Adopting Public Service Logic in Analysing Primary Care Services

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Keywords: co-creation, co-production, public value, patient-centred

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1. Introduction

The interpretation and evaluation of public services have been subject to recent critiques. The traditional public service strategies have failed in achieving the expected benefits and level of participation [1]. The New Public Management failed in achieving democratic and inclusive public services given the power asymmetries between providers and citizens [2]. Within this scenario, a new strategy, the Public Service Logic (PSL), has gained momentum by reforming the way of interpreting and assessing public services [3]. This new public service strategy aims at overcoming the limitations of the previous ones through the following considerations. First, it considers citizens as the only actor that can (co)create value: public service organizations can (co-)create offering, which becomes value as far as citizens use and experience it. This assumption leads to the second consideration: the activities and resources that service providers invest are only potential value (value proposition); if no interactions with citizens occur, no value is generated [4]. Thus, citizens become active co-creator of public and social value, instead of passive receivers. Public service organizations have to recognize the role of citizens and facilitate intrinsic and extrinsic collaboration with them to address citizens' needs and expectations more effectively. In addition, PSL claims that the value (co-)creation process is far from linear in contrast to the existing public service strategies [5]. Various actors in a public service ecosystem exchange different types of resources, norms and values over time with each other. Managing and monitoring the value (co-)creation process means analysing and organizing the dynamics analysing the whole service ecosystem and not only the dyadic relationship between users and service providers [6]. The intricacy and dynamism of the process of value (co-)creation led to a final consideration: the effects of the public service delivery may be negative [7]. Too often, the direct and indirect interactions between citizens and public service organizations have been taken for granted [8]. Conflicts, misunderstandings, power imbalances, negative experiences, and missing citizens' expectations are possible causes of value (co-)destruction [9]. Public service organizations have the duty to prevent, identify and address inconsistencies and potential failures.

This significant shift in analysing the process of value (co-)creation encourages public service providers and policy-makers to review the process of designing, organizing and evaluating public services. This call for change is particularly urgent in primary care (PHC), where the

recent Covid-19 pandemic has revealed several pitfalls and constraints [10]. Policy-makers and institutions are making substantial financial investments to increase the capacity and offering of PHC services and adopt patient-centred model of care, valuing the voice of citizens [11].

This paper aims to investigate to what extent PSL is appropriate for supporting providers and policy-makers in rethinking PHC models and increasing their focus on patients and citizens' needs. More precisely, this paper addresses the following research question:

> *How can the PSL support practitioners and policy-makers in rethinking the PHC models?*

In doing so, it examines an Italian model of PHC, Case della Salute (CdSs), and its coherence with PSL's principles. Then, it discusses how the critical analysis of the results can support practitioners and policy-makers in planning and developing the substituting Italian model of PHC: Case della Comunità (CdCs), which is part of the Next Generation EU program.

2. Theoretical background

2.1 Rethinking PHC services adopting a people-center perspective

PHC is defined as the 'provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustainable partnership with patients, and practicing in the context of family and community'[12]. The aging population, the increasing number of chronic patients and the shortage of health workforce encouraged practitioners and policy-makers to identify new models of PHC[13]. This revision of PHC models has been accelerated since the recent Covid-19 pandemic. The necessity to guarantee the provision of PHC services regardless the hygienic restrictions, the raising demand of care and the shortage of healthcare resources and personal protective equipment has forced healthcare systems to innovate [14,15]. In both phases of PHC model's revision, the main factor that has guided this rethinking process was the necessity to shift towards a people-centred approach. The focus of PHC should be the individual as a whole, not only his/her health condition [16].

Each country has innovated and reviewed the planning, implementation and assessment of PHC in different ways [17]. In Italy, a new model of PHC, Case della Cominità (CdCs), has been introduced at the beginning of 2022 thanks to the resources received from the Next

Generation program of the European Union [18]. The CdCs aim at becoming the reference point for the community; they are an accessible place where the community can access to get in touch with the health care system and find a response to its own health and social needs [19]. They constitute the privileged venue for setting a new model of care that focuses on the community and not on the healthcare providers [20]. Instead of defining a set of individualised health services that fall under the logic of the consumption model, the CdCs promote a community approach based that recognizes health as a common good [21]. The local community is involved in the planning, delivery and assessment of PHC services, enhancing the creation of more responsive and effective services [22].

In United Kingdom, the National Healthcare System rethought the community health services through the introduction of the NHS Long Term Plan in 2019 [23]. In particular, it gave people more control over their health, enhanced the collaboration through multi-disciplinary teams, encouraged the usage of digital technology for promoting telehealth and invested in prevention programs [24]. These objectives were achieved thanks to the development of an integrated network composed by formal health (e.g. general practitioners, home care assistants) and social actors (e.g. social workers) and informal actors (e.g. volunteers, family caregivers). The integration of different professionalisms facilitates the capacity to address all physical, social, mental needs concurrently [25] by providing personalized treatments [26].

Both countries have put in place new PHC models that overcome the dichotomy patient-provider with the adoption of a people-centred approach. The provider is no more the only actor in charge to support patients' health; the local community and patients themselves play key roles in the patients' recovery. Moreover, the response to numerous and diversified needs of patients requires a comprehensive and customized approach that overcome the traditional focus on the health condition of patients. When dealing and planning PHC services, it is important to consider patients' wellbeing as the outcome of several factors that differ from patient to patient: 'they are people first, then patients' [27].

2.2 Conceptual frameworks for describing and assessing PHC services

To drive the innovation of PHC models, many conceptual frameworks have been developed. Providing overarching guidelines guides healthcare providers towards changes and improvements [28]. It clarify all the relevant features that should be taken into account for describing and assessing the mechanism of PHC models, helping providers in be comprehensive [29]. However, the selection of the most suitable set of metrics and indicators

is challenging because several factors can influence the outcomes of PHC services concurrently [30]. The healthcare literature does not support practitioners in this direction as it reports a large number of conceptual frameworks that include several constructs of PHC performance [31]. For instance, Valentijn et al. (2013) identified four key constructs for describing and analysing primary care: first contact (i.e. having accessible services), continuity (i.e. guaranteeing coherence in care pathways over time), comprehensiveness (addressing all patients' needs), and coordination (i.e. integrating with other providers) [28]. Hogg et al. (2008) integrated these constructs with additional constructs that regard the characteristics of the healthcare systems (i.e. governance and resources), of the healthcare organizations (i.e. human resources, office infrastructure, organizational structure) and of other local organizations (i.e. surrounding health and social services, community). They also added constructs that refer to the performance of the services (i.e. quality of clinical care, patient-provider relationships, provider satisfaction) [32]. Regarding this last construct, Barbazza et al (2019) suggested to differentiate performance in sub-domains: care contact, primary care output, healthcare system outcomes and health outcomes [17]. Similarly, Watson et al. (2009) suggested differentiating the effects of PHC in immediate, intermediate and final outcomes. They also highlighted the importance to include in the analysis the contextual factors and the inputs of a given healthcare provider [33]. The usage of different constructs influences the type of information collected, the metrics selected and their interpretation [31]. For this reasons, Senn et al. (2021) contributed in reducing this fragmentation and confusion by synthetizing all previous frameworks about PHC in one comprehensive conceptual framework that can be syntetized in four main constructs:

- Context, which includes the specific characteristic of the context under investigation, including its healthcare system and population's needs;
- Organization and structure, which includes the governance and vision of the healthcare provider and its internal resources (e.g. human resources, information systems, facilities);
- Delivery of PHC services, which includes the main factors related to the service delivery such as: the integration, continuity, comprehensiveness of patient care;
- Performance of PHC services, which include population health outcomes and performance of the services (e.g. effectiveness, equity, efficiency).

Despite the numerous conceptual framework assessing and guiding the implementation of PHC model, the correct rout to the implementation of a people-centred approach is still

debated and unclear [34]. All the above-mentioned conceptual frameworks describe and assess the PHC services using a provider perspective mainly. Indeed, few constructs focus on real sources of value (co-)creation: the exchanges between patients and providers, the patients' experience and the capacity of the services to accomplish patients' needs. The large majority of constructs investigate the potential sources of value, which coincide with the resources, organizational structures and activities that the healthcare provider can implement to deliver the best service offering.

2.3 Dimensions of value in the public service delivery

According to the PSL, the role of public service organizations is limited to the creation of a service offering for citizens; they cannot create value without citizens. It is how citizens use this service offering that creates value [4,5,35,36]. In particular, Osborne (2021) identified four dimensions of value. The first dimension of value, *value in exchange*, is the most studied and investigated dimension. According to this dimension, the value created from a service delivery process is linked to the price that public organizations pay (or ask to pay) for the service. This value can be investigated at three different levels, each of which has a specific meaning. The value in exchange for citizens is the price that they have to pay for the service; for the system is the price that the service provider has to pay or the charge to citizens; and for the society is the price that the population pay for the service through taxes. The second dimension of value arise from the exchanges among citizens and service providers for the co-production and co-design of public and is defined as *value in production* [37]. The participation to co-production and co-design initiatives can benefit participants (i.e. citizens and providers) and the whole society thanks to the creation of more inclusive and effective services. The third dimension of value is the one created from the experience of the public service: *value in use*. The effects that emerge in delivering public services influence the service providers and the users that join the process, as well as the society thanks to the increase of social wellbeing. The last dimension of value arises from the capacity of the service to address its needs and is called *value in context*. As for the other dimension, value in context can influence individuals, when it studies the capacity to address users' needs, the service system, when it studies the capacity to address the inefficiencies of the service, and the society, when it studies the capacity to address social and economic needs [37].

Osborne et al. (2021) claimed that the process of value co-creation is much more complex [38] than this. Public services are delivered within an ecosystem of several actors and organisations

[6] with various (and sometimes contrasting) needs and expectations. Thus, the same process of value co-creation can generate positive effects on some actors and negative effects on others [38], confirming that resource integration among actors of the service ecosystem can also co-destroy value [39]. Co-creation and co-destruction are two 'sides of the same coin' [40] that continuously iterate with each other over time, as neither of these processes are permanent states [9]. The high interconnection and mutability of these processes increase the urgency of supporting PSOs with strategies and approaches for preventing failures and turning co-destruction in co-creation [9]. Moreover, the interactions are not limited to exchanges among citizens and service provider's representatives; rather, they occur within the entire service ecosystem, which is composed of a network of PSOs, citizens and local community [41].

By referring to the PSL, there is a need to shift the focus on citizens for investigating the real source of value in the public service delivery. This investigation is of paramount importance when dealing with health and social care services. Indeed, clarifying the process of value (co-)creation in the delivery of health and social care services will encourage healthcare practitioners and policy-makers to rethink the existing service offering for creating more democratic and effective services. Meanwhile, it will help preventing drawbacks and failures in the service delivery process, whose effects may be more serious on patients then ordinary citizens.

3. Method

Given the explorative nature of the paper's aim and the limited number of empirical research using PSL, a case study methodology was preferred [42]. Meanwhile, an abductive approach was chosen in collecting and analyzing data to increase the generalizability and objectivity of the results [43].

3.1 Context of analysis

The case under investigation is part of a larger research within the Coltivare.Salute.Com project, funded by the Politecnico di Milano in partnership with the health authority of Piacenza (PC), the Municipality of PC and the Emilia-Romagna Region. The project was chosen because it aims to analyze the Case della Salute (CdS) PHC model by identifying its strengths and weaknesses and providing some practical guidelines for its improvement. CdS model was introduce in 2010 and intends to create referral community-based facilities where citizens can

find answers to most of their health needs in integration with social professionals of the local territory [44]. However, their implementation in PC is still incomplete and fragmented as reported in Table 1. The typical CdS offer in PC is closed to a territorial outpatient clinic, supplemented with nursing office, home services and, in some cases, the presence of general practitioners. Sporadic examples of social and social care activities, which involved voluntary associations (especially in the pre-Covid period).

Table 1: Level of implementation of services foreseen by the national regulations in the CdSs of the Emilia-Romagna Region in PC

Services	**Evaluation (Emilia-Romagna Region)**
Prevention and promotion	(Information service) 78,8-90,2%**
Reception and orientation (information point)	61,6-74,5%**
Needs evaluation	(Integrated evaluation) 43,1-45,5%**
Assistance from the GP or pediatrician	80,6%* (#5-9 GP/CdS)
Nursing care	93%* (>#15 Inf/CdS)
Specialist care to support trails	Cardiology: 83,9%* Dermatology: 64,5%* Diabetology/Endocrinology: 41,9%* Ophthalmology: 58,1%* Pneumology: 25,8%*
Obstetrical care	29%*
Social services	Social care: 50/124 CdS*** Child protection social service: 1/124 CdS***
Diagnostic and outpatient services	32,3%
Mental health and pathological addictions assistance; cognitive disorders and dementia center	-
Outpatient surgery	48,4%*
Rehabilitation care	45,2%*
Home care services	51,6%*
Telemedicine and teleconsultation	-
Prosthetic distribution services	16,1%*
Foreigners' desk	35/124 CdS***

*Crea, 2020; **Regione ER, 2019; ***Regione ER database

From an organizational point of view, the regional deliberation of 2016 institutionalized the governance of the CdSs in Emilia Romagna highlighting a nursing role (called ROCS) as the main reference figure for the management of the CdSs. While specialists were present once a week or even less, a small number of nurses and administrators were staffed in CdS [45].

To gather a comprehensive understanding of the model of PHC, all the eight CdSs of the Municipality of PC were selected.

3.2 Data collection

The research team carried out 13 semi-structured interviews and one group interview with the representatives of the CdSs (i.e. ROCS) and the other key figures that should be involved directly or indirectly involved in the activities of the CdSs according to the regional legislation. The interviews were organized into three macro sections: (i) Organizational model for understanding the resources and roles involved in the internal management of the CdSs' activities; (ii) Service delivery, to study the internal and external interaction and integration with other services in the area; (iii) Performance plan, to analyze how of monitoring the objectives of the CdS.

Table 1: list of actors involved through interviews and focus groups

Service providers and other public institutions	**Citizens committees and associations**
• 6 ROCS of the CdC of PC; • 2 Directors of the local health authority (LHA) and the Distretto (which is an institution in charge of coordinating social services); • 2 Directors of municipal social services.	• 3 Representatives of local citizen committee; • 9 Representatives of patients and volunteer organizations (*group interview*).

3.3 Data analysis

One qualitative researcher transcribed the interviews verbatim, the research team read the transcript checking inconsistencies and asked to each interviewee to check the correctness. Then, one qualitative research analyzed the validated transcripts using Nvivo software. The analysis follows two main phases. In the first phase, the researcher coded the transcript using a traditional and well-known conceptual framework for describing and assessing PHC services. Among the several frameworks, the research team decided to use Senn et al. (2021) consolidated framework due to its comprehensiveness and novelty [31]. Following an abductive logic, the researcher used the dimensions of Senn et al. (2021) framework for setting the initial categories. The results of the initial coding were discussed with the research team and some changes were applied. In particular, two categories were grouped because its contents overlap: *workforce development*, which overlaps with human resources and management, and *patients enrollment*, which overlaps with comprehensiveness of care. Moreover, three categories were added because their content was not part of any categories of Senn et al. (2021): *current practices, old practices* and *challenges during Covid-19 pandemic*. Each dimension was analyzed by identifying (i) what works to identify the strengths of the current scenario; and (ii) what does not work or what could be improved, to identify the

current criticalities. Results of the coding were discussed within the research team and presented to the interviewees in aggregate form.

Table 2: The first coding matrix based on Senn et al. (2021)

The domains of Senn et al. (2021) [31]	
Population needs:	The population and patients' health and social needs that PHC services have to address.
Organization and structure of PHC model:	The organizational features that health service organizations put in place: government mechanism, vision and values, human resources and management, information systems, workforce development, facilities and equipment, quality improvement
Delivery of PHC services:	The activities that are performed for delivering PHC services: integration of patient care, interpersonal care, comprehensiveness of care, advocacy and community actions
Patient and population outcomes:	The positive health outcomes that are achieved through the delivery of PHC service, such as: longevity, quality of life, well-being, empowerment
Performance measures:	The performance equity, accessibility, appropriateness, efficiency, effectiveness, productivity

However, this framework was designed using the traditional strategies that consider service providers the primary source of value creation. To gather the real source of value-creation according the PSL, the researcher implemented a second step in which analyzed the processes that involved citizens. In particular, the researcher coded the text according to the dimensions of value for public service delivery: value-in-exchange, value-in-production, value-in-use and value-in-context [37], studying them at system, social and individual levels. In line with Osborne et al. (2021), for each dimension the research the research team studied the co-creation of value (what work) and the non-creation or co-destruction of value (what does not work) [38].

Table 3: The second coding matrix based on Osborne (2021)

The domains of Osborne (2021) [37]	
Value in use	The effects of experiencing CdSs' services on individuals, health and social care professionals and the entire society, both in positive and negative terms
Vale in production	The effects of co-production and co-design of CdSs' services on individuals, health and social care professionals and the entire society, both in positive and negative terms.
Value in exchange	The price that CdSs pay (or ask to pay) for delivering their services.
Value in context	The capacity of CdSs to address (or not address) the needs of individuals, CdSs' service model and the entire society.

4. Description of results

Following the paper's aim, the results present the main strength and weaknesses of CdS model in PC using a provider-oriented and a citizen-oriented view.

4.1 Results from adopting SENN conceptual framework

Using the framework of Senn et al. (2021), the research team analysed the case of PC. The more relevant findings are summarized in what follow.

4.4.1 Population needs

The PC local authority (named Distretto in Italy) collected and analysed the economic, demographic, health, social information of population and service offering in the so called "Piano di Zona" every three years. It also collected data on hospitalizations, visits, exams and prescriptions every year. By analyzing data, the PC local authority checked the adequacy of the service offering and, if necessary, modified it for addressing population's needs in a better way. However, this analysis did not involve the CdSs; it took place at macro level involving the main Directors of local health and social institutions and volunteering organizations. Moreover, the changes in the health service offering were not as frequent as needed.

4.4.2 Organization and structure of PHC model

The activities that the CdCs in PC were organized and performed include the structuring of the internal governance, the awareness of the CdCs' vision and values, the recruitment and management of health and social care professionals, the improvement of existing information systems, and the management of the facilities and equipment.

Governance and vision: According to regional legislation, each CdS should have a board that is coordinated by the ROCS, who should be seen as the point of reference for the voluntary associations and the one in charge to invite the various associations to the board.

The healthcare organization of PC gave the ROCS the only responsibility to open the 'chronic outpatient clinics' service, one in each CdS. For this reason, the ROCS did not have the necessary responsibilities and recognition to perform their role.

Human resources: Nurses became a reference point for patients and for every activity related to the CdS. Sometimes, they provided psychological support and practical advices that had an impact in terms of physical, psychological and social health. In addition, the figure of the nurse within the CdSs had the opportunity to work in integration with other professionals and

to intercept the needs of patients through a prevention programs. This change of perspective and proactive approach was not easy for nurses due to their hospital-based education and culture. While in the home care and chronic care services this change of perspective was taking place, within the outpatient services it was still anchored to a culture that focus on addressing population's needs (and not on its prevention).

> 'We are really trying to move from a conception of care which is need-based, to a conception of proactive medicine where it is the nurse who phones patients at home and makes an appointment for diabetes follow-ups" (nurse).

To facilitate this cultural change, the nurse within the CdS were asked to have a high level of competences and empathy towards patients, facilitating the establishment of trustful relationships.

> 'The empathic approach and the ability to engage patients was fundamental, because it ensures the adherence to the treatment' (nurse).

Another factor that facilitates this change of perspective was the sense of belonging of professionals towards the CdSs. While it was easy to generate this sense of belonging in professionals who experience the CdS on a daily basis, it was much more complex in those who attend the CdSs few days a week or a month.

However, the change of culture of nurses is not the only issue that CdSs had to face. The shortage of health workforce was so high that had a negative impact on the performance and workload of the other local health and social organizations.

> 'There is a problem of nurses and doctors' shortage that makes difficult maintaining high the quality of care. We have to work a lot on home care and on creating a system that is sustainable and helps them to stay at home as much as possible, because the resources, including human resources, are now hard to find' (Director of Social Services).

For enriching and updating professionals' competences, several training courses were organized at different levels. At corporate level, trainings were carried out in line with the strategic planning of the healthcare organization. At departmental level, trainings were organized within each department. At operational level, trainings were defined by each CdS. Some ROCS organized training initiatives for sharing with the professionals that habit the CdS some basic operative recommendations (e.g. fire and emergency procedures). These

training courses allowed professionals to get to know each other, encouraging collaboration and teamwork.

> ‘A lot of effort has been devolved for organizing training courses, facilitating this cultural shift and opening up new collaborations among professionals’ (nurse).

Information systems: Each CdS service had its own information system that did not integrate or communicate with the others.

During discharge, the shift of information between the CdS and the hospital professionals took place verbally. Then, information were transcribed on the informative system dedicated to home care services. This informative system was also used for scheduling patients’ home visits, assessing and monitoring patients’ needs.

To support nurses in delivering chronic care, nurses used ad hoc information system that tracks patients’ data, recorded services and assessed patients’ needs. Despite the information system was not integrated with any other internal and external systems of the healthcare organization, the data and results of a visit were organized in a pdf file and sent to the general practitioner of the patient automatically. For scheduling visits of chronic patients, nurses used another information system that was integrated with the one of the general practitioners.

In PC, any the informative system of the CdSs communicated with specialists, the local municipality and voluntary associations. All exchanges of data took place via e-mail or telephone to preserve the patients’ privacy.

Facilities: The ROCS were the reference point for maintenance and inventory of the technologies present within the CdSs. In fact, they had access to an informative system that allowed them to see all the equipment and technologies within the CdSs and send warning to the technicians for maintenance or restauration works. However, the purchasing of technologies of the CdSs was in charge to the healthcare organization’s departments. With the Covid-19 emergency, some technologies and equipment were no longer used, creating expenses for the company.

4.4.3 Delivery of PHC services

In delivering PHC, the CdS collaborate though multi-disciplinary teams, with actors and organizations outside the CdS, with patients and their families and the local community. Each form of collaboration is discussed in what follow.

Collaboration in multi-disciplinary teams: Teamwork is more or less present and standardized in all CdSs' services through regular meetings in which clinical cases are discussed. The exchanges of information were facilitated by information system, direct communication (e.g. telephone) or indirect communication (e.g. e-mail) in which no sensitive data can be communicated.

> 'I believe that the most effective way of working in a team is the use of words' (nurse).

Collaboration with actors outside the CdS: The integration between hospital and the CdS took place throughout the patients' pathways in pre-defined moments. For instance, during the hospital discharges the hospital professionals contacted the CdSs' ones and sent them the discharge report. Then, the professionals of the CdS and the hospital met for meeting the patient, and discussing the clinical case. The professionals of the CdS with the support of the social assistance of the local municipality assessed the socio-medical need and interviewed family caregivers in order to define the most appropriate setting of discharge and the expected date. During the hospital visit, every exchange of information and data is verbal. In case of activation of home care service, the information were transcribed on the informative system of home care assistance.

The municipalities were the actors in charge to deliver social services. The integration between CdSs' services and social services occur thanks to social assistant that worked for the healthcare organization. This relationship is stronger the more there is a spatial proximity between the CoS and the social services.

> 'There is a need to rethink how to establish an integration between the municipalities and the social part of CdSs' service" (nurse).

The integration between the chronic outpatient clinics of the CdS and the social services could occur in three different way. If patients were non-critical and compliant, the nurse invited patients to go to the local municipality. If patients were critical and not able to ask for support autonomously, the nurse contacted the social assistant of the healthcare organization. If nurse had to ask the collaboration of social services for a specific patient's need (e.g. transportation), the nurse contacted the local municipality.

> ‘Having social assistant within our structure or having social assistant of the municipality that habit the CdS even for few days a week could be really an advantage’ (nurse).

The integration between social services and the home care services of the CdSs was well structured and bi-directional.

Collaboration with patients and their families: There were no tools available for supporting CdSs’ professionals in engaging patients and their caregivers. Thus, the involvement of patients and the caregiver in the care pathway was left to the initiative and preferences of the nurses.

> ‘We usually try to establish relationships with patients and their caregivers during the outpatient clinic. Confidential relationship helps them in the care pathway" (nurse).

Collaboration with the local community: The involvement of the community and voluntary organizations occurred at corporate and local level. At the corporate level, it is managed by the company's communication and marketing department. At the local level, it is coordinated by the ROCS; this collaboration is stronger in small districts thanks to the easiness of establishing informal and direct relationships.

At the local level, the involvement of the population differs between the CdSs. In some CdSs, a collaboration with some voluntary associations began but the Covid-19 stopped any type of exchange. In other CdSs, thanks to the ad hoc projects, a strong integration was created with volunteers who in some cases became almost organic to the system.

4.4.4 Patient and population outcomes

The positive and negative health and social outcomes on patients and the local community in the short and long term are not collected by any of the local organizations and institutions.

> ‘Data collection is crucial. It would also be helpful to find a way to document the admission, how many people and in what kind of context they passed through CdS, and we were able to give them a response’ (nurse).

4.4.5 Performance measures: The performance analysis was carried out by the single operational units or departments and not by the CdSs.

> 'We [as the main reference of the CdS] have not put in place a performance system because I do not know to what extend I can influence the processes and what I can

monitor [...]. We are thinking about it. We are in a phase where we are also a bit neither flesh nor fish'.

The ROCS created an internal dashboard with the aim of achieving objectives related to the operational part of the chronicity, on which they had the direct supervision. The type of data that were collected and analyzed are: no. of people in charge with relative age, no. of people who have made a visit, no. of people who adherence to the care pathways. Every three months, ROCS collected data and entered them into the dashboard created on Excel manually. These data helped in defining: the minimum no. of outpatient clinics per week, the time needed for each visit, the no. of eye examinations needed, no. of electrocardiograms needed. The analysis of these data are used for defining the remuneration of the general practitioners and for identifying criticalities and suggesting improvements in the management of chronic patients. Thanks to these monitoring activities, the ROCS did not receive any contribution or support from the healthcare organization.

In addition, the healthcare organization asked the chronicity outpatient clinic to collect two types of questionnaires. The first one evaluated the care pathway of chronic care patients from the point of view of the multi-disciplinary team; while, the second assessed patients' point of view. The administration of the second questionnaire was not successful due to the length and complexity of the tool.

Table 4. Takeaway from traditional provider-oriented logic (Senn et al., 2021)

Population needs
• Population needs as an overarching guideline for planning PHC services; • Lack of awareness of the needs of CdSs' patients and caregivers.
Organization and structure of PHC model
• Lack of recognition of nurses' role in the CdSs; • Nurses as the reference point for assistance in CdS; • Difficulties in shifting the culture of CdS's professionals towards proactive medicine; • Training courses as occasions for increasing professionals' competences and creating positive working environment; • Low interoperability of information systems of the CdS; • Lack of freedom on the choice of facilities and equipment for the CdSs by the ROCS; • Abandon of some technologies due to Covid-19 pandemic, risking their obsolescence.
Delivery of PHC services
• Presence of multi-disciplinary teams that collaborate for the management of more complex clinical cases; • Effective collaboration between CdS and the hospitals and the social services; • Proximity as a key driver for services' integration; • Lack of predefined tools or protocols for engaging patients and their family in the care pathway; • Diversified and fragmented involvement of voluntary organizations in the planning and delivery of CdSs.

Patient and population outcomes
• Lack of collection and analysis of patient and population outcomes
Performance measures
• Lack of performance measure at CdSs level; • Focus on the performance of the single services, investigating their efficiency; • Lack of collection and assessment of patients' experience.

5.2 Results from adopting PSL

5.2.1 Value in use

The effects on individuals, health and social care professionals and the entire society that arose from having experienced the CdSs' services were both positive and negative.

Individual: During the services' delivery, health professionals establish trustful and emphatic relationships with patients, especially the chronic and fragile ones. This welcoming approach facilitates the dialogue between patient and the professional and the understanding of patients' preferences in the definition of the care path. Feeling cared, understood and happy with the chosen treatment, patients are usually very satisfied of CdSs' services.

> 'In my opinion, the management of chronic patients [within the CdS] is very well set, very, very effective. There are two nurses that cuddle patients; they have a very emphatic approach' (volunteer).

At the same time, the relationship with patients is not always straightforward. Several patients are demotivated because of their fragile condition that requires a drastic shift in their daily routine activities. Others do not accept the diagnosis and neglect their disease, which is very hard to tolerate also for caregivers. These negative attitudes of patients and their caregiver can undermine the recovery path and the treatments' adherence.

> 'Several patients deny their disease, this is the worst scenario. They do not take care of themselves. They repudiate and refuse to speak with everyone. This is the most complex situation to deal with' (volunteer).

The inadequate management of CdSs services can further reduce the well-being and satisfaction of patients and their caregiver. Health professionals highlighted three possible causes of patients' disappointments: the fragmentation of health and social care services, the narrow spaces of the CdSs and the drawbacks caused by Covid-19 pandemic. These open issues generated confusion in patients, long queue in uncomfortable and tiny rooms, and long waiting lists.

As patients and caregiver, third sector organizations establish trustful relationships with professionals of the CdSs and other local institutions (e.g. schools). These strong partnerships make professionals aware of the organizations' activities and encourage them to make their patients in contact with the organizations. This strategy for reaching new patients is fundamental because third sector organizations are facing several challenges in this direction.

> 'We have tried to join the local network of care since two years. We couldn't distribute too many flyers. We couldn't fulfil the all the waiting rooms. Every volunteer have tried to spread organization's awareness but the journey [for reaching new users] is very long and complex' (volunteer).

Services of third sector organizations are very appreciated by CdSs' professionals because of their quality. Unluckily, third sector organizations are often unable to guarantee continuity of the service over time nor to collaborate in partnership with other organizations for scaling up initiatives. These constraints reduce the effectiveness of their services of and their involvement in defining and delivering health and social care services.

System: The services of CdSs had also some impacts on the professionals that are employed. More precisely, professionals benefitted from the establishment of trustful relationships with patients that facilitated them in customizing the treatment according to patients' needs and expectations. At the same time, these relationships became hard to be managed when dealing with patients at the end of their life or patients living in hard to reach areas. The impossibility to resolve patients' condition and guaranteeing patients' adherence reduced the motivation and sense of effectiveness of professionals.

> 'When dealing with patients that get worse whatever I prescribe or suggest, I cannot see the any light at the end of the tunnel a part of the end of his life. This situation creates terribile sense of gulty' (nurse).

Experiencing CdSs' services allowed professionals to establish several relationships with colleagues, volunteers and other professionals employed in other private and public organizations and institutions. These collaborations facilitated the adoption of multidimensional evaluations of patients, which took into account the heath and social needs, and the creation of collaborative working environment. Giving their importance, collaborating moments were valued, planned in advance and facilitated through co-working spaces for raising them in number in some CdSs. During these collaborating moments, the possibility to share patients' data with colleagues made professionals able to monitor and improve their

routine activities, creating value for patients. However, the case study highlights that this sharing of information was very complex and time consuming because professionals used Excel and did not have adequate information systems.

> 'Within the local health organization, the email are protected. Thus, we can share email with colleagues freely. Instead, for sharing information with other external organization we should use a system that notifies clinicians with a pdf file' (nurse).

During Covid-19 pandemic, professionals employed in CdSs' services experienced stressful situations that were even sharpened by the shortage of health workforce. In this challenging scenario, new professional roles (e.g. family nurses) and working approach (e.g. micro-team) were introduced. These changes in healthcare professions valued professionals' expertise and rose professionals' motivation. At the same time, they required a shift in the culture of the CdSs' professionals that limited and postponed these roles' changes to happen.

Society: The experience of CdSs' services influenced also the local society. In particular, the local population is still quite confused about the purpose and services of the CdSs. The lack of awareness about CdSs' model of care was caused by an inadequate communication of this model to the local community.

> 'The CdS was built in the building that hosted the local hospital. In redesigning the spaces, the sign 'hospital' was left on the top of the building. I can understand that this sign is historical, but this a misleading way to communicate [the CdS]' (nurse).

5.2.2 Value in production

The co-design and co-delivery of CdSs' services generated positive and negative effects on volunteers and professionals of CdSs.

Individual: Third sector organizations' volunteers felt useful because they could provide their contribution and share their opinions with professionals, influencing the design of CdSs' services.

System: CdSs' professionals could establish trustful relationships with third sector organizations, creating occasions for integrating or improving health and social care services. In few cases, the collaboration generated dissatisfaction in participants. In particular, both professionals and volunteers were disappointed when the opinions and feedbacks of the volunteers were not taken into account and when Covid-19 blocked any form of collaboration.

> ‘It is not fair saying ‘ok’ to the third sector organization and doing whatever you prefer [regardless organizations’ opinions]’ (social worker).

5.2.3 Value in exchange

Being a public structure, the CdSs did usually not link the value of services to the price that they pay (or ask to pay) for delivering the services.

5.2.4 Value in context

The capacity of the services of the CdSs to be responsive to the needs of individuals, CdSs’ services and society was not always high.

Individual: The CdSs were not able to provide a help desk for informing and directing patients and caregiver to the service offering. The lack of referring points generated disorientation in citizens. This initial disorientation was mitigated during the assistance. Indeed, CdSs’ professionals were good at establishing trustful relationships with patients, understanding and modifying the type of relationships according to the patients’ needs. This attention toward patients increased patients’ adherence and wellbeing. The CdSs’ professionals were less effective in supporting caregivers, who experience stress and disorientation with negative consequences on patients’ wellbeing.

> ‘Once patients are discharged, their families don’t know what to do. They should be informed about several questions, such as their rights. [..] In that condition, families go berserk’ (volunteer).

System: While experiencing CdSs’ services, the necessity to provide patients with psychological and social support emerged clearly. The CdSs tried to address this need thanks to the third sector organizations, general practitioners and public institutions. The role of third sector organizations was constraints due to the limited spaces inside the CdSs, the low number of volunteers, the limited financial compensation, and the scepticism of professionals of relying on volunteers. The impossibility to perform activities within the CdSs also reduced the opportunities for third sector organizations to collaborate with each other and with the CdSs’ professionals with negative impacts on the activities’ effectiveness. The public institutions and general practitioners established strong partnerships with CdSs when they cohabit in the same places. The spatial distance, the lack of integration procedures and recognition of the role of CdSs reduced the effectiveness of the collaboration and, thus, of the CdSs’ services.

> ‘The integration of health and social services is not occurring in our CdS. Some services were introduced for increasing the collaboration with social assistants but we do not have social assistants or any other social services in our CdS’ (nurse).

To address social and psychological needs of patients, few CdSs were also planning to introduce new professional figures, such as psychologists or expert volunteers. However, their introduction requires a shift of culture in CdSs’ professionals and additional workforce, whose factors limited and postponed the introduction of new professional figures.

> ‘If nurses, health assistants, and other therapists that are empoyed in the CdS consider [the introduction of family nurses] as an opportunity for reinforcing collaboration and services’ integration, the evolution of nurse’s role will be easier’ (nurse).

During the Covid-19 pandemic, healthcare workforce had trouble in guaranteeing the essential services and collaborating with colleagues, with delays in visits and cancellation of some CdSs’ services. At the same time, this traumatic experience forced CdSs to improve their services. In particular, the CdSs improved the management of visits’ scheduling and the adherence to sanitation protocols, gaining improvements in term of services’ effectiveness.

> ‘A positive consequence of Covid-19 pandemic was the improvements in visits’ scheduling. Every patient has his/her own hour slot’ (nurse).

Moreover, the CdSs tried to improve its service offering by motivating professionals and finding new spaces for meetings. Indeed, recognizing the effort of professionals increases stimuli for improving the service delivery; while, setting areas for team meetings encourages services’ integration and coordination. The initiatives were planned and their implementation was ongoing. The CdSs invested also in new technologies for innovating the service offering. However, the adoption of these technologies never started and its launch was postponed due to the Covid-19 pandemic, with high costs of maintenance on CdSs.

Society: The delivery of CdSs’ services influenced also the needs of the local population. The CdSs with the support of local institutions mapped the resources, health and social services of PC province and the characteristics of the local population. This map is updated every three years and helps CdSs and the other health and social organizations in reviewing their service offering for addressing population’s needs in a better way. Among the improvements, the CdSs invested in increasing their extensiveness on PC province for reaching the remote and rural areas and ensure the accessibility to health and social care

services to all the local population. At the same time, the CdSs have to get ahead in addressing population's needs. Indeed, professionals and volunteers highlighted the necessity to involve local population for improving the understanding of their needs; transferring the population's need analysis to some experts risks to provide results that differ from the reality. Moreover, the extensiveness is still limited, especially in the suburbs where needs and fragility are more common.

> 'We should invest in the suburbs, where there is nothing, where there is the darkness. We have to bring there the light, the services and the institutions' (social assistant).

Table.5 Takeaway from the new Public Service Logic (Osborne, 2021)

Value in use
• Patients' satisfaction thanks to the establishment of trustful and emphatic relationships with CdSs' professionals; • Negative attitudes of patients and their caregiver as barrier for treatment's adherence; • Inadequate management of CdSs' services as a barriers for patients' satisfaction; • Enhancement of patients assisted by volunteering organizations thanks to strong relationships with the CdSs; • Difficulties in integrating CdSs' services with social ones due to the irregular support from the volunteering organizations; • Creation of more responsive services thanks to the establishment of relationships between patients and professionals; • Reduction of professionals' motivation when dealing with end-of-life patients; • Creation of more effective and complete services thanks to the establishment of relationships among professionals; • Creation of a collaborative working environment thanks to the establishment of relationships among professionals; • Negative impact of Covid-19 on professionals' wellbeing; • Organization culture as barrier for valuing professionals' roles, increasing professionals' motivation; • Low awareness of CdS due to ineffective communication strategies.
Value in production
• Increasing satisfaction in volunteering organizations thanks to their involvement in CdSs' activities; • Creation of trustful relationships among professionals and third sector organizations; • Dissatisfaction of CdS professionals and local volunteering organizations caused by tokenism of healthcare organization;
Value in exchange
• --
Value in context
• Disorientation in citizens in accessing CdSs' services; • Increasing patients' adherence and satisfaction thanks to trustful relationships with professionals; • Difficulties in reducing stress and disorientation in caregivers; • Difficulties in addressing all patients' needs due to limited spaces inside the CdSs dedicated to volunteering organizations and social services; • Difficulties in integrating health services with social ones due to low number of volunteers, limited financial compensation, and scepticism of professionals of relying on volunteers;

• Limited collaboration between CdSs and social services due to the lack of integration procedures and recognition of the role of CdSs.

5. Discussion and Conclusions

The present study aims at investigating the adoption of PSL as a means for supporting policy-makers and healthcare providers in rethinking the existing PHC models. To this end, a qualitative analysis was developed on an Italian model of PHC, i.e. CdS, studying its implementation in Piacenza province. The analysis investigated the same set data using the traditional provider-oriented logic, using Senn et al. (2021) conceptual framework, and the new PSL, using Osborne (2021) definition of value.

By comparing the two logics, three main constraints related to the traditional provider-oriented logic appear clearly. First, the traditional logic provided only guidelines for the effective usage of the internal resources of the CdSs. As highlighted by Osborne (2021), the improvement of the resources of the service provider does not create value, but only potential value. Therefore, the takeaways that emerged from the analysis using Senn et al. (2021) do not help providers in creating value. For instance, the necessity of improving the interoperability of CdSs' information systems and the management of CdS' facilities highlights issues whose resolution can raises the effectiveness of the CdSs resources' management but do not necessary create value for the local population. The main concern of this logic is the lack of evidence on the link between the issues/strengths that it pinpoints and the source of value (co-)creation/(co-)destruction. The lack of information system interoperability may cause inefficiencies in the management of patients' data, with possible negative impacts on treatments' management and, thus, on patients' health. However, these relationships may not occur if the number of patients are limited and professionals use other form of patients' data management (e.g. paper documents).

The second constraint of the traditional provider-oriented logic is its incapacity to provide clear guidelines for improving the service offering. Whilst this logic makes a clear picture of the as-is scenario highlighting its strengths and weaknesses, it does not guide providers in choosing the most suitable solution for overcoming existing pitfalls. For instance, the analysis through Senn et al. (2021) highlighted that professionals of the CdS do not use predefined tools and protocols for engaging patients in the care pathway. This takeaway clarifies the

existing scenario but it does not guide health providers in understanding the most suitable actions. Is the introduction of a set of tools for engaging patients needed? Similarly, the analysis through Senn et al. (2021) highlighted that the level of involvement of voluntary organizations is diversified in PC province. But, it this diversification a problem? To address these questions, health providers should make a step further for understanding their capacity to create value for the local population. First, they have to identify the main issues and prioritize them according to their relevance. Then, they have to design possible solutions for addressing the most relevant issues. However, these steps are not easy to accomplish. The same takeaway can be an issue for someone and a strength for others: the lack of tools for engaging patients can be for some professionals a strength because leave them freedom in choosing the most suitable form of engagement. Moreover, prioritizing the relevance of issues can be tricky because the same issue can be very relevant for someone but not for others. For instance, the involvement of voluntary organization in the planning and delivery of CdSs' services may be relevant for volunteers and patients but not relevant for health professionals.

The last constraint of the traditional provider-oriented logic is its incapacity to clarify the impact of the as-is scenario. For instance, the fact that CdSs did not collect the needs of the local population nor the experience and the outcomes of their services is very serious because they do not know the sources that allow CdSs to create value. However, this serious issue is weigh as the low interoperability of CdSs' information systems, which does not have the same impact on population well-being and satisfaction.

By analysing PSL, this research helps to detach the sources of value creation, shifting the focus from public service providers to citizens. The clarification of this change of perspective contributes to plan, manage, deliver and assess public services more effectively by taking into account the needs and expectations of citizens.

The new public service strategy presented here has some major theoretical and practical contributions. First, it contributes to unveil the process of value (co-)creation/destruction of public services, addressing one of the claimed open gaps of the Public Administration and Management literature [1]. Being one of the first attempts to analyse PSL empirically (see [1,3]), this research guarantees further conceptualization and validity of the concept of value (co-)creation. From a practical point of view, this study supports providers and policy-makers in rethinking the existing PC models to make them more responsive to population's needs and

expectations. Moreover, it provides evidence of the challenges that healthcare organizations may face in pursuing this new public service strategy.

Bibliography

[1] S.P. Osborne, K. Strokosch, Participation: Add-on or core component of public service delivery?, Aust. J. Public Adm. 81 (2022) 181–200. https://doi.org/10.1111/1467-8500.12536.

[2] L. Millward, ‘ Just Because We Are Amateurs Doesn ’ T Importance Of Expert Activists In Tenant Participation, Public Adm. 83 (2005) 735–752.

[3] L.M. Jenhaug, Suggestions for Developing Public Service Logic through a Study of Interactive Value Formation, Int. J. Public Adm. 44 (2021) 728–740. https://doi.org/10.1080/01900692.2021.1900244.

[4] C. Grönroos, Reforming public services: does service logic have anything to offer?, Public Manag. Rev. 21 (2019) 775–788. https://doi.org/10.1080/14719037.2018.1529879.

[5] S.P. Osborne, From public service-dominant logic to public service logic: are public service organizations capable of co-production and value co-creation?, Public Manag. Rev. 20 (2018) 225–231. https://doi.org/10.1080/14719037.2017.1350461.

[6] M. Petrescu, From marketing to public value: towards a theory of public service ecosystems, Public Manag. Rev. 21 (2019) 1733–1752. https://doi.org/10.1080/14719037.2019.1619811.

[7] T. Bovaird, S. Flemig, E. Loeffler, S.P. Osborne, Debate: Co-production of public services and outcomes, Public Money Manag. 37 (2017) 363–364. https://doi.org/10.1080/09540962.2017.1294866.

[8] E. Loeffler, T. Bovaird, User and Community Co-Production of Public Services: What Does the Evidence Tell Us?, Int. J. Public Adm. 39 (2016) 1006–1019. https://doi.org/10.1080/01900692.2016.1250559.

[9] M. Engen, M. Fransson, J. Quist, P. Skålén, Continuing the development of the public service logic: a study of value co-destruction in public services, Public Manag. Rev. 00

(2020) 1–20. https://doi.org/10.1080/14719037.2020.1720354.

[10] J. Lim, J. Broughan, D. Crowley, B. O'Kelly, R. Fawsitt, M.C. Burke, G. McCombe, J.S. Lambert, W. Cullen, COVID-19's impact on primary care and related mitigation strategies: A scoping review, Eur. J. Gen. Pract. 27 (2021) 166–175. https://doi.org/10.1080/13814788.2021.1946681.

[11] F. Mughal, C.D. Mallen, M. McKee, The impact of COVID-19 on primary care in Europe, Lancet Reg. Heal. - Eur. 6 (2021) 100152. https://doi.org/10.1016/j.lanepe.2021.100152.

[12] Institute of Medicine, Defining primary care: an interimreport, National Academies Press, Washington DC, USA, 1994.

[13] T. Bienkowska-Gibbs, S. King, C. Saunders, M.-L. Henham, New organisational models of primary care to meet the future needs of the NHS: a brief overview of recent reports, 2015. https://www.hee.nhs.uk/sites/default/files/documents/Literature overview from RAND Europe.pdf.

[14] S. Duckett, What should primary care look like after the COVID-19 pandemic?, Aust. J. Prim. Health. 26 (2020) 207–211. https://doi.org/10.1071/PY20095.

[15] S. Matenge, E. Sturgiss, J. Desborough, S. Hall Dykgraaf, G. Dut, M. Kidd, Ensuring the continuation of routine primary care during the COVID-19 pandemic: a review of the international literature, Fam. Pract. 39 (2022) 747–761. https://doi.org/10.1093/fampra/cmab115.

[16] D. Kringos, W. Boerma, A. Hutchinson, R.B. Saltman, Building primary care in a changing Europe, 2015.

[17] E. Barbazza, D. Kringos, I. Kruse, N.S. Klazinga, J.E. Tello, Creating performance intelligence for primary health care strengthening in Europe, BMC Health Serv. Res. 19 (2019) 1–16. https://doi.org/10.1186/s12913-019-4853-z.

[18] Presidenza del Consiglio dei Ministri, Piano nazionale di ripresa e resilienza, Rome, 2021. https://italiadomani.gov.it/it/home.html.

[19] Ministero della Salute, Modelli e standard per lo sviluppo dell'Assistenza Territoriale nel Servizio Sanitario Nazionale, Rome, 2022. http://www.salute.gov.it/imgs/C_17_pagineAree_4588_listaFile_itemName_0_file.pdf.

[20] V. Ghetti, Case della comunità … che fare?, Lomb. Soc. (2022). http://www.lombardiasociale.it/2022/02/11/case-della-comunitache-fare/.

[21] J. Polimeni, R. Balduzzi, A. Patanè, Il nuovo assetto delle Case della Comunità nell'ambito della riorganizzazione territoriale dell'Azienda Sanitaria Friuli Occidentale (ASFO, Università Cattolica del Sacro Cuore, 2022.

[22] F. Longo, Dalle Case della Salute a quelle di Comunità: quale vocazione?, Lomb. Soc. (2022). http://www.lombardiasociale.it/2022/02/28/dalle-case-della-salute-alle-case-della-comunita-quale-vocazione/?doing_wp_cron=1646056181.2563569545745849609375 (accessed October 1, 2022).

[23] A. Charles, C. Ham, B. Baird, H. Alderwick, L. Bennet, Reimagining community services: making the most of our assets, 2018. https://www.kingsfund.org.uk/sites/default/files/2018-01/Reimagining_community_services_summary_0.pdf.

[24] National Healthcare System, The NHS Long Term Plan, 2019. https://doi.org/10.38192/12.1.4.

[25] A. Charles, Community health services explained, King's Fund. (2019). https://www.kingsfund.org.uk/publications/community-health-services-explained#:~:text=Community health services provide support,the end of their life. (accessed October 1, 2022).

[26] A. Miles, B. Mphil, J. Elliott, A. Kt, The NHS Long Term Plan (2019) - is it person-centered ?, Eur. J. Pers. Centered Healthc. 7 (2019) 1–11.

[27] M. Lalanda, E. Gracia-Peligero, M.T. Delgado-Marroquín, They Are People First, Then Patients, AMA J. Ethics. 19 (2017) 508–509. https://doi.org/10.1001/journalofethics.2017.19.5.imhl2-1705.

[28] P.P. Valentijn, S.M. Schepman, W. Opheij, M.A. Bruijnzeels, Understanding integrated care: A comprehensive conceptual framework based on the integrative functions of primary care, Int. J. Integr. Care. 13 (2013). https://doi.org/10.5334/ijic.886.

[29] K. Peterson, J. Anderson, D. Bourne, M.P. Charns, S.S. Gorin, D.M. Hynes, K.M.

McDonald, S.J. Singer, E.M. Yano, Health Care Coordination Theoretical Frameworks: a Systematic Scoping Review to Increase Their Understanding and Use in Practice, J. Gen. Intern. Med. 34 (2019) 90–98. https://doi.org/10.1007/s11606-019-04966-z.

[30] C. Sausman, E. Oborn, M. Barrett, Policy translation through localisation: Implementing national policy in the UK, 2016. https://doi.org/10.1332/030557315X14298807527143.

[31] N. Senn, M. Breton, S.T. Ebert, C. Lamoureux-lamarche, Assessing primary care organization and performance: Literature synthesis and proposition of a consolidated framework, Health Policy (New. York). 125 (2020) 160–167. https://doi.org/10.1016/j.healthpol.2020.10.004.

[32] W. Hogg, M. Rowan, G. Russell, R. Geneau, L. Muldoon, Framework for primary care organizations: The importance of a structural domain, Int. J. Qual. Heal. Care. 20 (2008) 308–313. https://doi.org/10.1093/intqhc/mzm054.

[33] D.E. Watson, A.-M. Broemeling, S.T. Wong, I. Support, I.H. Authority, A Results-Based Logic Model for Primary Healthcare : A Conceptual Foundation for Population-Based Information Systems Modèle logique axé sur les résultats pour les soins de santé primaires : fondement conceptuel pour les systèmes d ' information démograph, Healthc. Policy. 5 (2009) 33–46. http://search.ebscohost.com/login.aspx?direct=true&db=cmedm&AN=21037902&lang=es&site=ehost-live.

[34] I. Huybrechts, A. Declercq, E. Verté, P. Raeymaeckers, S. Anthierens, The Building Blocks of Implementation Frameworks and Models in Primary Care: A Narrative Review, Front. Public Heal. 9 (2021) 1–16. https://doi.org/10.3389/fpubh.2021.675171.

[35] C. Grönroos, Service logic revisited: who creates value? And who co-creates?, Eur. Bus. Rev. 20 (2010) 298–314. https://doi.org/10.1108/09555340810886585.

[36] C. Grönroos, Value co-creation in service logic: A critical analysis, Mark. Theory. 11 (2011) 279–301. https://doi.org/10.1177/1470593111408177.

[37] S.P. Osborne, Public Service Logic: Creating Value for Public Service Users, Citizens, and Society Through Public Service Delivery, Routledge, New York, 2021.

[38] S.P. Osborne, G. Nasi, M. Powell, Beyond co-production: Value creation and public services, Public Adm. (2021) 1–17. https://doi.org/10.1111/padm.12718.

[39] S.P. Osborne, Z. Radnor, K. Strokosch, Co-Production and the Co-Creation of Value in Public Services: A suitable case for treatment?, Public Manag. Rev. 18 (2016) 639–653. https://doi.org/10.1080/14719037.2015.1111927.

[40] L. Plé, Why Do We Need Research on Value Co-destruction?, J. Creat. Value. 3 (2017) 162–169. https://doi.org/10.1177/2394964317726451.

[41] M. Powell, S.P. Osborne, Social enterprises, marketing, and sustainable public service provision, Int. Rev. Adm. Sci. 86 (2020) 62–79. https://doi.org/10.1177/0020852317751244.

[42] R.K. Yin, The Case Study as a Serious Research Strategy, Sci. Commun. 3 (1981) 97–114. https://doi.org/10.1177/107554708100300106.

[43] G. Kovács, K.M. Spens, Abductive reasoning in logistics research, Int. J. Phys. Distrib. Logist. Manag. 35 (2005) 132–144. https://doi.org/10.1108/09600030510590318.

[44] Regione Emilia-Romagna, DGR 291/2010 Case della salute, Bologna, 2010. https://salute.regione.emilia-romagna.it/normativa-e-documentazione/leggi-atti/regionali/delibere/archivio/dgr-291-2010-201ccasa-della-salute-indicazioni-regionali-per-la-realizzazione-e-lorganizzazione-funzionale201d/@@download/file/Dgr. 291.2010.pdf.

[45] Regione Emilia-Romagna, DGR 2016/2253, Bologna, 2016. https://servizissiir.regione.emilia-romagna.it/deliberegiunta/servlet/AdapterHTTP?action_name=ACTIONRICERCADELIBERE&operation=downloadTesto&codProtocollo=GPG/2016/2253&ENTE=1.