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FOREWORD

The Annual Conference of the EuroMed Academy of Business aims to provide a unique international forum to facilitate the exchange of cutting-edge information through multidisciplinary presentations on examining and building new theory and business models for success through management innovation.

It is acknowledged that the conference has established itself as one of the major conferences of its kind in the EuroMed region, in terms of size, quality of content, and standing of attendees. Many of the papers presented contribute significantly to the business knowledge base.

The conference attracts hundreds of leading scholars from leading universities and principal executives and politicians from all over the world with the participation or intervention of Presidents, Prime Ministers, Ministers, Company CEOs, Presidents of Chambers, and other leading figures.

This year the conference attracted about 300 people from over 70 different countries. Academics, practitioners, researchers and Doctoral students throughout the world submitted original papers for conference presentation and for publication in this Book. All papers and abstracts were double blind reviewed. The result of these efforts produced empirical, conceptual and methodological papers and abstracts involving all functional areas of business.

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Many people and organizations are responsible for the successful outcome of the 7th Annual Conference of the EuroMed Academy of Business.

Special thanks go to the Conference Chair Professor Diego Begalli, the Conference Organising Committee and the University of Verona, in Italy, for accomplishing an excellent job.

It is acknowledged that a successful conference could not be possible without the special co-operation and care of the Track Chairs and Reviewers for reviewing the many papers that were submitted to this conference. Special thanks to the Session Chairs and Paper Discussants for taking the extra time to make this conference a real success.

The last but not the least important acknowledgment goes to all those who submitted and presented their work at the conference. Their valuable research has highly contributed to the continuous success of the conference.

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VALUE CO-CREATION AND VALUE CO-DESTRUCTION IN THE PATIENT-PROVIDER RELATIONSHIP. THE CONTRIBUTION OF THE "HEALTH LITERACY" PERSPECTIVE

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ABSTRACT

Patient empowerment, patient engagement, patient involvement, and patient-centered care are popular buzzwords in the fields of health policy and health care management. However, in spite of their topicality, still little is known about the issues which concern the involvement of patients as co-producers of health care services and co-creators of value. Besides, most of the scholars are inclined to focus their attention on the intrinsic value-added ascribed to health care co-production, thus overlooking the possibility of value co-destruction which is associated with the engagement of patients in the provision of health care. This paper is aimed at conceptually exploring the ideas of value co-creation and value co-destruction in the health care service system, pointing out a link between the "health literacy" concept and the co-production of health care services. This topic is approached according to a theoretical perspective, with the eventual purposes of shedding light on two important determinants of value co-destruction and inspiring further efforts of research. In particular, value co-destruction is conceived as a two-way street, where both health care providers and patients are involved. Indeed, both of them could accidentally or intentionally contribute in the process of value destruction, undermining the positive outcomes which are usually ascribed to patient engagement. Individual health literacy and organizational health literacy are understood as two crucial tools to enhance the involvement of patients as co-creators of value and reduce the risks of value co-destruction. Adopting this point of view, conceptual and practical implications are drawn, which pave the way for further developments.

Keywords: *Health literacy; Organizational health literacy; Co-production; Value co-creation; Value co-destruction*

INTRODUCTION: THE OPTIMISTIC IDEA OF PATIENT ENGAGEMENT

Patient engagement and patient involvement are generally understood as both crucial policy goals and key managerial priorities to enhance the quality of health services and to improve the

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sustainability of the health care system (Durand, et al., 2014; Coulter, 2006). Moreover, the process of patient empowerment is assumed to be imperative to revisit the traditional bio-medical approach to care. Actually, it promotes the reconceptualization of the patient as a co-producer of value, rather than as a consumer of health care services who relies on the support of health care professionals to deal with health-related problems (Fumagalli, et al., 2015). Even though patient engagement is generally described by scholars and practitioners as a multi-faceted concept, which assumes a lot of challenging definitions (Gallivan, et al., 2012), it could be ultimately understood as a process of activation, by virtue of which the patients develop an increasing awareness of the actions they have to take "*to obtain the greatest benefit from the health care services available to them*" (Gruman, et al., 2010, p. 351).

Such an interpretation of patient engagement is consistent with the assumption that health care professionals are only one part of the health care service system. Actually, patients themselves are deeply involved in all the types of activities which concern the protection and the promotion of the health status, thus playing the role of critical "*co-producers of health*" (Coulter, 2012, p. 80). From this point of view – and in line with what Grönroos (2008) has argued dealing with services in general – the process nature of health care provision is emphasized. Consequently, health care professionals are called to perform two complementary functions dealing with the patients. On the one hand, they operate as enablers who have to facilitate the activation of the patients in the provision of health services with the eventual purpose of achieving patient-centered care (Michie, et al., 2003). On the other hand, they serve as catalysts, encouraging the willingness of patients to be involved in the process of health care provision (Thompson & McCabe, 2012).

To the knowledge of the Author, still little is known about the effects of patient engagement on health outcomes, as well as on cost savings. However, several scholars agree in claiming that the involvement of patients in the provision of health care services allows the achievement of significant results, including: the establishment of a safer healthcare environment (Sharp, et al., 2014), the enhancement of the relationships between the health care professionals and the patients (Roseman, et al., 2013), the improvement of the patients' preference for collaborative decision making (Durand, et al., 2014), the encouragement of patients' self-management of care (Simmons, et al., 2014; Jordan, et al., 2008), and – last but not least – the advancement of patients' satisfaction (Manary, et al., 2013).

In spite of the prevailing optimism about the effects associated with the engagement of users as active partners of providers, in the field of service marketing Plé and Cáceres (2010) have argued that the enhanced interaction between them may also result in a process of value co-destruction, which in turn paves the way for a decline of the well-being of those who are directly or indirectly involved in the relationship. Going more into details, co-destruction of value is likely to happen when users and providers participate in the process of service provision adopting different perspectives, bringing

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incongruent inputs, and aiming at the achievement of diverging ends (Smith, 2013). In other words, co-destruction of value implies a misuse of the available resources by the providers, the users, or both of them, which could be either accidental or intentional. In the former case, users and providers are not aware that the clash of their interests and/or activities undermines the service value. Alternatively, in the latter case they deliberately struggle to achieve personal advantages.

The risk of value co-destruction is especially high when the provision of health care services is concerned. In fact, the patients usually lack the knowledge, the skills, the experience, and the understanding to be effectively involved in a co-creating partnership with the health care professionals (Teunissen, et al., 2013). In addition, most of the patients are unwilling to be engaged in the provision of health care, due to the condition of physical and psychological weakness which is associated with the illness (Palumbo, 2014). Lastly, patient engagement could produce ethical tensions, since it leads to increased inequity in the access to health care services (Thomson, et al., 2005). At the same time, health care professionals may play a significant role in co-destroying value when they are urged to embrace a patient-centered approach to care. In particular, they could be interested in limiting the involvement of patients in the process of health care provision, in order to avoid their potential loss of control on clinical decisions (Owens & Cribb, 2012). Indeed, most of health care professionals are still loyal to a purely bio-medical approach to care, which is illness-centered and neglects the patients' contribution in the creation of value (Wood, 2012).

This paper is aimed at conceptually exploring the idea of value co-destruction in the provision of health care in the light of a mainly theoretical perspective. For this purpose, a conceptual association between value co-creation, value co-destruction, and health literacy is suggested. It is assumed that the enhancement of individual and organizational health literacy is crucial to implement patient engagement and to achieve health care co-production. Otherwise, when appropriate levels of individual and organizational health literacy are lacking, the involvement of patients in the provision of health care may result in value co-destruction, which negatively affects the well-being of both the users and the providers of health services.

The article is organized as follows. The next section depicts the health literacy concept and distinguish individual from organizational health literacy. Besides, it points out the role played by both individual and organizational health literacy in enhancing the involvement of patients in the provision of health care. Drawing from these considerations, the third section includes a theoretical framework, which depicts how limited individual and organizational health literacy pave the way for value co-destruction in the health care setting. The fourth section discusses several practical implications: in particular, it identifies the interventions which could help to avoid value co-destruction and to encourages the engagement of patients in the provision of care. In the concluding section some

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stimulating insights are worked out, which inspire further conceptual and practical developments.

HEALTH LITERACY AS A REQUISITE FOR HEALTH CARE CO-PRODUCTION

Health literacy is mainly understood as a purely individual trait. In fact, the health literacy concept was originally conceived in terms of "*functional health literacy*" (Parker et al., 1995), which indicates the basic personal abilities to collect and comprehend written and verbal health information (literacy) and to process the numerical data included in the latter (numeracy). Nutbeam (2008) expanded this restricted definition, claiming that health literacy includes both interactive and critical skills. The former consist of the capacity to build familiar and comfortable relationships with the health care professionals, which allow to improve the quality of patient-provider communications and – consequently – to enhance the interpersonal exchange of information. On the other hand, critical competencies include the ability to identify and appreciate the different alternatives available for the purposes of health protection and promotion, which in turn enhances the achievable health outcomes due to increased effectiveness and appropriateness of care.

Blending these perspectives, health literacy has been ultimately depicted as "*the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions*" (Baker, 2006, p.878). In the light of this definition, it is evident that individual health literacy is a crucial requisite to engage the patients in a co-creating partnership with the health care professionals, thus encouraging the co-production of health care services. In fact, the scientific literature has widely shown that the individual health literacy skills predict: the patients' predisposition to the self-management of care (Macabasco-O'Connell, et al., 2011), the adoption of health seeking behaviors (Bourne, et al., 2010), the proper knowledge of the disease (Gazmararian, et al., 2003), the readiness to use preventive services (Scott, et al., 2002), and the appropriate understanding of health information (Chugh, et al., 2009). Therefore, limited individual health literacy hinders the enactment of collaborative relationships between the health care professionals and the patients. People living with poor health literacy skills are unwilling to be engaged in a co-creating partnership with the providers of care, delegating to the latter most of the decisions which concern the protection and the promotion of the health status.

Both scholars and practitioners have paid an increasing attention to the issues associated with individual health literacy. Alternatively, organizational health literacy is a widely overlooked topic (Parker & Hernandez, 2012), whose effects on patient engagement and on the achievement of enhanced health outcomes is poorly discussed (Palumbo & Annarumma, 2014). This circumstance is quite surprising, since the health care organizations host most of the interactions between health care providers and patients, thus serving as the main context for the implementation of health care co-

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production. From this point of view, organizational health literacy could be conceived as the ability of health care organizations to "*make it easier for people to navigate, understand, and use information and services to take care of their health*" (Brach, et al., 2014, p. 213). Sticking to this definition, organizational health literacy implies an evolution in the role of health care organizations from relievers – that is to say self-reliant and specialized solvers of ill health status – to enablers – that is to say facilitators of patient activation and involvement in the provision of care.

Brach and Colleagues (2012) suggested ten attributes which are considered to affect the health literacy of health care organizations, thus emphasizing the complexity of the organizational health literacy concept. Going more into details, health literate health care organizations are assumed: 1) to contemplate health literacy into organizational planning and quality improvement; 2) to encourage a leadership which recognizes the importance of health literacy to organizational mission and values; 3) to engage the served population in the design of both information and health services in a perspective of continuous health literacy improvement; 4) to create proper organizational conditions to overcome the stigma associated with limited health literacy; 5) to improve the ability of health care professionals to handle health literacy issues; 6) to consider the needs of individual living with poor health literacy at all points of contact between patients and providers; 7) to provide patients with easy access to health information; 8) to design and distribute easy to understand written, audio, and visual materials, which are tailored to the needs of poor health literate individuals; 9) to improve inter-organizational relationships with the purpose of enhancing the capacity to address health literacy in high-risk situations; and 10) to clearly communicate to poor literate patients the mechanism of health care services' co-payment.

In line with this theoretical framework, Willis and Co-Authors (2014, p. 518) argued that three different types of interventions are key to enhance organizational health literacy: 1) government and policy actions; 2) organizational/practitioner actions; and 3) partnership actions. The first category falls outside the purposes of this article, since it does not concern the immediate interaction between patients and health care providers, while focusing on the interdependencies between the health literacy concept, the health system, the educational system, and other relevant social and cultural systems. Otherwise, both organizational actions and partnership actions are imperative to facilitate the establishment of a co-creating environment within health care organizations. In particular, the former involve: the development of a shared organizational vision about health literacy, the inclusion of a specific health literacy concern in the main policies of the organization, the identification of health literacy champions to foster the organizational commitment to meet the needs of poor health literate patients, and the engagement of health care professionals in the initiatives aimed at the enhancement of organizational health literacy through improved educational initiatives and the reconceptualization

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of the traditional bio-medical approach to care. On the other hand, partnership actions include the establishment of collaborative and cooperative relationships between the entities which operate within the health system, to encourage a systemic effort toward health literacy and improve the access to community-based health literacy resources.

Drawing from these considerations, it could be argued that health care co-production is a two-way street. On the one hand, it deeply relies on the willingness and ability of patients to be engaged in the provision of health care as active partners of regular providers; on the other hand, co-production of care requires favourable organizational conditions, which are vital to the establishment of a co-creating environment in traditional health care settings. When either individual health literacy, organizational health literacy, or both of them are missing, the ambition to involve the patient in the process of health care provision is undermined. Actually, in these circumstances the relationship between the health care providers and the patients is biased, paving the way for value co-destruction rather than value co-creation.

Value co-creation and co-destruction in health care provision

The risk of value co-destruction is especially significant within the health care service system, where the process of service provision is the result of the interaction of agents who bring different perspectives when dealing with health-related phenomena. In fact, patients adopt a first person perspective, since they immediately perceive the fall of the psychic and physical well-being associated with the illness. Alternatively, health care professionals are likely to endorse a third person perspective, appreciating health issues in technical and reductionist terms. Therefore, patients and health care professionals may express diverging ends and conflicting beliefs, which in turn hinder the establishment of a co-creating partnership.

When conflicts between them arise and disagreements are not properly handled, patients and health care providers are likely to co-destroy value, undermining both the effectiveness and the appropriateness of care. Drawing from the conceptual framework arranged by Plé and Cáceres (2010), patients and health care providers are understood as two complementary service systems, which interact and share material and non-material resources for the purpose of service provision. Obviously, the misuse of available resources by either patients, health care providers, or both of them undermines value co-creation, paving the way for the achievement of deficient health outcomes and impoverished well-being. According to what has been shown above, inadequate individual and organizational health literacy are important determinants of resource misuse, engendering a process of value co-destruction.

Patients living with marginal health literacy skills are likely to not properly use their own resources, as well as the assets of health care organizations, thus deeply affecting the appropriateness of health

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care. In fact, inadequate functional health literacy jeopardizes the patients' understanding of diagnoses and treatments suggested by health care professionals. As a consequence, it hampers medication adherence, undermines patients' compliance, and discourages the convenient utilization of health care resources (with regards to these particular issues, see among the others: Franzen, et al., 2014; von Wagner, et al., 2007; Institute of Medicine, 2004; Williams, et al., 1995). Besides, poor interactive health literacy prevents the opportunity to fill the cognitive gaps which are produced by inadequate functional skills by leveraging on the establishment of clear relationships with health care providers. In fact, impaired interactional health literacy restrains the individual ability to extract meaningful health information from the multiple communications they establish with health care providers or other sources of health information, thus frustrating the individual ability to navigate the health system (Devraj, et al., 2015; Dalrymple, et al., 2004). Lastly, limited critical health literacy involves patients' poor awareness about health-related phenomena, concurring to reinforce their unwillingness to participate in critical dialogue with health care professionals and to become involved in decision making for health in line with a patient-centered model of care (Heijmans, et al., 2015; Sykes, et al., 2013).

In sum, limited individual health literacy sets the condition for a biased relationship between health care providers and patients. In these circumstances, the involvement of the patient in the provision of health care paves the way for unexpected consequences, including the exacerbation of the patients' health conditions and the related increase in the demand for care. Actually, poor health literate patients are not able to navigate the health system, thus being exposed to higher risks of inappropriateness. Therefore, the process of value co-destruction engendered by limited individual health literacy does not solely concern the fall in the individual well-being. It also implies increased health care costs, with subsequent drawbacks on the sustainability of the health care system. This process of value co-destruction is mainly accidental, since it is produced by the impaired capacity of patients to handle complex health related phenomena and to adequately interact with the providers of care (for the sake of the argument, see Robertson and Colleagues, 2014). Besides, several scholars have argued that the engagement of patients with poor health literacy skills increases their dependency from the support of providers, turning out to be counter-productive (Schulz & Nakamoto, 2013).

However, in most of the cases value co-destruction in the health care service system is produced by inadequate organizational health literacy. In fact, health care organizations are usually unable to establish an environment which empowers patients and enables them to operate as co-producers of health, since the traditional bio-medical model of care is still prevailing. It emphasizes the role played by providers in dealing with the biological determinants of health, thus overlooking the contribution of patients in the success of health care provision. Poor health literate health care organizations neglect

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that the patients need the establishment of a friendly and comfortable environment to be effectively involved in the provision of health care. As a consequence, when the enhancement of organizational health literacy is missing, patient engagement turns out to be harmful for both patients and health care professionals. On the one hand, the former may suffer from an increased dependence on the latter, since health care professionals maintain their control on health information, while patients are not able to handle the complex issues which arise in the health care setting. On the other hand, organizational and time constraints hinder a patient-centered approach to care by health care providers, who maintain a bio-medical slant (Légaré & Witteman, 2013).

The poorer the levels of organizational health literacy, the higher the risks of value co-destruction in the health care service system. Limited organizational health literacy implies the arrangement of a hostile environment, where information are not easy to understand and inadequate attention is paid to the information needs of people living with low functional, interactional, and critical health literacy skills. From this point of view, poor organizational health literacy could be understood an intentional determinant of value co-destruction in the health care service system. Actually, the lack of organizational efforts aimed at enhancing the capacity of patients to properly handle the available health resources and at encouraging health care professionals to engage patients in the provision of health care is the result of a voluntary managerial approach, which favours the traditional bio-medical model of care and prevents the transition toward the empowerment of patients as critical co-producers of health.

Figure 1 provides a graphical synthesis of what has been discussed above. Health care co-production entails a revisited relationship between health care professionals and patients, which emphasizes the role played by both of them in the success of health care provision and in the achievement of the desired health outcomes. It rejects the still prevailing bio-medical approach to care, which maintains that health care professionals are the sole relevant agents in the process of health care design and delivery, identifying the patients as mere consumers of health care who are not able to affect the way the service provision is implemented. Quite the opposite, patients are assumed to have a lot of dormant assets, which are generally disregarded in the health care setting. Hence, the lack of co-production implies the inability to benefit from these sleeping resources, negatively affecting value creation.

The engagement of patients in the provision of health care is eventually aimed at activating these sleeping resources, allowing them to participate in the decisions and initiatives which concern health protection and promotion in a perspective of enhanced value co-creation. However, in most of the cases the attention is focused on the institutional conditions which paves the way for patients' empowerment, while the practical requisites of patient involvement are neglected. As it could be

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figured out from the above discourse, individual and organizational health literacy are two key determinants of patients engagement. On the one hand, individual health literacy affects the ability of the patients to collect, process, and understand health information, thus influencing their capacity to navigate the health system. On the other hand, organizational health literacy could be understood as an enabling factor: it involves the establishment of a favourable environment to patient involvement, inciting recipients of care to actively take part in the process of value co-creation.

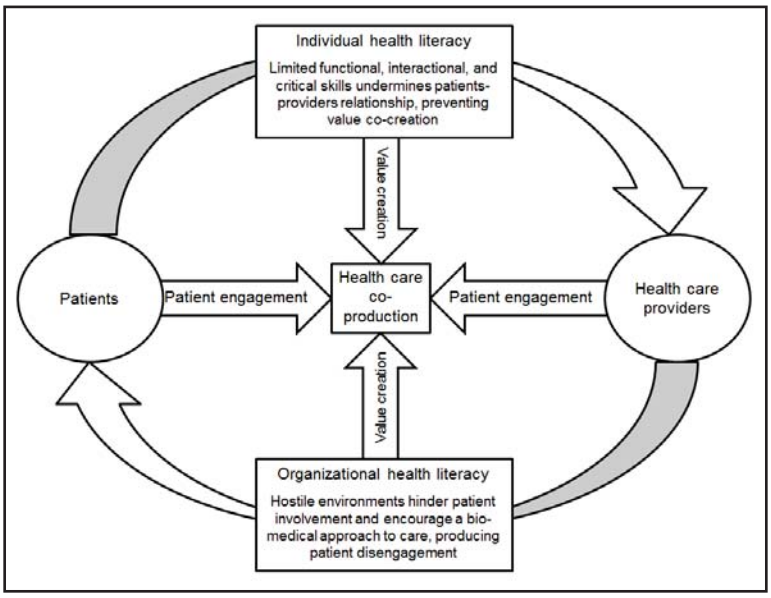

Figure 1. *The process of health care co-production.*

Inadequate individual health literacy undermines value co-creation and produces poor self-management of care and low self-efficacy perception, which in turn frustrate the establishment of collaborative relationships between the patients and the providers of care. Besides, a poor health literate health care setting impairs the ability of the patients to handle complex health-related phenomena and produces increased risks of misuse of the available resources. Therefore, limited individual and organizational health literacy set the conditions for value co-destruction in the health care setting. On the one hand, marginal individual health literacy prevents the ability of the patients to effectively communicate with the health care professionals and to achieve self-management of care. On the other hand, inadequate organizational health literacy hinders a co-creating partnership between the patients and the providers of care, even when the latter have adequate functional, interactive, and critical skills. In fact, it implies the establishment of a hostile environment, which discourages patient engagement. Besides, the mix of adequate organizational health literacy and poor individual health literacy may be harmful: it paves the way for significant risks of resources misuse, due to the inadequate understanding of health information by poor health literate patients.

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AVOIDING VALUE CO-DESTRUCTION IN HEALTH CARE SETTINGS

Individual and organizational health literacy are conjoined twins: both of them are required to realize patient engagement and to enhance the value which is generated through the involvement of users in the design and delivery of health care services. As it could be argued from the theoretical framework which has been depicted in the previous section, the disregard of either individual health literacy, organizational health literacy, or both of them in promoting the establishment of a co-creating partnership between the patients and the providers of health care produces momentous drawbacks. It impairs the contribution of patients in the process of health care provision and incites health care professionals to reiterate the traditional bio-medical approach to care, which is illness-centered and considers patients as mere consumers of health care services. As a consequence, it could be assumed that the lack of efforts aimed at addressing individual and organizational health literacy paves the way for value co-destruction, undermining the well-being of the entities involved in the provision of care and jeopardizing the sustainability of the health care system.

In spite of these considerations, scholars and practitioners are used to deal with individual and organizational health literacy as unrelated issues, thus neglecting the significant interdependencies which exist among them. Therefore, still little is known about the overall impacts of inadequate health literacy on both the health outcomes and the sustainability of the health care system. As well, most of the evidences which support the effectiveness of the interventions aimed at improving individual health literacy may be considered unreliable, since they do not appreciate the role played by organizational health literacy in affecting, on the one hand, the engagement of the patients in the provision of health care and, on the other hand, the willingness of health care professionals to perform as enablers of the patients' sleeping resources, thus dismissing their traditional role of healers and illness relievers.

To achieve enhanced conditions of value co-creation within the health care service system, individual health literacy and organizational health literacy should be jointly managed and harmonized each other. With regards to individual health literacy, the ability of patients to understand health information and to properly navigate the health system is crucial to the effective establishment of a co-creating partnership in the health care setting. In fact, poor health literate patients are not able to deal with complex health-related phenomena, are not willing to set up a fair and unbiased relationship with the health care professionals, and are not proficient in discriminating between the *pros* and *cons* of different health treatments available. Hence, specific interventions aimed at educating patients in health-related issues and enhancing their self-efficacy perception are imperative to encourage patient involvement and to realize the value-added which is apparently associated with the co-production of health care. In these words, the patient-provider relationship turns out to be a contact between two

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experts, where both of them contribute in the success of the health care provision.

Notwithstanding, the improvement of individual health literacy could be trivial if not supported by the advancement of organizational health literacy. Actually, when the importance of health literacy to organizational mission and values is overlooked and health literacy concerns are not contemplated into organizational plans and goals, health care professionals are not incited to promote patient engagement in the provision of care, thus preserving their loyalty to the traditional bio-medical approach to care. Therefore, within poor health literate health care organizations, the functional, interactive, and critical health literacy skills of patients are sterilized. Although health literate patients are able to participate in the process of value creation, they are restrained to do so due to a hostile environment, which fosters a "fix-it" approach to care and hinders the involvement of patients in the provision of health services. When these circumstances prevail, there is a high risk that value is co-destroyed: the disengagement of the patients implies impaired medication adherence and increased disagreements with the health care providers, which in turn engender the misuse of the available resources and the achievement of meager health outcomes.

From this point of view, the enhancement of organizational health literacy is a crucial part of the initiatives aimed at the engagement of patients, requiring both strategic and managerial changes. First of all, health literacy should be contemplated within organizational planning, being conceived as one of the main strategic concerns of health care organizations. As well, appropriate measures to check the levels of organizational health literacy should be arranged and monitored, informing corrective actions when patients are found to be not able to navigate the health care service system, because of the complexity of health information and the hostility of the health environment. Particular attention should be also paid to the encouragement of inter-organizational relationships within the health care system, with the purpose of improving the access of both patients and health care professionals to community-based health literacy resources, which in turn allow to reduce the risks of misuse of available assets. Last but not least, the sensitivity to health literacy of health care professionals should be aroused, making them more willing to engage and empower the patients.

CONCLUSION AND FURTHER DEVELOPMENTS

Dealing with health care co-production, individual and organizational health literacy are the two faces of the same coin. Both of them affect the relationship between the patients and the providers of care, setting the conditions for the establishment of a co-creating partnership in the health care environment. Nonetheless, dealing with patient engagement, the scientific and the professional literatures have widely overlooked the role played by organizational health literacy, mainly focusing on the individual ability of patients to collect, process, and understand health information in order to

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properly navigate the health care system. In addition, even though the awareness of the scholarship about the characteristics and the effects of organizational health literacy is currently arising, still little is known about its impacts on patient empowerment and health care co-production.

The theoretical framework suggested by this paper is aimed at nourishing the debate about this important issue, conceiving individual and organizational health literacy as conjoined twins and emphasizing the interdependencies between them. They are assumed to be crucial to the implementation of health care co-production. The missing of either individual or organizational health literacy paves the way for a biased relationship between the health care providers and the patents, thus preventing the establishment of a co-creating partnership and engendering increased risks of value co-destruction. Further conceptual and empirical developments are needed to figure out the complex interdependencies existing between individual health literacy, organizational health literacy, and health care co-production, clarifying how they interact enhancing value co-creation or provoking value co-destruction.

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