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Value Propositions in Public Collaborations: Regaining Organizational Focus Through Value Configurations

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There is consensus that complex problems of contemporary society call for public service collaborations. So-called public service logic (PSL) focuses on joint value creation among a multiplicity of actors in service ecosystems. Despite recognizing various actors, this logic is essentially user-centric, with the service user being the one realizing the value. Consequently, single and collaborating organizations cannot deliver value, only *potential* value, or so-called value propositions. The elusive public service logic takes a network value configuration for granted and as a starting point. Drawing from two cases in Swedish healthcare, this paper argues that two other value configurations (chain and shop) are also relevant for understanding the development of value propositions – and that these may be related to both intra- and inter-organizational processes. Theoretically, we conclude that just like public service logic, other collaborative public management theories need to recognize the importance of a multiplicity of value configurations and that these are often related to both intra- and inter-organizational processes. We conclude that managers should not adopt the latest network trends without first reflecting on the relevance of existing internal processes.

Introduction

It is commonly argued that both public administration and new public management (NPM) trajectories have helped make inward-oriented (e.g. focus on internal production processes) public service organizations (PSOs) fit to address relatively simple challenges (Ansell, Sørensen and Torfing, 2021; Osborne, 2020). This focus is argued to be less appropriate in contemporary society, in which an increasing outward orientation (such as collaborating with other organizations as well as individual citizens) among PSOs is called for (e.g. Mintzberg, 2015). The most common feature of such outwardness is probably the need to collaborate, across PSOs (Agranoff and McGuire, 2004), across sectors (Klijn and Koppenjan, 2012) with citizens (Cooper, Bryer and Meek, 2006), or with

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all of the above actors and sectors (Eriksson and Hellström, 2021).

The call for various forms of collaboration is based on the alleged complexity of the problems that PSOs are responsible for addressing (Ashworth *et al*., 2013; Bryson *et al*., 2017). The advances of modern society – such as medical and technological progress – have also brought risks (Beck, 1992): climate change, forced migration, pandemics and the like – societal and global issues paramount for the responsible PSO to solve alone (Sørensen and Torfing, 2011). These complex challenges are not only difficult to solve (Christensen, 2012; Geuijen *et al*., 2017), but also to define because of the inherent uncertainty and likely goal conflict among stakeholders (Peters and Pierre, 2017; Pollitt and Bouckaert, 2017). Consequently, since the early 1990s, many countries have implemented various forms of collaboration and networks to address such complex public challenges (Turrini *et al*., 2010).

Similarly, a variety of collaborative or network theoretical approaches emerged in the early 2000s (e.g. Agranoff and McGuire, 2004; Ansell and Gash, 2008). However, the way in which value is created in these collaborations remains under-theorized in the public administration and management literature and poorly understood in practice (Jo and Nabatchi, 2016). Recently, public service logic (PSL) (Engen *et al*., 2021; Osborne, Nasi and Powell, 2021) has gained increased attention in public administration and management literature. In PSL, value creation is an essential concept that focuses on collaborations between service provider and citizen at the micro-level (e.g. Hardyman, Daunt and Kitchener, 2015) and/or between a multiplicity of actors in public service ecosystems at the macro-level (e.g. Petrescu, 2019) in their efforts to create value.

However, the value concept is elusive. According to seminal work in service management and marketing, which inspired the early elaborations of PSL, value is not an objective construction, but should be understood to be individually determined (Grönroos, 2011; Vargo and Lusch, 2004). Moreover, value should be understood to be context-bound (Chandler and Vargo, 2011), particularly to social context (Rihova *et al*., 2013) and, consequently, value to emerge intersubjectively (Helkkula, Kelleher and Pihlström, 2012). In a public management context, PSL (e.g. Osborne, 2020) has sought to balance the original individualized conceptualization of value with so-called public value(s), a construct that focuses on value at the collective level (Moore, 1994), such as the common good or the public interest (Beck Jørgensen and Bozeman, 2007). Despite these developments, Cluley and Radnor (2020a) argued that what value is remains largely unidentified. The value concept, and the creation thereof, will be discussed further in the theoretical section below.

Thus, the developments in PSL have been important for increasing our understanding of value creation, not least by focusing on the citizen/user level – often as a pivotal actor in inter-organizational collaborations in public service ecosystems (e.g. Petrescu, 2019). However, the conceptualization of value in these ecosystems is rather elusive, which has meant that the organizational level has been left relatively unelaborated in PSL. This level is argued to be vital in order to understand the prerequisites for value creation as in the development of *potential* value – to eventually be realized as real value by citizens and other actors (Eriksson *et al*., 2020; O'Cass and Ngo, 2011; Skålén *et al*., 2018). Like other collaborative and network approaches, PSL places focus on the interface between organizations in the system. PSL also recognizes the individual citizen or service user to be essential in these collaborations, and in realizing value from value propositions. We argue that both these foci are important, but that the organizational focus has become lost. Just as in other collaborative theories (Span *et al*., 2012), it is assumed that value creation in PSL builds on a network idea. We argue that network is just one configuration for creating value, and the other configurations may influence a joint value proposition. Therefore, building on two empirical cases, this paper seeks to put the focus on three different value configurations (network, chain and shop) that are essential for the organization to develop value propositions – both directly with other public organizations and indirectly as organizational conditions that influence collaborations with other actors in the ecosystem. Thus, the research question of this paper is: *How do different value configurations influence the development of potential value through public service organization collaboration?* Again, the word 'potential' is used because it is a premise in PSL that the individual user realizes value.

The paper proceeds as follows. The theoretical background offers an overview of the

collaboration field, followed by a section on value creation. We then present the three ideal types of value configuration, which we use to analyse the empirical material. The methods section presents data collection and analysis, followed by the results from the two cases in the findings section that illustrate different value configurations. The discussion theorizes value creation in collaborations by analysing how the value configurations influence value propositions through collaboration. The paper concludes with implications for research, as well as policymakers and practitioners.

Theoretical background

Collaborations in the public sector

There is general consensus that, in an increasingly complex world, there is a similarly increasing need for collaboration (Cristofoli, Meneguzzo and Riccucci, 2017), not only to improve a particular public service, but to solve meta-problems of public service delivery (Keast and Brown, 2002). Thus, collective impact is sought, rather than leaving the issue at hand to be solved by the responsible PSO alone (Denhardt and Denhardt, 2015; Pollitt, 2003). For example, in healthcare, which is our studied case, value is seen as being created in complex constellations, which involve many different actors in the patient's health service network, rather than just one PSO alone (Nordgren, 2015). It is also argued that the need to coordinate fragmented services is a consequence of past trajectories (Christensen and Lægreid, 2011), such as decentralization of accountability of NPM (Andersson and Liff, 2012). Collaborations are proposed to be viable only when the advantages of the collaboration are clear (Åhgren, 2014) and when inter-organizational interaction entails purposive forms of service integration (Åhgren and Axelsson, 2005; Nordgren, Planander and Leifland, 2020). Ideally, the benefit of these collaborations includes more appropriate use of common resources and improved service delivery to citizens (Koliba *et al*., 2017; Meier and O'Toole, 2003). Collaborations may also help participating PSOs achieve their own goals (Christensen and Lægreid, 2015; Ferlie, 2017), as well as goals shared with the other actors (Koliba *et al*., 2017; Willem and Lucidarme, 2014). However, a benefit is that (successful) collaborations may nurture further collaborations by learning from one another, generating trust (Agranoff and McGuire, 2004; O'Leary and Vij, 2012).

Despite the potential, collaborations involve numerous challenges. For instance, collaborations may decrease PSOs' accountability and transparency and may lead to increased conflict and deadlock (Sørensen and Torfing, 2009). Moreover, the presence of the authorizing environment and the bureaucratic structures of each organization are often evident, entailing differences in prioritization, goals, legislation and culture between the participating organizations (Agranoff and McGuire, 2004; Klijn and Koppenjan, 2012; Willem and Lucidarme, 2014). Moreover, the informal ideal of collaborations entails fragility because of the dependence of individual enthusiasts and an unaccustomedness to work informally among the participants. The informality may also entail a stronger focus on participating individuals, which means that the differences in status, power and mandate they bring to the table become an important factor (Agranoff and McGuire, 2004). However, the inter-personal dimension in collaborations, as part of the organizational level, remains under-theorized (Cristofoli, Meneguzzo and Riccucci, 2017).

Naturally, the structure of collaborations may differ. In a seminal paper, Provan and Kenis (2008) presented three types of collaboration. In the first, all participating organizations share responsibility in an informal and decentralized way. In the second, one organization takes the lead in a centralized and formalized way, managing the network. In the third, a centralized and separate administrative entity is created to govern the network in a formalized way. It has been argued that coordinating mechanisms become more important in decentralized collaborations, whereas the presence of a lead organization tends to entail more traditional managerial activities and control in practice (Markovic, 2017). Because the ideal of informality, non-hierarchy and consensus is often the point of departure of research on collaborations, the presence of top-down aspects is often neglected (Span *et al*., 2012). Moreover, the collaborative ideals may be hampered and rejected in a context in which managers still draw from traditional public administration and NPM (Hansen and Waldorff, 2020).

However, it is commonly argued that traditional management may be ill fit in collaborations in which an 'integrative leadership' approach (Crosby

and Bryson, 2010) may be more appropriate, focusing on stimulating interaction between participants, exchange of resources and how to design a service with respect to the common goal (Crosby, Hart and Torfing, 2017). In practice, collaborations may be governed by 'distributed leadership' (Crosby, Hart and Torfing, 2017), in which employees without formal managerial authority are expected to lead as coordinators, facilitators, mediators and so forth (Bryson *et al.*, 2017; Cristofoli, Meneguzzo and Riccucci, 2017; Eriksson *et al.*, 2020). Connective capacities are essential for this role (Edelenbos, van Buuren and Klijn, 2013), including stimulation of interactions, building trust and commitment, solving conflicts and leading the network towards a common goal (Klijn, Steijn and Edelenbos, 2010). However, the difference between the goals of the participating organizations must be recognized as well (Vangen, 2017).

It is argued that organizational learning may be better in bureaucratic networks than in collaborative ones (and other 'post-bureaucratic' organizations), due to the absence of a stable core in the latter (Andersson, Stockhult and Tengblad, 2021; Pollitt, 2009). However, Ferlie *et al.* (2011) found that a long-term career in a network offered a stable core that enabled organizational learning and memory in post-bureaucratic organizations, such as team-based leadership (rather than individual) among healthcare professionals (Martin, Currie and Finn, 2009).

In sum, collaborations in the public sector have often focused on structure and leadership, and more recently, on aspects such as trust and relationship (Cristofoli, Meneguzzo and Riccucci, 2017). Collaboration is often assumed good per se: '[c]ollaboration has become a hammer and nearly all problems have become nails' (Silvia, 2018, p. 472). However, collaboration is only relevant if it has the potential to develop potential value, including better organizational performance, outcomes or lowered costs (Agranoff, 2007; Bardach, 1998; Kenis and Provan, 2009; Klijn, Steijn and Edelenbos, 2010; Sørensen and Torfing, 2009). Nylén (2007) argued that collaborations should be evaluated more on value creation than cost effectiveness. The value creation in collaborations has often been taken for granted, focusing research on *how to collaborate* instead of the more specific *how to collaborate to develop potential value*.

Value creation in collaborations

The emerging PSL stems from a critique of NPM's alleged inherent manufacturing logic, in which PSOs have been organized as if they produce and deliver tangible goods, and has led to an internal focus on processes (Grönroos, 2019; Osborne, 2018). In (public) services, the production and consumption processes cannot be separated (Osborne and Strokosch, 2013; Osborne, Nasi and Powell, 2021) as the service is intangible and occurs in the service meeting when provider and service user interact (Normann, 2001). Consequently, the user is always a co-producer in a service approach, entailing that the relationship and interactions between staff and user are crucial (Eriksson, 2019). Recently, Cluley and Radnor (2020a) challenged the dominant focus of value co-creation on provider–user interaction and proposed a framework that focuses on value co-creation as a continuous – and relational, fluid, heterogenous and changeable – process rather than an interaction or outcome, composed of a multiplicity of elements: human, environmental, cultural and material.

Rather than producing and delivering value, PSOs can only offer potential value, so-called value propositions (Grönroos, 2019; Skålén *et al.*, 2018); these value propositions sometimes need to be coordinated among several organizations (Eriksson *et al.*, 2020). Value is then realized in the user's life situation, which means that the PSO's potential value is combined and integrated by the user with other actors' potential value offerings and resources, including knowledge, skills and so on from friends and family, private enterprises and third-sector organizations (Osborne *et al.*, 2015). Thus, value is a subjective phenomenon that will vary between different people and change over time (Cluley and Radnor, 2020a).

Lately, PSL has increasingly focused beyond the provider–user interface to include a number of actors participating in the collaboration of mutual value creation (Petrescu, 2019). Thus, value co-creation in these public service systems includes actors from public, private and third sectors, as well as citizens/service users (Eriksson and Hellström, 2021; Osborne *et al.*, 2015). The premise is that all actors engage in mutually beneficial value creation in which they contribute with various knowledge and skills (and physical products) (Kinder *et al.*, 2020; Petrescu, 2019). Recently, it has also been recognized that value at the different levels

(individual users, groups and society) needs to be recognized in these public service systems (Cluley, Parker and Radnor, 2021; Dudau, Glennon and Verschuere, 2019). Consequently, public services are not only a concern for the responsible PSO, but also require the involvement of all system actors (Osborne, 2020; Radnor *et al*., 2014). Again, because value cannot be delivered in PSL – neither as products, nor as policies – it is important to understand how combinations of resources are used by the actors (Osborne, 2020).

The recognition of value at the three levels (individual users, groups and society) also entails that perceptions of value between levels may be in conflict (Eriksson and Nordgren, 2018). In addition, value perceptions may vary within each level: for instance, individual public service users (prison inmates, for instance) and citizens are likely to perceive different benefits from public prisons (Osborne, 2020), and value perceptions may vary between collaborating organizations (De Graaf and Van der Wal, 2010). Moreover, it is often assumed in PSL that public service users are rational actors, which is not a matter of course (Cluley and Radnor, 2020b). In addition, in a public sector context, it should not be assumed that beneficial outcomes are always the case (Engen *et al*., 2021; Voorberg, Bekkers and Tummers, 2015). Consequently, there has been a call for a more nuanced understanding of value and the creation of value (Dudau, Glennon and Verschuere, 2019) in public management; for instance, to recognize that value should not be assumed to be created equally for all, but that disvalue (Cluley, Parker and Radnor, 2021), value destruction (Järvi, Kähkönen and Torvinen, 2018) or value diminution (Vafeas, Hughes and Hilton, 2016) is as likely an outcome (for one or more actors across levels) as creation of value.

In sum, value creation in PSL has shifted the focus from the provider–user sphere to public service ecosystems. In both cases, however, only the individual actor can realize value by combining potential value provided by others (the PSO, family and friends, etc.). Like NPM, PSL draws on developments in the private sector. Consequently, much of the elaboration has been about the difference between private and public sector: besides individual value, collective or public value is essential for PSOs (Alford, 2016). A returning 'customer' is good news in the private sector, but a returning client to a social service office may be understood as a service failure (Osborne, 2018); the reluctance, fear and discomfort among public service users (e.g. patients, prisoners) are likely to be higher than for private sector users (Eriksson and Nordgren, 2018). PSL has added important aspects to value creation, but the focus on the individual customer and/or ecosystems has meant that the organization of the value proposition, or development of potential value, has not received sufficient attention.

Value configurations

We argue that PSL – by focusing on distancing itself from NPM – neglects previous models of value creation that have their merits. Instead, different situations and problems require different types of value creation. For example, not all problems, even in collaborations, are to be considered complex, many intra- and inter-organizational processes developed to solve particular problems (not complex) are likely to be valid. In this subsection, we present three ideal types of value configuration that are all relevant for collaborations and that we use to analyse the empirical material.

In the 1990s, Stabell and Fjeldstad (1998) presented their three ideal types of value configuration that are generic across sectors: value chain, value shop and value network. In a Weberian sense, *ideal* should not be understood as 'better', but rather as 'pure', which means that, in practice, versions and combinations of the configurations are likely to be found.

The value shop is appropriate when the problem is diffuse, hard to define and the focus is on problem definition by gathering competences. This is the traditional way of organizing healthcare, a legacy from an era when the causes of illness were rather unfamiliar (Stabell and Fjeldstad, 1998). In the shop, individualized solutions to the problem are needed when users seek public services with manifestations that are hard to attribute (Christensen, Grossman and Hwang, 2009). Rather than sending the public service user around between various PSOs, in the value shop, competences and expertise are gathered and various examinations/tests are carried out more or less at the same time. Thus, value creation through a value shop stipulates 'value is created by mobilizing resources and activities to resolve a particular customer problem' (Stabell and Fjeldstad, 1998, p. 414).

The value chain (Porter, 1985) attracted increased attention in the 1990s in order to mitigate the fragmentation caused by silo-ization in many bureaucratic organizations (Christensen and Lægreid, 2011; Pollitt, 2003). In the chain, value is added in pre-defined steps in a linear process of refinement (Stabell and Fjeldstad, 1998). The value chain has been shown to be appropriate in cases where the problem is known and standardization and best practice may be the most appropriate way to organize services. Thus, the chain requires that problems can be solved with great precision and in the same way for most users. The impact of the chain in public services has been massive and claimed to have been a positive contribution to the public sector, even by PSL proponents (Osborne *et al*., 2015). However, too much focus on measuring quantifiable output has been criticized for having reduced the trust in public employees, and increased the administrative burden on them (Quist and Fransson, 2014).

The value network is particularly advantageous in long-term services, such as chronic diseases, where the patient can take great personal responsibility for managing their disease, but still needs support in various forms from PSO experts – often assisting with a network through which public service users can support each other and through IT solutions that report and receive feedback from professionals (Stabell and Fjeldstad, 1998). The network configuration is increasingly mentioned as a form of care suitable for elderly people with multiple illnesses (Eriksson *et al*., 2020), but is also applicable to more preventive measures.

A few years before Stabell and Fjeldstad (1998), Porter's value-chain model was criticized by Normann and Ramírez (1993). Instead, they proposed that value was co-created in value-creating systems as 'synchronic and interactive, not linear and transitive' (Ramírez, 1999, p. 50) and involved a multiplicity of actors who reconfigured their roles and relations to create value in new forms (Normann and Ramírez, 1993). The systems understanding of value creation – underpinned by its technological development – entailed that the potential role of the service users in particular broadened in relation to *what* they can do, *where* they can do it, *when* things can be done and with *whom* (Levin and Normann, 2001; Normann, 2001).

Methods

Setting

The empirical material draws from two cases in Swedish public healthcare, in which collaborations are central. The cases – cancer care and elderly care – demonstrate the complexities in aging societies in which an increasing proportion of the population is older and suffers from multiple and chronic illnesses, while at the same time the workforce decreases (Osborne, 2020). This particularly puts mainly tax-financed healthcare systems under strain. Hence, the changed population structure and disease panorama also require healthcare services to change.

Both cases are set in Västra Götaland, Sweden's second-largest region, located in the southwestern part of the country. In the decentralized and mainly tax-financed Swedish healthcare system, the main responsibility of the regions is to provide healthcare to their inhabitants (1.7 million in Västra Götaland and 10.4 million in Sweden in total; Statistics Sweden, 2021) in public hospitals and primary care units. Within each region, the municipalities' responsibilities include providing elderly care at public institutions or their homes. At both levels, there are private and third-sector actors that provide care on behalf of, and compensated by, region or municipality, respectively. At an overarching level, national governments and agencies stipulate laws, directives and recommendations for all 21 regions and 290 municipalities in the country.

The first case (hereafter referred to as Case A) is set in cancer care and covers the whole of the present region (as well as the northern parts of another region). A national cancer strategy was launched in 2009 (Statens offentliga utredningar, 2009). A central feature of the strategy of western Sweden was the appointment of clinically active physicians as so-called process-owners of their respective team, often based on cancer diagnosis. The second case (hereafter referred to as Case B) is set in elderly care and covers 15 of the region's 49 municipalities. In Case B, management and employees at municipalities, primary care and hospitals developed a care model for the elderly with chronic and multiple diseases based on collaboration, trying to bridge a fragmented and poorly coordinated system (Statens offentliga utredningar, 2020). The collaboration consisted of

Table 1. Respondents' backgrounds and data collection

Case	Type of healthcare	Data collection	Number of respondents	Profession
A	Cancer care	Focus groups, semi-structured	18	Process-owners (all physicians)
B	Elderly care	Individual interviews, semi-structured	34	Managers, coordinators, staff in teams (physicians, nurses, nurse assistants)
Total			**52**	

three levels: the management network, the learning network in which practitioners on the floor shared experiences and mobile teams at the patients' homes. The coordinators held collaborations together, both vertically and horizontally.

Data collection and analysis

In Case A, five focus group interviews with the process-owners were conducted. Between three and five process-owners participated in each focus group. In total, 18 process-owners participated in the semi-structured focus groups. All groups had mixed gender representation, with a total of 8 women and 10 men. In Case B, 34 individual and semi-structured interviews were conducted with managers, healthcare staff and coordinators. Focus groups and interviews for both cases were recorded after verbal consent had been collected and transcribed verbatim after the interviews. See Table 1 for respondents' backgrounds and data collection.

Thematic analysis for the two cases was carried out, similar to the procedure of template analysis (Brooks *et al*., 2015; King, 2012) with seven steps: (1) *familiarization* with the data in which transcripts and recordings were listened to and discussed; (2) *preliminary coding*, categorizing data based on similarities and in relation to purpose, research questions and close to expressions used by respondents and also in developing *a priori* themes (tentatively defined themes based on theoretical interest; in this paper, the value configuration literature; e.g. Stabell and Fjeldstad, 1998); (3) *clustering* themes based on similarities to and differences from second-order themes; (4) producing an *initial template* that links clusters together; (5) *developing the template* by applying it to further transcripts and modifying themes in an iterative way; (6) *applying the final template* on the remaining material; and (7) *writing up* (King and Brooks, 2017). Deviating from the procedure, in the final step the second-order themes were sorted into dimensions based on the three different value configurations (shop, chain and network). Some themes were omitted (for instance, themes addressing problem types and solutions to address these problems, as they were not clearly found in the empirical material, but were central in the value configuration literature). Other aspects were given more room than is typical in the respective configuration; for instance, trust is a key feature in contemporary Swedish public administration and was widely discussed by the respondents. For validation (Lincoln and Guba, 1985), and to ensure that nothing was misunderstood or that empirical material was not 'forced' into *a priori* themes based on theory, tentative themes were presented for stakeholders (and many of the respondents) on various occasions to ensure they recognized the data and the themes. Figure 1 shows the final second-order themes, primary coding categories (expressions close to the interviews/focus groups) and overarching dimensions (constructed based on the three ideal types of value configuration).

Findings

In this section, different value configurations in the cases are illustrated. More specifically, the dimensions and themes in Figure 1 are presented. First, the shop dimension and connected themes will be presented for each case, followed by the chain and network dimensions and their respective connected themes, which are also presented for each case. By way of introduction, Table 2 offers typical examples of quotes from the qualitative data collection: the focus group discussions (Case A) and individual interviews (Case B).

Shop: Professional knowledge

In Case A (cancer care), an explicit reason for launching process ownership was to move away

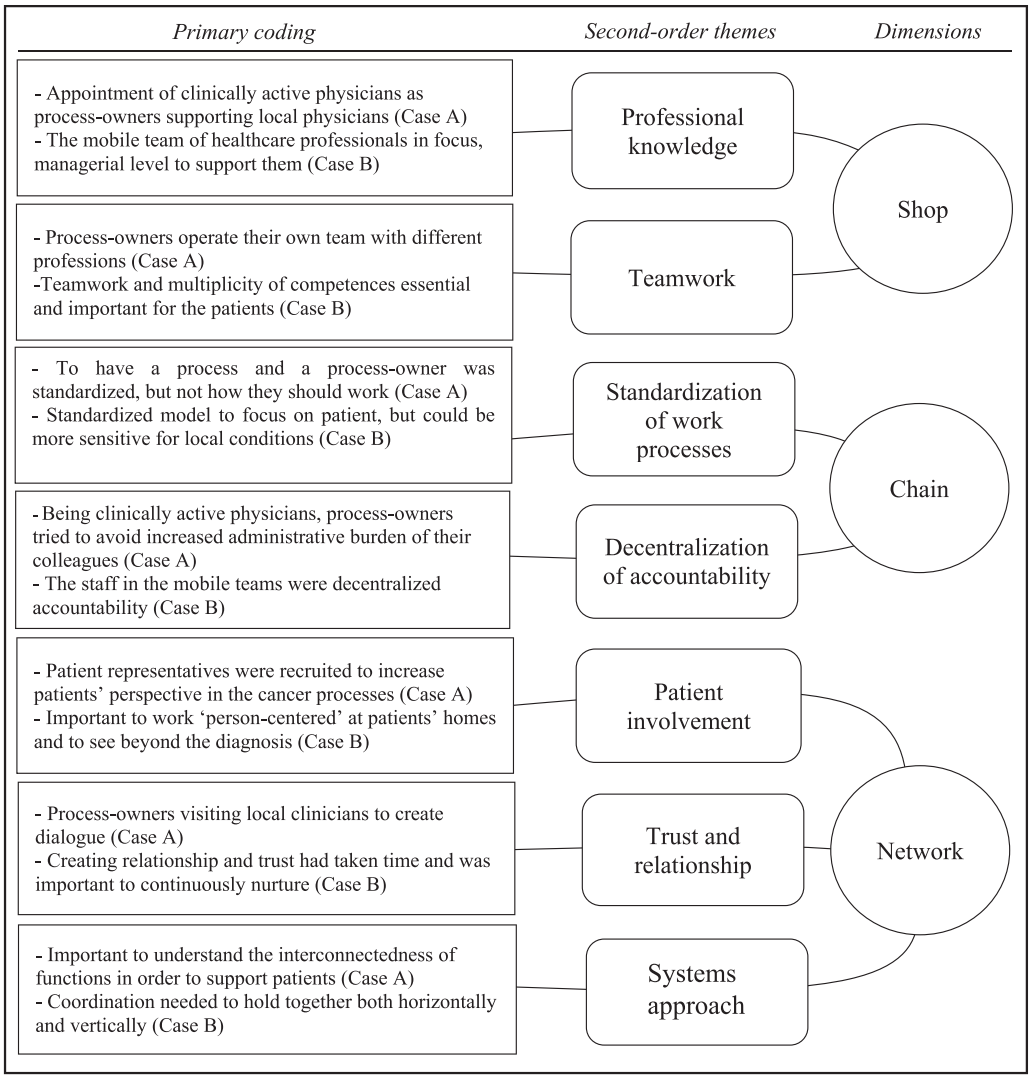

Figure 1. Data analysis

from managerialism and let the professionals in healthcare have a greater say. The process-owners were supposed to be clinically active physicians with responsibility for developing and disseminating knowledge about their particular field. Other than that, the cancer centre let the process-owners themselves decide how to run their respective processes and put together their process team, often represented by various professions from different hospitals in western Sweden. The cancer centre's staff supported the process-owners by such means as providing statistics, training and education, and facilitating networking meetings, as well as administering travel expenses and so on. The *professional knowledge* applied not only to the process-owners themselves. Many responding process-owners said that an important task was to 'lend a helping hand' to the hospitals, enabling local clinicians to have a greater impact on their job.

In Case B (elderly care), concerning *professional knowledge*, managers mentioned that they should not 'interfere with the process', but should rely on the professionals on the floor to do their work. However, it was also mentioned that traditional ways of working made it difficult and 'unnatural' for general practitioners to work at older patients' homes, because they were trained to work with diverse patients – not only older patients – and to have colleagues to discuss issues with. This was a

Table 2. Quotes from the two cases

Dimension	Quote
Shop	*… we work with very engaged people, who want to do their best, and therefore you don't need to force them to do things… if we can show and convince them that it is good for our patients, then we don't need any imposed regulation*. (Process-owner and physicians, Case A) *It is hard to reach teamwork if we are always at different physical places. The closeness in everyday work, just to sit down with a cup of coffee and discuss patients… that does not really work*. (Manager, Case B) *We should not interfere with the process*. (Manager, Case B)
Chain	*… her boss says that this* [reporting to the register] *is of a low priority and then one starts to wonder what kind of mandate that one is having*. (Process-owner and physicians, Case A) *… some think we are nagging* […] *they all have lots to do* […] *so when they don't manage to report* [performance measures] *it is because they don't have time for it*. (Process-owner and physicians, Case A) *We physicians are very competitive, we want to be the best in class, right? There's nothing wrong in being compared with others*. (Process-owner and physicians, Case A) *It's a darn measuring of minutes and seconds all the time, we are clocked all the time*. (Nurse assistant, Case B)
Network	*… when talking to people one realizes that seeds have been sown and things start to happen* […] *people think more over organizational borders now*. (Process-owner and physicians, Case A) *… we have some very active ones and I always get a little thoughtful about these people that always comes back, that always wants to participate* […] *those I call 'professional patients' that I am not too fond of. How do you find the 'right' persons?* (Process-owner and physicians, Case A) *When relations are established and you know your role, then I believe that this kind of work runs rather smoothly, both management and on the field. You cannot just write a manual and everything will work*. (Manager, Case B) *It is so much and eventually one does not know what is what. I, who sits in the middle of this system, hardly understand anything*. (Manager, Case B)

reason why it had been difficult to recruit general practitioners to these teams.

Shop: Teamwork

In Case A, *teamwork* mainly addressed their own process team, consisting of various professions.

In Case B, physicians, nurses and nurse assistants from hospitals, primary care and municipalities would ideally treat patients at home in collaboration. One physician mentioned the importance of the collaborations and relationships with other staff at patients' homes, but another said it was difficult for physicians to be part of the group of nurses. However, *working in teams* was essential for the patient group with multiple and chronic illnesses. When all staff participated, most nurses and nurse assistants considered the collaboration to be good. However, even though official documents stated that nurse assistants should participate in these meetings, many of them were not involved, and some interviewed nurse assistants did not know that the teams existed and had bumped into the nurse/physician at a patient's home by coincidence. The nurse assistants said, 'the physicians do not really exist in our world' or 'we are at the bottom of the ladder'. More team meetings between assistants, nurses and physicians were required, as were more rehabilitation staff, to address a holistic view of clients that incorporated social, medical and spiritual aspects.

Chain: Standardization of work processes

In the cancer case, traditional healthcare organization based on medical specialization – and thus human anatomy – caused various problems, not least an inability to address the patient's holistic medical situation. Introducing *processes* through training and education to the newly appointed process-owners was an attempt to bridge units and cut across silos. However, many process-owners mentioned that their role sometimes came into conflict with traditional, more 'bureaucratic' or 'chain-of-command', aspects of healthcare organization. These process-owners felt they lacked a mandate because they were not responsible for either economy or staff at the hospitals. Others argued that this was an enabler for value creation since they could focus on 'creating dialogue'. It was *standardized* that there should be processes run by clinically active physicians as process-owners, but

not how they were supposed to run their respective team. However, it was standardized on the next level of abstraction in which the process-owners of the different cancer processes met continuously to exchange experiences and learn from each other. There was a sense of 'connection' and 'creating identity' in these meetings, that there were others doing the same thing. Many had created similar arenas for their respective cancer process.

In the case of elderly care, the different organizations had tried to collaborate for years, but when they started to map the *process*, it became evident that no organization could see the complete patient journey and that collaboration was necessary if they were to have a holistic approach to care of the elderly. The model had started in a few municipalities and then spread in the rest of the area. Some of the municipalities mentioned that the *standardization* was good, since it clearly put the patient at the centre and was a model that had obviously worked elsewhere. Others were critical of the adopted model, arguing that little consideration was given to local prerequisites and already established collaborations.

Chain: Decentralization of accountability

In the cancer case, the local clinicians were *accountable* for registering data, but reporting rates among the local clinicians were sometimes too low. Because the process-owners did not have a mandate, they felt that they were not in a position to require local clinicians to improve data reporting. Some clinicians did not report sufficiently because of a heavy workload, and asking for data could not only add to the stress but also take the focus off treating patients. Being active physicians themselves, the process-owners understood everyday work and could be careful not to place a burden on their colleagues: 'It is easy to measure, and it can be misused'.

In the elderly care case, the decentralization of staff working close to the patients (physicians, nurses, nurse assistants, rehabilitation personal) was an important aspect of decentralization of accountability.

Network: Patient involvement

In Case A, the process-owners had also added patient-reported data to the traditional medical data. *Patient involvement* was also included in more qualitative ways. For instance, some process-owners had recruited patient representatives in their teams, which had been important for identifying areas in need of improvement; for example, by bringing attention to situations in which patients risked falling through the cracks between organizational units, as well as providing feedback on printed information to patients. However, finding patients to involve was difficult and those willing to participate were 'not exactly the weak patients'. Some of the process-owners were more sceptical about patient involvement, arguing that collecting patient-reported data was a 'political thing' or 'politically correct' rather than being based on medical evidence.

In Case B, official documents and coordinators also mentioned the need to work in a 'person-centred' manner and to see the whole person, not only the diagnosis, and with *patient involvement* in the teams. The nurse assistants explained that the broader life situation, everyday situations, relatives and so on had to be taken into account in their everyday work, but that no one had asked them how the teams should work in a 'person-centred' way.

Network: Trust and relationship

In the cancer case, the first year as a process-owner had been spent travelling around western Sweden to meet the local hospital representatives in order to 'get an understanding' of how they worked and to establish dialogue with the local physicians to create *trust and relationship*. That the process-owners themselves worked clinically 'made dialogue easier' and created 'trust among colleagues'. Ideally, the collaboration with local clinicians created a sense of 'doing something together' and enabled more direct and honest communication. To some, having 'history in the field' helped them gain 'authority' in contacts with other clinicians, whereas others felt that having a 'history' meant they had 'more enemies than friends' among the local professionals.

In the elderly care case, the collaboration between the three organizations was said to have developed over time. In the first years, the organizations were stuck discussing organizational responsibilities and boundaries. Over time, a *relationship* developed between the participants and *trust* grew, which made the process of addressing issues and improving services much smoother. It was argued that the organizations had to

continually nurture the relationship by discussing and understanding each other's rules and tasks to maintain trust. When functioning ideally, the collaboration meant that clients received better care and treatment by meeting many professionals from different organizations at the same time, not least the nurse assistants, who were often the staff members the clients knew best.

Network: Systems approach

In the cancer case, the cancer centre emphasized the cancer care *system*, often by using a picture of an aqueduct: the patient's journey in the upper furrow, supported by clinicians in the upper vault and continuously, with each vault existing to support the level above. Many process-owners agreed with the interconnectedness and how things 'hung together' at the same time, highlighting that 'knowledge and interest derive from the floor' and that 'we are supposed to do things for the patient'.

In Case B, the *system* supporting care of the elderly consisted of various networks: management network represented by managers and politicians (local and 'regional' networks existed, but the distinction is not important here). These networks were important for discussing problems at the local level and understanding each other's perspectives. In learning networks, staff working at homes met to share experiences, and at local levels, the teams themselves met. Coordinators were supposed to hold together both horizontally and vertically and were described as a bridge between managers and teams. This was especially important in the beginning – to hold the collaboration between organizations and professions together – but it is important not to be a burden or 'control apparatus', but rather to absorb difficulties at local levels and pass on updated information.

Discussion

We analyse how the value configurations influence value propositions through collaborations. It is highlighted that a strict focus on the network value configuration is too narrow when aiming to develop potential value in public service collaborations. When focusing on the organizational level of the studied PSOs, it becomes apparent that the development of potential value is also dependent on the shop and chain value configurations. Each value configuration serves a different purpose, and therefore enables different 'building blocks' for potential value creation through value propositions of PSO collaborations. By utilizing the ideal value configurations suggested by Stabell and Fjeldstad (1998), the findings of the present paper propose that public service collaborations – and hence research concerning the newly emerged PSL (Engen *et al.*, 2021; Osborne, Nasi and Powell, 2021) – must acknowledge that distinct value configurations influence each other and describe different organizational processes that, in concert, hold potential to facilitate the creation of the value propositions for the end user/citizen.

The shop is likely to be more appropriate when the problem to be solved is diffuse and a considerable amount of expertise is required to quickly identify the causes of the problem (Christensen, Grossman and Hwang, 2009). Empirical examples of this are found in both cases, but most prominently in Case B, in which physicians, nurses and nurse assistants worked around elderly patients for optimal treatment in their homes rather than sending patients back and forth between healthcare specializations. It is likely that the professional knowledge of the shop is more prominent when knowledge that is more specialized is required to define the needs and problems of public service (Ferlie, 2017). Management's trust in the professionals' expertise ethos (Denhardt and Denhardt, 2015) has been central in the Swedish discourse over the last decade (e.g. Statens offentliga utredningar, 2019), in which the need to increase the professionals' autonomy in the public sector has been emphasized. Consequently, professional-led collaborations have been encouraged. The emphasis on trust in our Case B in cancer care shows similarities with the managed clinical networks in UK cancer care (Addicott, McGivern and Ferlie, 2007), in which professional collaborations are 'managed' in both cases by the professionals themselves and in which trust is a critical component. The empirical data illustrate how the creation of the value propositions is contingent on the reliance on professional knowledge and teamwork, which highlights the prospect that the shop configuration may hold in practice.

However, this has proved easier said than done. The traditional public administration, with its hierarchies and rules, has not always been easily combined with professional autonomy; features of the chain brought about by the NPM

paradigm – in which standardization of processes has sought a one-size-fits-all model at the same time – hinder autonomy (Hellström, Lifvergren and Quist, 2010), as seen to various degrees in both empirical cases. The administrative burden of staff to report output (Moynihan, Herd and Harvey, 2015), typical of the chain configuration, may be somewhat counteracted if those with expert knowledge rather than managers also decide what to report and what may not even need to be reported (Ferlie *et al*., 2016). However, the empirical data also highlight the benefits of the chain configuration in its ability to convey, both within the studied PSOs as well as across organizational boundaries, a clearer understanding of how various actors' actions have to be efficiently connected in order to successfully cater for the needs of the service user.

A systems perspective is central in the networked configuration, which recognizes the active role of a multiplicity of actors (Fjeldstad *et al*., 2020), as seen in both cases. This is deemed necessary in order to gather resources provided by the responsible PSO, but also when knowledge and skills are required from other actors or when responsibility is unclear, such as for many contemporary challenges (Sørensen and Torfing, 2011). The required knowledge and skills may also include the citizens or public service users. This perspective may not be easily combined with the professional knowledge of the shop, not least because it may interfere with expectations about what public employees and public service users should do (Eriksson, 2019; Osborne, 2020). Relatedly, the notion of individualization in public services – as in modern society overall (Beck, 1992) – promoted by sector-specific concepts (such as patient or person-centredness in healthcare; Andersson and Liff, 2012), is not easily combined with the standardization feature of the chain (Stabell and Fjeldstad, 1998). Despite these inherent challenges, the findings of this paper show that the network configuration has potential to develop the value proposition for the user/citizen through facilitating a systematic approach towards service delivery characterized by trusting relationships and patient involvement.

Collectively, the shop, chain and network configurations emphasize that processes within and between organizations are essential for developing potential value in collaborations. This focus on the organizational level is typically and deliberately avoided by PSL (Grönroos, 2019; Osborne, 2018). Instead, the focus of PSL is either on citizen/public service user or diffuse public service ecosystems (e.g. Osborne, 2020). In doing so, important aspects regarding the way in which the organization – either alone or jointly with other organizations – develops its value propositions, as potential value that the actors concretize to real value (Eriksson *et al*., 2020; Skålén *et al*., 2018), have been left unelaborated, both in theory and in practice.

The PSL literature is often overly positive about the notion of value creation (Cluley, Parker and Radnor, 2021; Dudau, Glennon and Verschuere, 2019) and we believe that the value configurations may help to increase understanding of the complex factors that influence organizations' ability to develop joint value propositions. For instance, the assumptions that value is mutually created in public service ecosystems by resource-integrating actors (Eriksson and Hellström, 2021) builds on an ideal that is also prominent in the general collaboration literature, in which non-hierarchy and informality are assumed (Span *et al*., 2012). However, the empirical cases show that the presence of bureaucratic structures, managerial top-down aspects and standardized one-size-fits-all solutions is a reality in these collaborations. In this sense, different value configurations might both facilitate and hinder value propositions through PSO collaborations (cf. Cluley, Parker and Radnor, 2021). As Provan and Kenis (2008) have illustrated, formal structures are often needed to support collaboration, and it is important that formalization supports collaboration rather than making it more difficult.

As the inter-organizational collaborations are not always self-organized, coordination may often be essential. In both cases, a new administrative unit was created (the process ownership and the coordinators in Cases A and B, respectively) to govern the network (Provan and Kenis, 2008). The idea that this type of centralized collaboration entails more traditional managerial features (Markovic, 2017) is shown, to a certain extent, in the empirical material, in which reporting of the value chain's output was central in the narratives, but it also avoids one single organization fully controlling the network and thereby creates better conditions for meeting the interests of all organizations, as it avoids too much competition between different organizational value configurations.

Moreover, the under-theorized (Cristofoli, Meneguzzo and Riccucci, 2017) interpersonal

dimensions of collaborations were also clear in both cases. Shop configuration and professionalization may be an ideal, but it may also be difficult for some professions to be involved in the teamwork (such as the physician 'being part of the gang' with the nurses), as well as for some professions to access leadership (process ownership was for physicians, not nurses). Thus, the differences of mandate and power in collaborations (Agranoff and McGuire, 2004) within organizations and between organizations should not be neglected, as these are likely to impact potential value creation. In relation to this, the choice to lead, not only from professionals, but also from those with long-term careers in the collaborations (Ferlie *et al*., 2011), may be important to maintain the organization learning and retention of important values and norms that are important in order for collaborative networks to last over time (Andersson, Stockhult and Tengblad, 2021; Pollitt, 2009). Our study shows how organizational learning and retention of important values are essential intra-organizational processes that support value creation through collaboration over time.

PSL makes little mention of leadership, and it is clear that, in collaborations, another type of leadership is required. In both cases, an 'integrative leadership' (Crosby and Bryson, 2010) was found among the managers, arguing that it was important to facilitate interaction between participants. The process-owners mentioned that they often lacked a formal mandate and that this 'distributed leadership' (Crosby, Hart and Torfing, 2017) was sometimes difficult, but also an enabler as it could focus more on creating trust – an essential feature in a network configuration (Fjeldstad *et al*., 2020). Whereas Crosby and Bryson (2010) emphasized integrative leadership as an inter-organizational phenomenon, our study adds that integrative leadership also constitutes intra-organizational processes that might facilitate value creation through collaboration.

Conclusion, limitations and future research

This paper has broadened the scope of the factors that influence value propositions through collaboration by illustrating how the value configurations of shop, chain and network distinctly influence the collaboration and the value propositions. Each configuration highlights different inter- and intra-organizational processes, within and between organizations, which serve different purposes in forming the value proposition. The shop configuration underscores the need to acknowledge professional knowledge and teamwork as central; the chain configuration contributes by accentuating the need for actors' actions to be connected; and the network configuration is vital for facilitating trusting relationships and patient involvement. Despite the configurations' inherent differences, they all influence value propositions that are later realized into real value by the public service users (and other actors in the public service ecosystem). Focusing on the organizational level in value creation is an essential perspective when value creation offered by PSL emphasizes abstract public service ecosystems or the citizen. The contribution to practice and policy is the importance of recognizing a multiplicity of loci for value creation in collaborations.

This paper has several limitations. First, the focus has been on value creation, not the central issue in general PAM literature (Moore, 1994), as well as the developments of PSL (Alford, 2016), of what value *is* in a public administration context. Thus, future research could connect the value configurations to perceptions of value at different levels: public, individual and potential in-between levels (e.g. Eriksson and Nordgren, 2018). Second, the empirical material draws from a Swedish context only, and only cases from healthcare. The decentralized healthcare system, relatively long-term NPM implementation and consensus orientation in public administration (Christensen and Lægreid, 2002; Wiborg, 2015) are but a few aspects that make the Swedish case less typical, in some respects at least. Thus, similar research on value creation in collaborations in other public services and in other countries is likely to be needed.

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