it or do something, and then they will give me some suggestions about how to clean better or do something extra, but I think it’s mostly one way to do it and since it’s about your health the price is not an important factor, you just have to choose the best. And you know that they are the experts.

PARTICIPANT F: I don’t think I have ever really gotten a choice. I mean when I was a kid and they asked me if I wanted braces and I was like no. But then my parents convinced me to do it.

PARTICIPANT C: But probably when we will be older we will have to choose much more because you will have bigger treatment then probably our teeth will need now. I know that my stepmom went to the dentist and she had to choose between one package that was one solution and the other one. And then she had really a document where everything was written. You know, for this solution you will have these many appointments and then after these many months you have to come back and bla bla bla. So the document had all the conditions and than also the final price. Because maybe if it’s 500 crowns for that time or 800 crowns, it’s not that different but when we speak about thousands or two thousand then you might want to think about that. And maybe you just have less time and you will choose the option that is the quickest because you don’t really want to have this really long treatment that is for one year. Because I know some treatments are really long. Because you need to adapt your mouth and maybe to take out some parts or something.

PARTICIPANT E: And I think that also depends on the trust. If you need to fix something immediately but you don’t have the money. If you have built a trust with the dentist you can say, fix this for me and I will pay you in the future. In Greece this is possible if you have gained the trust between each other.

FACILITATOR: When you have gone to the dentist, has it always met your expectations?

PARTICIPANT A: Usually it meets my expectations. But I don’t have that high expectations when I go there so. You know like PARTICPANT SIX: said I just go there because I have to
do the check-up. So my expectations are close to nothing. As long as they do their job in a good way I don’t expect anything extra.

PARTICIPANT B: I love going to dentist and I think it is super fun so it’s just been one time when the dentist was a bit rude that I didn’t like it. But otherwise I look forward.

PARTICIPANT C: I think that from the hygiene part, for example there are different doctors there doing that. So no I can decide which I want because there were some of them where I was expecting something a bit better than what I got so then I was disappointed. But when it comes to treatments I think that maybe you didn’t expect to have so much pain the day after or I wasn’t expecting to feel good again so quickly so then it’s a positive. Usually with this dentist that I have now it’s always a positive. You know that the expectations are exceeded. So it’s positive.

PARTICIPANT D: Since I have always gone to the dentist from a recommendation my expectations were always met.

PARTICIPANT E: Yes, I think that if you don’t have any special requests or so, they meet the expectations. You know, it’s just about them doing their job well. I never had higher expectations that what I got, and never a bad experience from a dentist. I go there, they see if something is wrong and they fix it. Okay it’s done.

PARTICIPANT F: Yeah, I mean, sure, the expectations are usually met. Only thing is that when I was a kid I found out that braces really hurt.

PARTICIPANT C: I know right, and I did not expect that. No one told me that it would be really painful every time the adjust it and so.

PARTICIPANT F: Yes, exactly. So that was kind of surprising.

FACILITATOR: Going back, some of you seem to really enjoy going to the dentist. Can you elaborate a bit about that?
PARTICIPANT B: I have a friend that has really big anxiety going to the dentist, so she has to take a pill before and her boyfriend always have to with her. I never felt anything like that. I never had a problem going to the dentist. And afterwards I always feel super clean in my mouth and I always had like a positive feedback from the dentist as well. So I mean, until the day when they have to pull out my teeth, maybe then I’m not going to like it anymore. But for now I really like going to the dentist and to the doctor because I feel really safe and I’m really relying on their expertise in that they fix me if something is wrong.

PARTICIPANT C: I agree. Especially in general with doctors, if you know that you have something that doesn’t work I’m really looking forward to meeting them and figuring out what is the problem and solving it as soon as possible.

PARTICIPANT B: Me too.

PARTICIPANT C: And also I think that the check-up that you do is also a way to say that okay I’m fine and everything is fine and I’m doing it in a good way and I don’t have to worry about anything. Then of course when they tell you… Like when you are with your mouth open and they say “oh, I see something here”, and you say no really oh my god please [jokingly]. But in general I really like it, I mean if everything is going well I really like to go there. There might be an anxiety that something might be wrong but when they tell you it’s fine then you feel great.

FACILITATOR: We’ve been touching this all through the discussion, but just to make it clear, why are you going to the dentist?

PARTICIPANT A: Just to make sure that my teeth are in good health

PARTICIPANT B: Same for me, not much more to it.

PARTICIPANT C: It’s like a prevention.

PARTICIPANT E: The problem afterwards may be pricier so it is better to go regularly to avoid that.
FACILITATOR: We’ve been comparing a bit between going to the dentist and going to the hospital in the discussion. Could you elaborate a bit about that? What differences are you seeing and why do you think that is different?

PARTICIPANT A: You know, for me, if I go to the hospital it is something that I wish to have fixed right away. I want to have an instant fix of something, you know like my throat is hurting or something. So therefore, I want help when I’m there. While for the dentist I’m more there to check-up and to make sure that everything is fine. It’s a different approach and a different mind-set.

PARTICIPANT B: It’s the same for me as well, like usually when I go to the doctor you go there because something is wrong with you. You feel something is wrong. But I mean you can go there for check-ups as well. I mean for breast cancer for example you go a few times to make them feel you and whatever to see that nothing is wrong, so there are check-ups there as well to make sure that nothing bad is happening, so in that way it’s the same.

PARTICIPANT E: Yes I agree, if you are going to the doctor it is more likely that you need to fix something immediately but for the dentist more likely you go there because you have to do twice a year a cleaning or just do a check-up because you are more vulnerable.

PARTICIPANT B: I guess it’s much easier as well to feel on your body if something is wrong.

PARTICIPANT E: Exactly.

PARTICIPANT B: I mean, you can feel if it hurts in your teeth and your mouth.

PARTICIPANT C: But it might be for other reasons.

PARTICIPANT B: Yes, you know, you might have bitten yourself.

PARTICIPANT C: Exactly.

PARTICIPANT B: But if you have a hole or something it’s much harder to see for yourself, or you know if you are beginning to have one it’s hard to feel and discover that.
PARTICIPANT C: And maybe when you feel it it’s really too late to prevent.

PARTICIPANT B: Yes, then it is too late. So it is good to go to the dentist in order to prevent having a more expensive visit in the future.

FACILITATOR: Do you have anything you want to add that we haven’t discussed yet?

PARTICIPANT A: I don’t know, don’t think I have anything.

PARTICIPANT B: I mean, it is value right? So for me the going to the dentist the value is mostly about the money, like how much you are going to pay. But also that they are there 100 % with you. As well as they have their expertise and are willing to transfer that into you, in order that you are going there and you feel that you are getting something back when you leave. Not just that your teeth are clean but also that you feel trust and commitment as well between you and the dentist. I think that is really important and valuable to me.

PARTICIPANT E: Yes I think they have value because, as I said, in our age it is more possible that your tooth get bad than your body so you have some standard value that you go there every time for cleaning and check-up and that’s how you build the trust.

PARTICIPANT B: It feels as well like the dentist they are earning money if you have bad teeth. But they still… I mean my value is increasing if they help me prevent it from happening again. I want to feel that they don’t just want you to come back with bad teeth so that they can earn money but I want to feel that they are actually trying to help you doing what is best for you. So I think that is high value as well.

PARTICIPANT C: And I think that it also creates trust. For example for me, the check-up are for free so it’s more that every time I’m going there and I don’t have anything, he is kind of wasting his time, but on the other side it makes me come back every time. And then he could find something, I hope not, but then there is opportunity for him.

PARTICIPANT F: I also think that the value is in the prevention of something bad. It’s more about having the insurance that you are actually fine and healthy.
PARTICIPANT B: And I mean for the Folktandvård (public) they are not going to put in braces for example if you don’t need it. And I don’t know how that is for a private dentist, I mean, then you have to pay for it and they might do it. But that’s a value as well, that they are saying that you don’t need it. So you are not going to get braces. And then you kind of trust them more because they don’t just want to earn money.

PARTICIPANT D: Yes, one problem with the private dentists are that… I have heard some stories that they although you don’t have anything, they just make up something that you have a problem with your teeth, or they even just say that you need a cleaning even if you don’t really need it and they do it just to earn some extra money.

PARTICIPANT B: And then the trust is going to be hurt. And the trust is really valuable.

FACILITATOR: Has this prevented you from going to a private dentist?

PARTICIPANT B: No, for me it’s just that I’ve been moving around so much so it is more convenient to keep going to Folk tandvåren because they are everywhere. With the private I would have to do some new research and find a new dentist and I just really want it to be quick.

FACILITATOR: All right, if you don’t have anything else I think we are done. Thank you guys so much.