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Whose responsibility is it anyway? Unpacking prevention during service delivery to support value co-creation

Kirsty Strokosch[a], Michael J. Roy[b] and Jennifer McLean[c]

[a]Department of Work, Employment and Organisation, University of Strathclyde, Glasgow, United Kingdom; [b]Stirling Management School, University of Stirling, Stirling, United Kingdom; [c]Glasgow Centre for Population Health, Glasgow, United Kingdom

ABSTRACT

Preventive reforms typically emphasize individual responsibility or the mobilization of community assets, but an enduring implementation gap exists. The ongoing stalemate calls for a fundamental shift in the way public services are understood and delivered. Central to this shift is understanding the complex interplay between roles, responsbility and multi-layered contexts shaping service delivery and outcomes. Drawing on qualitative research on health and social care, we explore how roles, responsibilities and service delivery approaches are framed. Through our analysis, we propose three broad approaches to service delivery, contributing to the nascent literature on value co-creation in complex public service settings.

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The call for preventive, outcomes-focused reforms emphasize the potential of collaborative approaches to deliver transformative change and context-informed solutions to complex social problems (Christie 2011). Despite their attractiveness, preventive policies and asset-based approaches, which emphasize the capacity of individuals and communities, are challenging to embed (Boswell, Cairney, and St Denny 2019; Cairney et al. 2025) and an implementation gap remains (Finch, Wilson, and Bibby 2023; Walsh, Wyper, and McCartney 2022). While the social determinants of health (Solar and Irwin 2010) are increasingly recognized by Western policymakers, we argue that an enduring rhetoric of responsibilization is broadly incompatible with a preventive agenda. Moreover, while 'asset-based approaches' offer a framework to approach services

CONTACT Kirsty Strokosch kirsty.strokosch@strath.ac.uk

differently (see McLean et al 2017), complex and multifaceted public service delivery systems do not always facilitate effective implementation or impact.

From a healthcare perspective, prevention is defined as maintaining good health and counteracting the processes that lead to bad health by, for example, taking action to diagnose medical problems before they escalate: 'a range of measures to rope off the top of the cliff before the problem arises rather than parking an ambulance at the bottom when it is all but too late' (Boswell, Cairney, and St Denny 2019, 202). The narrative of prevention, while holding weight with policymakers and practitioners, is shaped within a broader and institutionalized framework of service delivery. Under the medical model, for instance, individuals are understood as being in deficit, with insufficient resource and competence, and reliant on professionals to 'fix' them (Morgan and Ziglio 2010). At the same time, neo-liberal rhetoric on responsibilization positions service users as 'autonomous, individualised, self-responsible, self-acting, self-directing and decision-making' who can and should change behaviours or modify lifestyles to improve their own health (Varey et al. 2021, 1) to reduce immediate demand and related pressures on the statutory service system (Cairney et al. 2025). However, what the deficit model and responsibilization agenda have in common is their disregard for the structural factors in the social environment that favour or harm health – the 'social determinants of health' (Morgan and Ziglio 2007) – action on which is central to furthering the preventive agenda (Marmot 2005).

Partly in response to the limitations of the deficit model and responsibilization, the asset-based approach to public health has emerged. Having its roots within the Asset-Based Community Development movement that emerged in the United States (Kretzman and McKnight 1993), this paradigm recognizes both individual agency and the collective capacity of communities, promoting a shift from 'doing to' towards 'doing with' and suggesting responsibility is shared rather than imposed (Hopkins and Rippon 2015). Despite offering potential for change, asset-based approaches have not especially taken root within public service delivery systems, with high demand for services and cost reductions creating difficult conditions for co-production. Furthermore, the shift towards 'doing with' requires broad and deep systems transformation. We argue that by investigating the translation of prevention in practice during service delivery, including the level of responsibility actors can take (rather than placing responsibility on them) and the multifaceted service environment shaping relationships and outcomes, we can better understand the complexity of value co-creation process and the possibilities for change. This leads us to the following research questions: how are roles, responsibilities and approaches framed during service delivery; and what shapes value co-creation and preventive outcomes in practice?

Our discussion starts with an analysis of how preventive services and actors' roles and responsibilities have been shaped under New Public Management (NPM) and how asset-based approaches have attempted, but largely failed, to re-frame responsibilization as a mechanism for empowerment. We then draw on the service management literature to understand the importance of relationships and contexts shaping value co-creation, before analysing data from health and social care in Scotland to offer illustrative insights. Through our discussion we contribute to the broad literature on public service reform (Dan, Lægreid, and Špaček 2024) and particularly the nascent literature on value co-creation in complex public service environments (e.g. Best, Moffett, and McAdam 2019; Rossi and Tuurnas 2021). Our specific contribution is twofold: first, to complement the spectrum of asset-based and deficit approaches, we identify a humanistic approach during service delivery which emphasizes a shift in our understanding of responsibility to reflect heterogenous service users/communities. Second, we emphasize that multi-layered and interconnected contexts form the bedrock of the implementation, shaping how public managers steer organizational performance, and how service users and communities are involved in value co-creation, the level of responsibility they might take, and the experiences and outcomes of public services.

Unpacking prevention: from responsible consumers to assets

Since the 1980s, NPM has developed as the pre-eminent model of public service reform (Dan, Lægreid, and Špaček 2024) with policy reforms, including prevention, unravelling under neo-liberalism (Pollitt and Bouckaert 2017). NPM emphasizes outputs and supply-driven efficiencies to reduce pressures on statutory services and implement reactive, short-term fixes (Glasby et al. 2021). Of course, this links also to the short political cycles shaping policy commitments and the pressure on public services across many Western nations (OECD 2023). With an emphasis on individualism, NPM endorses a shift in responsibility away from the state and frames individual service users as empowered consumers, independent and capable of exercising choice to support personal health and wellbeing. However, in practice, public service consumers are almost always treated as passive actors with limited control over the processes and impact of public services (J. Clarke 2005).

Although responsibilization suggests empowering consumers to manage their own health and wellbeing, implementation strategies are described as forcing autonomy rather than building agency, and poor health is associated with individual deficits and poor choices (J. Clarke 2005; Skarli 2023). By responsibilising individuals, decision-makers and commissioners can justify reductions in public spending, muddy lines of accountability and shape

service provision as 'efficient instruction where clients are informed of actions to take without consideration of the relevance or … feasibility of those actions' (Liebenberg, Ungar, and Ikeda 2015, 1009). This adds ambiguity to the roles of front-line service providers and service users, but also creates public services designed for archetypal service users who fit the system, rather than person-centred and contextually informed provision which accommodates diverse needs.

NPM's autonomization of individuals as consumers separates them from the realities of their lived experience and social and structural failings (e.g. deprivation, lack of access, insufficient resource) contributing to poor health and wellbeing (Marmot 2005). Individual choice, for instance, is often criticized as the main contributor of health inequalities, as opposed to embedded structural drivers (e.g. policies, economic forces) (De Andrade and Angelova 2020) or social conditions – despite strong evidence pointing to the various social determinants of health inequalities (e.g. deprivation) shaped by historical factors, past and current policy decisions (e.g. public sector austerity) and long-enduring social inequalities (Marmot 2005; Walsh, Wyper, and McCartney 2022). The critique of responsibilization is well established in critical social work and community development literature (Friedli 2013; Liebenberg, Ungar, and Ikeda 2015). More recent public management literature connects responsibilization with value conflicts and value co-destruction within service systems (Skarli 2023). We turn to the literature on community development literature and asset-based approaches to provide alternative positioning.

Rooted in Antonovsky's (1979) theory of 'salutogenesis' (the opposite of pathogenesis), the asset-based approach proposes that individuals have two types of assets: the cognitive skills to understand and manage their situation; and the necessary agency to access, use/reuse available resources. Put simply, lived experience enables individuals to recognize their needs, while communities often have available resources to help meet those needs. Those assets are not only physical or financial, but also include relationships (e.g. friendships) and participation (Friedli 2013).

Asset-based approaches emphasize the value of participation (e.g. opportunity for increased social connections) and its outcomes (e.g. more informed and engaged communities). They offer an important counter to the (pathogenic) deficit approach, typically associated with acute healthcare, by emphasizing the capabilities of individuals/communities, rather than their problems and deficiencies (Morgan and Ziglio 2010). However, the two have latterly been described as complementary (Daly and Westwood 2018; Van Bortel et al. 2019), with the deficit approach employed to ascertain and prioritize need, and the asset-based approach used to uncover individual and community resources to support and sustain health and wellbeing (Martin-Kerry et al. 2023). The ethos of the asset-based approach thus

broadly aligns with prevention, tackling downstream issues before they become potentially insurmountable problems.

Critical to the asset-based approach is the recognition and re-positioning of community assets. Assets contributing to health and wellbeing are not limited to those of statutory providers, or of the individuals receiving services, but include those of families, friends, associations and organizations that comprise civil society, and the social and economic infrastructure of the community (e.g. transport infrastructure, community buildings and relational resources, including resilience and commitment to learning) (Van Bortel et al. 2019). This broadens the suite of actors involved in value co-creation beyond NPM's emphasis on public service managers and passive consumers. It further suggests that responsibility is shared across a community and beyond individual consumers. However, the complexity of actors contributing to value co-creation can be overlooked by decision-makers (Strokosch and Roy 2025). While the preventive agenda extends beyond statutory actors to include interventions (e.g. social prescribing of community activities) from various local actors, their role is often on the periphery rather than viewed as an essential cog in the system. Indeed, one of the central critiques of the asset-based approach concerns its disregard of the structural determinants of health inequalities (Friedli 2013; Maclure 2023) including the unequal distribution of power across society (Daly and Westwood 2018). Focusing on assets assumes that individuals/communities have the necessary agency to instigate and maintain change for personal benefit but disregards the complexity of factors driving health inequalities (Friedli 2013) and the complex environment within which value co-creation takes place. Furthermore, the implementation of asset-based approaches is criticized for focusing on changing the community to leverage internal resources (Maclure 2023) rather than on changing decision-makers' and commissioners' perceptions of communities, the assets they have, and the community investment required for effective mobilization. Indeed, the asset-based approach is often framed as a polemic: reacting against NPM's individualism but ultimately falling short of embedding individuals and communities as central resources in value co-creation.

Whilst asset-based approaches aspire to increase community participation, the critical literature emphasizes their limited capacity to overhaul the structural environment to facilitate impact (see Roy 2017). Mobilizing and growing assets through trust and relationship-building is necessary to foster collaboration (De Andrade 2016; Martin-Kerry et al. 2023). However, relationship building is facilitated by the infrastructure enabling or constraining collaboration and learning across actors. With fragmented public service delivery, competition and performance management under NPM, along with cost reductions and work intensification, the space and resource for relationship-building and learning is at a premium. Indeed, the asset-based

approach is criticized, at best, as a rhetorical tool, with implementation gaps explained away as a lack of understanding among front-line service providers regarding the practical application of the approach (De Andrade 2016) and, at worst, a tool for neoliberalism which conceals the structural and institutional frames which establish and preserve inequality (MacLeod and Emejulu 2014; Roy 2017).

Understanding systems of actors, relationships and contexts

Over the past decade, public administration and management scholars have increasingly drawn insights from service management literature (Vargo and Lusch 2016) to understand the complexity and dynamism value co-creation within service ecosystems (Hodgkinson et al. 2017; Rossi and Tuurnas 2021). With its roots in institutional theory, a service ecosystem lens (Vargo and Lusch 2016) can be applied to understand who is contributing to value co-creation and how roles, responsibilities and practices are framed during service production. The lens acknowledges the complexity of 'service exchange' between various actors, working within and according to different institutions (e.g. norms, rules and values) to integrate resources (Vargo and Lusch 2016). These complexities exist not only between layers of the ecosystem but also within them.

From a service management perspective, value is not embedded in services but is experienced and contextualized through iterative negotiations between various interdependent stakeholders who exist in interconnected contextual backdrops (Vargo, Wieland, and Akaka 2015). Value is heterogenous, including external value for multiple beneficiaries (Alford 2016) and made up of experiential dimensions and longer-term outcomes, which may be tangible or relational (see Osborne, Nasi, and Powell 2021).

The relational nature of value co-creation is fundamental. 'Service' is positioned as the basis of all exchange; each actor contributes and integrates resources in the form of 'knowledge and skills for the benefit of another' (Akaka, Vargo, and Schau 2015, 210). In a public service context, this takes place across multiple often unequal actors, including those within organizations but also between networks of organizations across sectors, with/between policy and decision-makers, and with/between service users, citizens and communities. The power asymmetries across stakeholders is stark and the scarcity of resources and political context of public service delivery will always create winners and losers of value co-creation (see, for example, Skarli 2023). Adding complexity, public service users are not a homogenous group; they may have more or less agency, resources (e.g. local supports) and knowledge at their disposal, and their socio-economic environment may impact on their capacity to navigate and access public services.

Critical to value co-creation is the phenomenological positioning of micro level experiences and how they are influenced by an individual's own context (Strokosch and Osborne 2020) as well as institutions at the meso and macro levels shaping value co-creation (Akaka, Vargo, and Schau 2015). The micro level is not synonymous with service user interactions; it can include the micro level of any actor, including for example, policymakers, frontline service providers and citizens, depending on the focus of analysis. Each plays a role in subjectively experiencing and evaluating value during interactions, experience and within their own circumstances (Akaka, Vargo, and Schau 2015). It follows that value cannot be delivered, either as a service output or policy, but is shaped through individual experience and evaluated subjectively within the broader social context, including collectively agreed values (Akaka, Vargo, and Schau 2015). Furthermore, experience is not a one-off encounter but is built up over time through interactions with various actors and resources across the ecosystem (Helkkula, Kelleher, and Pihlström 2012).

'Nested' institutions guide how interactions unfold and impact actors' experience and evaluation (Akaka, Vargo, and Schau 2015). Resource integrations are shaped by social and economic structures and context-specific institutions within organizations and communities. Indeed, the legacy of local contexts is shaped by previous policy decisions and historical factors and by structures which define relationships (e.g. commissioning models, participation structures). For public service users, their context is also shaped by access to and relationships with local support mechanisms including family, friends, the local infrastructure (e.g. travel links, accessible services). Drawing on social construction theory, Edvardsson, Tronvoll, and Gruber (2011) stress the importance of the social context within which resource integrations take place and the way in which value is evaluated: 'Different customers may perceive the same service differently, and the same customer might perceive the service differently between occasions in a different social context' (328). Different contexts may, therefore, call for diverse approaches to value co-creation (Edvardsson et al. 2014).

Empirical setting

The analysis presented below offers an illustrative example of the health and social care services in Lanarkshire, west central Scotland, which is home to some 655,000 people or 12% of Scotland's population. With a strong industrial and mining heritage, the people of Lanarkshire have seen a challenging legacy of de-industrialization on their contemporary health and social care profiles (see NHS Lanarkshire 2023): life expectancy in Lanarkshire has decreased over the last 10 years, and was 1.4 years below the Scottish level

at 75 years for males and 79.6 years for females in 2021. This is in line with the poorest areas in the UK, who have suffered acutely from UK austerity policies since 2010 (Walsh, Wyper, and McCartney 2022).

In Scotland, the asset-based perspective is central to the policy and practice response to inequalities. Policies and legislation have proposed bottom-up approaches and co-production to tackle widening social inequalities as preventive and placing individuals, communities and third sector organizations in an active, participative role (e.g. Care Act 2014; Community Empowerment Act 2015; Scottish Government 2025). Community planning is well established in Lanarkshire across the two local authorities, North and South Lanarkshire, taking a cross-sectoral collaborative approach to confront key overarching priorities around poverty, deprivation, and inequalities. Since 2016, each local authority has had a Health and Social Care Partnership with joint delegated responsibility, along with Lanarkshire NHS Board, for decision-making, resourcing, and spending across primary, community, social and some aspects of hospital care.

Methods

Data were collected as part of a broader research project commissioned to explore health and social care integration in Lanarkshire. We employed a qualitative muti-methods approach (Creswell 2015) using a series of interviews, focus groups and observations. In total, we conducted 25 interviews and two focus groups with participants delivering health and social care from across the statutory and third sectors and with people using services (Table 1). All statutory and third sector participants were working at the community level, except one participant with a pan-Lanarkshire role (an NHS manager).

Participants were purposively selected initially, with guidance from practitioners within our project team; we then implemented snowball sampling to expand our pool of participants. Participants included a range of professionals from the statutory sector (e.g. social workers, physiotherapists, occupational therapists) and chief officers from third sector organizations.

Table 1. Breakdown of participants.

	North Lanarkshire	South Lanarkshire	Pan Lanarkshire (with interests across local authority areas)
Statutory sector	6 interviews	3 interviews; 1 focus group (4 participants)	4 interviews
Third Sector	4 interviews	6 interviews	
Health and social care service users	1 direct observation	1 direct observation; 2 interviews	Focus group (8 participants)

One focus group and two interviews were conducted with those with lived experience of health and social care services in Lanarkshire. They were part of the broader project's Lived Experience Advisory Panel who were recruited from Lanarkshire-based community organizations. They were selected to provide a spread of gender and geographical location (North and South Lanarkshire) and to capture the voices of underrepresented groups (e.g. care experienced, disabled people, minority ethic communities).

As part of the broader project, we conducted eight community asset mapping sessions, split equally between North and South Lanarkshire, and collected in-depth observational data during two sessions. The observations lasted approximately 3 hours and involved 10 community participants in each session who were recruited from underrepresented groups, with a spread of age and gender. We observed discussions around health and the social determinants of health, definitions of community assets and the identification of assets that supported personal and local community mental health and wellbeing. All necessary institutional ethical approvals were obtained prior to commencing the research.

Thematic analysis uncovered patterns and nuances in our data. We followed Braun and Clarke (2006, 2017) framework, achieving data immersion by reading and re-reading, generating initial codes across the entire data set, collating codes into potential themes and reviewing them against the broader data set, refining themes 'as stories about particular patterns of shared meaning across the dataset' (V. Clarke and Braun 2017, 592) to interpret data and report our analysis. Throughout the processes of coding and developing themes, interpretations were questioned and discussed by the research team to support reflexivity and transparency (V. Clarke and Braun 2017). Preliminary findings were also shared with participants and project team members and the analysis was refined to reflect comments and support validity (Guba and Lincoln 1994). An overview of analysis is illustrated in Table 2, with our analysis presented thereafter.

Community capacity

While observational and interview data show the breadth of valuable *community assets*, ranging from intangible relationships (e.g. with families/friends, colleagues at work or through volunteering) to tangible resources (e.g. green spaces and jobs), our analysis also highlights resource deficits and inaccessibility. While organic connections with others were evident in communities, participants pointed to the diminution of local services over time. The gaps in grassroots enabling services (e.g. information, advice and 'handholding' services) supporting people into crucial services were raised by all, and the inaccessibility of services was discussed frequently. In part, this was associated with lack of capacity within the service system to cope with

Table 2. Summary of thematic analysis.

Insights from data	Sub themes (codes)	Theme
Community organizations Community spaces Statutory service providers Local employers/jobs Infrastructure	Tangible assets	Community capacity
Friends, family Caring/compassionate relationships. Lived experience of service users and service staff. Relationships across service providers.	Intangible assets	
Third sector organizations invisible to statutory providers and service users.	Invisible assets	
Challenges accessing public and third sector services. Gatekeepers.	Inaccessible assets	
Disconnect between service areas (silos). Health inequalities rooted in social inequalities. Short-term focus Goals are narrow and operationally focused	Misunderstood needs	(Mis)understanding the complex system of needs, responsibilities and connections
Limited shift towards community-led approach in practice. Traditional governance structures to connect communities and decision-makers ineffective. All services under strain.	Community capacity	
Different roles for different needs. Complexity system of actors difficult to navigate. Building relationships, communication and learning across roles/sectors important.	Diverse roles	Understanding service delivery roles and responsibilities
Responsibilities across system need to be clearly defined and understood. Complexity of social problems needs coordinated approach across multiple actors. Concern that responsibility should not be shifted to communities.	Shared and delineated responsibility	
Metrics focused on acute care Short-term projects. Emphasis on delivering services for all.	Operationally focused services	Operational Vs humanised services: the importance of context
Person-centredness with a holistic view of person. Trusting service relationships. More flexible.	Humanising service	
Local level complexities are drivers of social inequalities. Embedded inequalities over time. One-size-fits-all approach not effective.	Context-informed	

heightened and increasingly complex demand. However, the design of the system and deep-seated structural legacies were also described as 'not reaching the target audience', especially more vulnerable, often hidden, groups. Lived experience participants emphasized the challenges of accessing services due to insufficient local infrastructures, hidden or fluid third sector provision and difficulties accessing services, particularly GPs who were often positioned as gatekeepers to other services.

The lack of resources and limited support networks impact remote communities and more vulnerable service users' ability to access and navigate the complexities of the system to capitalize on community assets: '. . . it's like you want to give up before you even start, because that system is made to crucify you, not help you' (Lived Experience). Such gaps in tangible assets and relational connections were described as exacerbating social inequalities. Indeed, the analysis suggests a shortfall with regard to how local needs are articulated and understood, with limited consideration of local contexts and the complexities and root causes of social problems. At the same time, an overemphasis on the operational aspects of service delivery is evident.

(Mis)understanding the complex system of needs, responsibilities and connections

Deep-rooted social inequalities were mentioned frequently across participants, who noted an enduring status quo: 'It's like housing issues . . . We've been talking about the same stuff for years' (SL Third Sector). There was unanimous agreement that people are facing interrelated, complex social problems (e.g. loneliness, financial problems) which can be misunderstood and present as health issues, thus contributing to pressures on statutory healthcare. Participants said solutions require a multi-actor response. In part this concerns building better connections and relationships across actors, with some also arguing for a broader societal shift in expectations to foster shared responsibility:

> In terms of health seeking behaviours, people want a medical model, they want to see a doctor, they want to get some fancy scans and they want some medicine . . . how do we start to kind of shift understanding . . . But it happens, in those forums of connection and relationship and discussion . . . Working together because actually you want to bring that internal locus control back into the community. (Healthcare)

Most participants emphasized the capacity of the community to meet unmet needs, while also taking pressure off increasingly squeezed statutory providers. However, some also suggested that the 'toxic cycle' of health inequalities was fed by the lack of infrastructure to invest in the third sector and related preventive services, with resources targeted

towards short-term or reactive work. This reflects both the crisis impacting health and social care services (e.g. not enough hospital beds; social care staff crisis) but also the dilution of the preventive agenda. The observational data revealed that neighbourhood collaborations to capitalize on community assets need to be driven from the bottom-up, but that requisite governance structures for feedback to local decision-makers were missing: 'There's no community council, no place-based organization, no development trust … no one to drive forward collaborative working'. However, when in place, Community Councils were described as poorly attended and ineffective.

Those involved in decision-making and some third sector anchor organizations, especially in North Lanarkshire, described a preventive rhetoric from local-level decision-makers, but the analysis suggests this has not yet translated into practice. For instance, third sector participants generally did not feel represented in local decision-making and said more could be done to coordinate services on the ground. Furthermore, one participant called for a cautionary approach in framing and implementing asset-based approaches, saying that charging communities with meeting ambitions could be viewed as shifting, rather than sharing, responsibility.

Understanding service delivery roles and responsibilities

Overall, there was recognition that actors bring specific skillsets and play nuanced roles during service delivery to cater for diverse needs, and that understanding each other's role was important to contend with social problems within tight resource constraints. The diversity of roles played adds complexity to the system, and a lack of co-ordination across providers makes service access and navigation difficult. There were also examples, particularly from North Lanarkshire, of effective co-ordination meeting the operational goals of service providers (e.g. freeing up hospital beds) and facilitating preventive outcomes for service users (e.g. providing holistic services to support health/independence).

Some statutory sector participants said that tackling inequalities was not on all service providers' agendas, with their primary function to deliver services and outputs, evidencing the pre-eminence of NPM. While inequalities were visible to all participants in their day-to-day work, front-line statutory service providers offered little detail on how inequalities were understood or dealt with, beyond reacting to instances of social deprivation (e.g. a community nurse described buying food after finding someone had nothing in their cupboard). One participant suggested that insufficient governance mechanisms targeting goals of inequality were embedded in service production, reflecting on a disconnect between preventive goals and implementation: 'Have you done your legal duty? Tick box. Done.

Boom … And … a lot of these services have been up and running for decades … So they've never had [an Equalities Impact Assessment (EQIA)] … And once the EQIA is completed, there's no review … ' (Healthcare).

All participants talked about the need for relationship building across actors/sectors, describing relational capacity as a core intangible asset for joint working, avoiding service duplication and improving service experience. Reflecting on the 'hugely complicated system', one participant also suggested that a discussion with and decision by the public was needed to clearly articulate broad roles and responsibilities:

> Is [the NHS] about keeping you alive or is it about keeping you well because those two aren't necessarily the same thing … what you need to do is think of health … about acute medicine, … [as how to] keep you alive or stop you having a serious incident … that also needs to be a service in its own right. And then the health and social care part of it is really about keeping you living well … we're still thinking these things as the one thing, and I don't think that's possible … (NHS Manager)

Participants overwhelmingly pointed to the need for shared responsibility, but had nuanced interpretations of its meaning in practice. Most statutory sector participants described responsibility as reflecting both the limited capacity of services to meet increasing demand and an attempt to shift away from the medical model's deficit approach. There was a clear demarcation of roles between service provider and user which amounted to shared but delineated responsibilities: the statutory provider delivers services within their discrete remit and refers individuals onwards to other services; individual service users maintain their own health and wellbeing, acting on signposting to follow up and access recommended services. Aligned with the NPM narrative, some described this as 'empowering people' to make choices to improve their health and wellbeing. Others suggested a deficit approach and the professional's role in determining the necessary level of support required by individuals (e.g. in developing care plans) while recognizing a tendency among service users and families to expect and provide a higher level of professional support. They pointed to the need to change mindsets around the scope of statutory provider's responsibilities and to support preventive measures and improve the quality of life over the long term.

> … you want to wrap them in cotton wool. That's not the best thing for my mum … we need to keep her independent … We've actually put packages of care in place … [where] we don't want things to go wrong so let's do more, when in actual fact, if you're going into that home to make that person's food that becomes what that person thinks: 'oh my home support worker does that'. (North Lanarkshire Health and Social Work Manager)

Third sector and service user participants offered a different conception of shared responsibility which centred on the life context of service users. They stated that too much responsibility was placed on vulnerable service users, who might not have the necessary knowledge or support networks to navigate the services and therefore needed more 'handholding'. Linked to this, and in contrast with statutory service provision, third sector services were more flexible, enabled through nuanced values, work practices and rules. Service users said that without flexible support they would likely have the same experience as their parents before them, thus perpetuating cycles of inequality.

Operational vs humanized services: the importance of context

Prevention was defined differently, suggesting both conceptual vagueness and its diverse interpretation according to actors' distinct institutional frequencies. Differences across professional groups (e.g. health and social care staff) and between statutory and third sector delivery were especially stark, but the operational focus of service production and its reactive nature was recognized by all. The health and social care system is organized to reduce pressure on acute care to prevent people going into statutory 'service land' from which they may not be able to exit. Participants noted less consideration for the pressures on other parts or indeed on individuals'/communities' contexts. Those with lived experience corroborated the operational focus, describing their experiences as akin to being on a 'conveyor belt'. They talked about being categorized according to inflexible protocols or rules, which stereotyped them into groups erroneously. Any focus on prevention (or further deterioration) of inequalities was less evident in the data. This can be explained perhaps in relation to the extreme pressures on services but, overall, the operational focus neglects outcomes: '*we're supposed to be putting the child at the centre . . . but each area are just thinking, "How do we get our waiting list times down?" but they don't look at the domino effect of what that impacts on every other service*' (South Lanarkshire Healthcare).

Various participants argued for a shift towards outcomes, supported by understanding local needs and resources. Those with lived experience emphasized the importance of embracing and exhibiting caring and compassionate values to establish and maintain trusting, person-centred and 'humanising' services. Although the statutory sector was described as more cumbersome, with relatively rigid work practices, front-line statutory sector providers offered examples of working in this way. Interestingly though, lived experience and third sector participants spoke about the flexibility of third sector organizations in adjusting their role to, for example, deliver services at short notice or to engage consistently with and build relationships

with service users to help them access 'more meaningful' services. The operational focus of statutory services, by contrast, created inflexibility.

The discrete social and personal context shaping access to, engagement with and experience of services was discussed at length. Participants with lived experience of looked after care reflected '*you might not know the same stuff as an adult that's lived at home their whole life . . . you're automatically at a social disadvantage . . .* ' The knowledge/resources of social or family networks help or hinder individuals in navigating and accessing complex service landscapes or in making changes for themselves. The responsibilization agenda overlooks such nuance in individuals' life context. Third sector participants further emphasized that inflexibly designed public services could constrain service access and use, especially for those with limited support networks or infrastructures. While public services may create short-term efficiencies and value accrual for archetypal service users, it does not create easy to navigate, compassionate service pathways in the evaluative judgements more vulnerable service users and hinders the attainment of complex social goals such as reducing inequalities. Furthermore, third sector participants said that some groups may also have lower expectations, suggesting a degree of resilience to make do. This does not facilitate transformative change or shifts in outcomes.

> if you're more ready to engage because you've got less crisis, but maybe it's not poverty, so you can travel there [for] support. Whereas if you're living in [a deprived area] and you're living in poverty and you rely on the poor public transport . . . you won't be able to engage those people . . . it takes longer, it takes more resources, it is much more hard work to convince and support somebody . . . They've struggled most of their life. This is something else that they've got to bother about it, and they'll just cope with it . . . But the way they cope is not necessarily healthy . . . (SL Third Sector)

Overall, the disproportionate and negative impact on the experience and outcomes of more vulnerable groups suggests that services are largely not designed or implemented within the preventive agenda but rather, rooted within the neoliberalist agenda of responsibilization.

Discussion and contributions

We will now discuss our findings within the broader literature. The intricacy of multiple actors integrating resources, operating on different frequencies and driven by different goals, and norms highlights the complexity of value co-creation (Strokosch and Roy 2025). Within this, and drawing on our analysis and the literatures previously discussed, we have developed three distinct service delivery approaches, which reflect the institutions guiding service providers, the nuanced roles played and the different levels of responsibility expected and held across resource integrators. The approaches

Table 3. Service delivery approaches.

	Deficit approach	Asset-based approach	Humanistic approach
Service philosophy	'Doing to'	'Doing with' *or* 'shifting to'	'Doing humanistically' to build capacity at an appropriate rate for the individual
Protagonists of value co-creation	Professionals.	Individual service users and local communities.	Complex system of inter-connected, context-based actors, including service users.
Understanding of value creation	Value embedded into services provided and delivered to service user.	Value created, at least in part, by individual for themselves or the community with participation mechanisms connecting decision-makers and communities.	Value is co-created between actors during interactions (relational process) and the experience and evaluation of value is influenced by the actor's context
Anticipated balance of responsibility	With the service provider usually for a set period of time; problems to be solved by others (e.g. professionals)	Capacity to meet own needs either as an individual or community or working collaboratively and sharing responsibility.	Shared responsibility but focusing on context might consider where further responsibility is with service provider to support service user to overcome social and structural barriers.
Roles and involvement of service user	Passive service users or consumers or patients during service delivery, but expected to take on health advice of professional	Active service users, citizens and communities whose involvement is appended through collaboration and empowerment (e.g. co-production)	Active service users, with different needs and capacity to contribute, through day-to-day, trust-based relationships.
Goal of prevention	Operational and internally focused on operational service production (e.g. efficiency of services, quality of services, cost reduction)	Individual and community agency and outcomes through participation and collaboration.	External value outcomes for service users, communities and society, including capacity building.

are discussed below and summarized in Table 3. It is not our intention to suggest that one approach is superior – although some may be more established and accepted than others – but rather to explain that iterations of each take place within a complex public service delivery system.

Traditionally the deficit approach is associated with healthcare and finding solutions for ill health under the philosophy of 'doing to' (Morgan and Ziglio 2010). Prevention under the deficit approach is typically defined in operational terms. For example, healthcare practitioners might administer ongoing treatment to manage a health condition and prevent it from worsening, or a reduction in mobility might necessitate increased social care to complete day-to-day tasks and prevent accidents. The onus of responsibility (and power) thus falls primarily on the professional, who is accountable for

safeguarding passive service users' interests and the scope and ethos of value co-creation is narrow (i.e. reducing pressures on statutory services and reducing costs). The professional and the service output hold value that is delivered *to* services users, reflecting a linear logic of service delivery which separates the professional as service provider and service user as consumer (Osborne 2018).

Collaboration between actors, each with mutual responsibility for the achievement of outcomes underpins an asset-based approach (De Andrade 2016). This recognizes the role of individuals and local communities in value co-creation and forwards a mantra of 'doing with' with individual service users/communities. The role of statutory provider shifts from expert or 'fixer' to value co-creation facilitator (Haug 2024) but its application depends on having effective participative structures to enable connections across resource integrators. Without embedded connections to encourage shared responsibility, the asset-based approach may be interpreted as a means of shifting responsibility to service users/communities to lessen pressure on statutory services and reduce costs, and effectively 'capitulating' to neoliberalism (MacLeod and Emejulu 2014). Although individual service users have assets under NPM, they are positioned as consumers, empowered through choice and appended through extrinsic participative structures (Osborne and Strokosch 2022). Such articulations do not fully capture the essence of the assets forwarded by Antonovsky (1979), with the environment failing to acknowledge, appreciate and enabledifferent levels of agency, tacit knowledge and lived experience.

Distinct from the asset-based approach, the humanistic approach to service delivery does not emphasize community or individual capacity to solve their own problems. Rather, its starting point is external value for service users and communities (Alford 2016; Osborne, Nasi, and Powell 2021) and the integration of various resources which are enabled/bound by nuanced and shared contexts (Vargo, Wieland, and Akaka 2015) therefore offering flexibility to meet needs. Fundamental to the humanistic approach is the pragmatic positioning of the service user and lived experience as a critical asset *and* their life context as an elemental factor shaping the value co-creation processes and evaluations of the value produced (Helkkula et al. 2012). Shared responsibility underpins the humanistic approach, but this can only take place when we take a holistic understanding of the service user's life context, including the socio-historic and economic factors shaping and often constraining resource integrations (Akaka, Vargo, and Schau 2015; Edvardsson, Tronvoll, and Gruber 2011). The starting point for understanding desired outcomes and opportunities for value co-creation is therefore constructive alignment to the individual and their social context, rather than operational pressures or an assumption of resources beyond lived experience. Importantly, this recognizes that public service providers and service

users are not equal resource integrators, a point which tends to be overlooked in the service management literature (e.g. Vargo and Lusch 2011).

Shaping the three service delivery approaches discussed above, we propose that three nested contextual environments, each with different sets of institutions, influence the potential for value co-creation and can enable or constrain service delivery, preventive impacts and outcomes.

First, understanding community contexts is imperative to appreciating needs and local resources and for the subsequent mobilization of assets for value co-creation (Akaka, Vargo, and Schau 2015). This represents a departure from the asset-based perspective which generally presents communities as asset-rich. Appreciating the local contexts within which value co-creation plays out requires analysis of the upward pressure from communities, in terms of a community's needs, values and resources to integrate resources, but also the social, economic, political and historic determinants enabling (or constraining) processes of value co-creation (Edvardsson et al. 2014). To achieve efficiency, effectiveness and outcomes, service delivery approaches should be selected and applied in local contexts, rather than the operational preference of providers, or assumptions of available assets. This moves away from a blanket individualist conception of responsibility to a contextually grounded one which is appreciative of local realities.

Second concerns the context of organizations and professionals. This means understanding the institutional arrangements which legitimize, embed and strengthen how service providers work, including service delivery approaches, but also their strategic orientation towards prevention and the balance of responsibilities. According to Cairney et al. (2025) long-term and typically ambiguous preventive goals are often sidelined because they are not an established norm. Indeed, the pre-eminence of NPM makes it challenging for asset-based and humanistic service delivery approaches to take root in practice, particularly within statutory sector organizations. Shifting towards an asset-based perspective, for instance, requires the development of a shared agenda, negotiated and agreed with the community (Hopkins and Rippon 2015) and focusing on building/sustaining relationships (Strokosch and Roy 2025) and outcomes (e.g. reducing inequalities). Such strategic re-orientation requires local flexibility by service providers, but also clear re-direction and steering from commissioners and decision-makers which emphasize outcomes (Osborne et al. 2021).

Finally, the contextual environment of individual actors, and especially service users, who both contribute to value co-creation and evaluate value accrued over time (Edvardsson et al. 2014; Strokosch and Osborne 2020). We propose that to improve outcomes, preventive services should capture non-archetypal service users, recognizing the social and structural (rather than individual) deficits which impact their access to and navigation of complex public service systems (Marmot 2005) and whether they can take *shared*

responsibility. Our analysis shows that service users' lives do not necessarily align with standardized services, which regularly assume a reasonable level of assets (e.g. family support network, access to transport). Thus, for preventive services to better meet needs, they should be designed and delivered in a backward- and forward-looking way. Backward to understand the complex factors shaping an individual's social context which mediate the potential for impactful change, and forward-looking to consider what impact different service delivery approaches might have. This aligns to Osborne's Public Service Logic which centralizes value for service users and communities (e.g. Osborne, Nasi, and Powell 2021) and to our proposed humanistic approach to service delivery which is cognizant of service users' contexts and how they shape value co-creation.

Our contribution lies in the demarcation of three different approaches to service delivery, which unpack the roles and balance of responsibility across key stakeholders. In doing so, we offer insights as to why long-term preventive goals are not being met, suggesting that outcomes are not achieved by shifting responsibility to service users and communities, or by simply *acknowledging* community assets, but by understanding how resources are mobilized and integrated according to and within a complex and interconnected context (Edvardsson, Tronvoll, and Gruber 2011). This allows us to better understand the complexity of value co-creation. Our humanistic approach, especially, is aligned to the extant literature on value co-creation in public service settings, where diverse and non-archetypal service users exist. Beyond this, our exploration of multi-layered contexts, comprised of nested institutions which guide resource integrations, experience and evaluation (Akaka, Vargo, and Schau 2015) offers insight into the complexity of value co-creation processes and some explanation (and concern) regarding the endurance of NPM in guiding public services and the limited potential to effect outcomes-focused change. Embedding alternative logics encapsulated in different approaches to service delivery (i.e. the asset-based and humanistic approaches) requires deep institutional transformation across services, organizations and society to reorientate towards a long-term preventive agenda and overcome power asymmetries constraining the application of outcomes-focused service delivery.

Limitations and future research

Our research is not without limitations. Analysis is based on a relatively small illustrative example, and the sample is not representative of health and social care actors working in Lanarkshire, with GPs and private sector social care providers not participating. Nevertheless, given the context of de-industrialization and high levels of deprivation in Lanarkshire, we suggest the findings offer rich empirical insights

which may have transferability to similar contexts (Eisenhardt and Graebner 2007). Our research also poses further questions which were beyond the focus of this study, particularly around the need for a recalibration in the balance of responsibility among actors contributing to value co-creation. In response, we identify three broad gaps in need of further exploration.

First, our analysis suggests not all actors have the same power or resources to contribute to value co-creation. 'Zooming in' on vulnerable service users to understand their environment is thus an important area for future research to understand how services might be better designed and delivered to support outcomes (Strokosch and Osborne 2020). Similarly, third sector organizations have diverse capacity to deliver services, but financial constraints may limit the extent to which they can fill the expanding gaps left by public sector cutbacks. Although there is some nascent literature of the value offered by the third sector (e.g. Eidslott, Wæraas, and Sirris 2024) there is scope to develop further knowledge on the assets at local level, mapping their existence, capability and capacity, although the dynamism of the third sector may make it difficult to track with accuracy. We also need to measure the impact of those community resources to clearly evidence their value to commissioners.

Second, the above analysis suggests that working together synergistically across organizational and sectoral boundaries is critical to value co-creation and that the relational work within the system is a core asset facilitating this. Thus, there is imperative to unpack relational assets in more detail, including questions about how to effectively collaborate with communities, but going beyond traditional mechanisms of participation to consider relationship management among a diverse set of actors who contribute to complex social goals.

Finally, and linked to the previous point, recalibration cannot be achieved solely by including additional collaborative mechanisms but requires deeper institutional change and learning across actors. In part this necessitates a more fundamental shift towards our understanding of value and how it is created. Governments play a central role here, articulating and measuring a strategic and shared vision of long-term goals which reflect the values of society and are reflected in the ethos and approaches of service providers. However, further research is necessary to explore how systemic change might be instigated and embedded to shift mindsets around the roles and responsibilities of actors. Different levels of analysis are required to fully understand the complexity of that change process across policy, organizations, sectors and communities.

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