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Governance: an Essential Lever for Innovating Home Care services for the Elderly Through Co-Production. First Insights from the Evaluation of Three Years of Experimentation in Friuli Venezia Giulia

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Governance: an Essential Lever for Innovating Home Care services for the Elderly Through Co-Production. First Insights from the Evaluation of Three Years of Experimentation in Friuli Venezia Giulia

Anna Zenarolla

Abstract: The paper presents a reflection on the role of governance in innovating home care services for elderly people, drawing upon the first insights of a qualitative evaluation research on the experimentation of an innovative model of home care service promoted by the Friuli Venezia Giulia Region to contrast the institutionalization of non-autonomous elderly people based on co-production and the personal budget. The results have highlighted the decisive function exerted by the governance system existing at the micro level in inducing the path dependence effects and the crucial role of the intermediate level of the governance system to prevent these effects from having distorting consequences. Moreover, what has emerged is the importance for governance to assume a participative configuration in order to balance adequately the necessity to guarantee equity with the strict adherence to the local context that characterizes social innovation as well as co-production.governance, co-production, social innovation elderly, home care.

Keywords: co-production, citizens' participation, service personalization, elderly

Introduction

The aim of the paper is to reflect on the role of *governance* in innovating social services drawing upon the first insights of a qualitative evaluation research on the experimentation of an innovative model of home care service promoted by the Friuli Venezia Giulia Region to contrast the institutionalization of non-autonomous elderly people, based on co-production and the personal budget. *Governance*, in fact, is a key component of social innovation processes. Hence, it is important to pinpoint how it may be developed and which factors may promote rather than hinder its implementation. The paper is structured in five paragraphs: the first describes the context of the experimentation and its objectives and features; the second presents the aims and method of the evaluation research; the third describes the results of the experimentation that emerged from the research; the fourth summarizes the main theoretical references related to social innovation, co-production and governance; the fifth discusses the results.

The context

Friuli Venezia Giulia is the second oldest region in Italy and is located in the north eastern part of the country. At the beginning of 2021, its population was 1.201.510, 0,4% decreased from 2019, and the elderly were 319.219, 26,6% of the total population. Since the last nineties, FVG has been implementing policies aimed at contrasting institutionalization and promoting home care for elderly people. In particular, the framework of the 1998 regional law (number) 10 introduced the issue of the involvement of elderly people in drawing up and managing health and social policies regarding aging. This legal measure highlighted their right to be cared for at their home also when not self-sufficient, by setting up various kinds of health and social interventions. This legislative framework has given a great impulse to start a regional reorganization of residential services to enhance the quality of their interventions as well as to improve home care for not self-sufficient elderlies. As well as in the rest of the country, home care for non-autonomous older people in FVG is not adequate to satisfy their increasingly complex and multidimensional needs as well as the impossibility of their relatives to take care of them. Public health and social services which are provided at home are quantitative and qualitative inadequate to guarantee long-term and extensive care as a request by not self-sufficient people, due to their standardization, lack of integration, shortness and so on. Therefore, the burden of home care especially affects relatives, that are often overwhelmed on one hand by taking care of their parent, on the other by the high costs they incur to pay private assistants, who usually are non-professional. In 2020, 6.786 elderly people and adults

have been taken care at their home by public social services which were delivered by municipalities in partnership with no profit organizations, which are specialized in home care. Moreover, multiple FVG legislative measures have been implemented to support relatives and parents involved in home care and to promote innovative models of co-housing (LR 6/2006, art. 41; DGR 1625/2019). LR 6/2006, art. 41 has introduced a special subsidy - called Fund for Possible Autonomy and Long Term Care (FAP) - aimed at promoting home care by supporting older people's relatives and parents involved in care and young and adults who want to experiment autonomous way of housing. During 2020, 8.677 people have received the regional grant introduced by the FAP. Most of them are not self-sufficient elderly people and need to be supported by parents and private carers. The rest of them are young and adult people with disabilities and they also need to receive relevant support from private carers.

As regards innovation in home care, there have been defined two innovative models depicted in specific Regional Guide Lines (DGR 671/2015, DGR 2089/2017, DGR 1625/2019): "Abitare Possibile" that is focused on renovating residential services, first by reducing the number of accommodated older people (limited to twenty); "Domiciliarità Innovativa" which experiments innovative forms of cohousing with at least ten not self-sufficient elderly people into civil houses involving relatives and volunteers of the community. These two models are both based on these principles: citizens' participation, personalized care and health assistance, citizens' co-production, integration with local communities, integration of social and health services. The peculiarity of these residential services is that elderly people are not considered as guests who will stay in these structures for a limited period (also if very long) but as inhabitants may consider their staying in these facilities as being at home. So, it is possible for them to take active part in the management of the assistance and daily activities such as cleaning the house, making their bed, preparing meals, clearings the tables. Moreover they may remain there until their death). Also, their relatives can visit them whenever they want and may remain in the residence as long as they want. These two experimental lines have been combined with specific regional guidelines, which translate operatively these are aimed at developing common practises among all the subjects involved in the projects.

Moreover, in 2019, (DGR 1624/2019) a new legislative measure has been implemented: personal health budget, which is a financial instrument aimed at promoting the users' free choice of the service as well as the provider. Thirteen experimental projects are currently underway and are managed by third sector organizations.

Methods

In order to evaluate if and how the experimental projects of "Inclusive Housing" have reached the finality and objectives pursued by the Regional guidelines mentioned above, we have carried on a qualitative research aimed at exploring the outputs and outcomes obtained by the projects and the obstacles and the leverages they have encountered during the past three years of experimentation. The general aim of the evaluation research (Bezzi, 2003) was to collect useful data and information for the Friuli Venezia Giulia Region in order to decide whether to continue or abandon these experimentations and which potential changes and improvements introduce (Bezzi, 2003; Palumbo, 2001).

Considered the complexity of these experimentations regarding the number and typology of the providers, direct and indirect beneficiaries, types of interventions and modalities of delivery, we have adopted both a positivistic and constructivist paradigm (Stame, 2001) and *multi-method approach* (Palumbo, 2001). In accord with the positivistic paradigm, the research aimed at accounting for the outputs and the outcome of the experimentations to compare them with the expected objectives and results. In accord with the constructivist paradigm, the research aimed at exploring which processes and mechanisms supported each experimentation about context variables and implicit and explicit theories of the providers, as well as the unexpected results emerged from the context. By doing so, we expected the research to enter in to the so called "black box" - that is the principles and assumptions regarding nature and finality of the service, users' role, families' and community's role - and contributing to improve the knowledge of the providers and of all the subjects directly and indirectly involved in the experimentations. This knowledge is expected to improve the quality of the interventions and to empower the effectiveness of this experimentation facing elderly needs, improving strength factors, and overcoming weaknesses. The instruments that have been adopted were the semi structured interview and the focus group as well as the analysis of the projects and monitoring reports. We conducted six interviews and three focus groups with the providers, four interviews with social services managers and four interviews with Health Districts officers.

Theoretical references

As mentioned in the introduction, social innovation and co-production are the two main aims pursued by the Friuli Venezia Giulia Region through this experimentation. Social innovation and co-production are both umbrel-

la concepts, namely widespread and complex concepts which have received many different interpretations.

With regard to social innovation, the various interpretations and operational declinations it has received during its long and articulated evolution (Barbera, 2020; Cahill, 2010) have placed, in some cases, greater emphasis on the more commercial features, considering that innovation aims at increasing the efficiency and effectiveness of the welfare (Murray et al. 2010), while in other cases, they have placed more emphasis on the aspect of structural social transformation (Moulaert et al., 2005; 2010; Busacca, 2013). All these definitions share some key elements: the ability of social innovation to respond to a collective need, both old and new, in a different and better way than in the past, which concerns the relational dimension referring to the sphere of relationships between actors both in the production and in the service fruition; the technological dimension referring to the tools adopted to address the public problem, which may concern both the offer of new products and services as well as the improvement of the efficiency of the existing ones, both the old and the new, can be identified as one of their unifying characteristics; and the structural impact, that is, the ability of the intervention to flourish in the social context in the medium-long term, thereby increasing the number of beneficiaries reached or by reaching different geographic areas to those in which it was experimented (Cancellieri & Speroni,2018). Therefore, it is possible to distinguish three main dimensions in it: content, process, and empowerment. Content refers to the response to social needs that are not met by the market or the government; process refers to the transformation of social relations in a participatory manner; and empowerment refers to the strengthening of socio-political capacities and the expansion of access to resources necessary for the satisfaction of social needs (Gerometta, Häusserman, Longo, 2005; Moulaert et al., 2005). As we can see the dimension of social relationships is crucial in triggering as well as in spreading and implementing social innovation. In fact, it plays a particularly important role in triggering innovation at a local level where the establishment of relationships is facilitated by the spatial proximity as well as by common interests (Moulaert et al., 2005).

The diffusion and consolidation of social innovation can sometimes proceed from one territorial level to its neighbouring level through horizontal, formal and informal networks, seizing available opportunities to establish connections with organizations operating on a larger scale; this process can develop from the bottom to the top or from the top to the bottom depending on whether the innovation originated through the autonomous initiative of a local context or, alternatively, was promoted at a central level (Eizaguirre et al. 2012). Other times it may follow the affinity of the interests of the organizations involved, the governance systems, and the welfare sys-

tems present in even distant territorial contexts, assuming a more horizontal and cross-sectional dynamic in which social relations between actors and the networks of social innovation play a crucial role; this process may be hindered by the different institutional and organizational levels it must go through, in which it may encounter key individuals and organizations that are more or less amenable to establish alliances and to open the access to resources distributed in various ways (Kazepov, Colombo, Tsaruis, 2020).

Co-production as well represents an umbrella concept which has received several interpretations and definitions (Ewert & Evers 2014; Voorberg *et al.* 2014, Palumbo 2016), and has been realized in various different ways. All of these converge to recognize as key components of co-production, the active and voluntary involvement of clients in the process of services, and in the different phases of the service cycle, that are commissioning, designing, delivery, assessment (Bovaird 2007; Fotaki 2010; Jo & Nabatchi, 2018; Nabatchi et al., 2017; Osborne et al., 2016; Osborne et al., 2018; Pestoff, 2006). It represents an innovative way of service delivery which implies the interdependence between all the actors involved both at the operative individual level of the service related to the empowerment of the users, as well as at the strategic level of the planning related to the dynamics of the collective participation (Bovaird 2007). These levels may be placed along a continuum that implies the consumer co-production, the participate co-production and the enhanced co-production which is characterized by the users' involvement at the operative level as well as at the planning level, and therefore represents a special means for innovating services (Osborne & Strokosch, 2013). The possibility to proceed along these levels depends largely on the relationships of governance developed between citizens who use the services and public authorities. Drawing from these dimensions, Bracci and colleagues (2016), efficaciously suggest using the term co-production with a strict meaning for situations where citizens produce services, partly or wholly, with or without public intervention but with public financing; the term co-management when service delivery is realized by organizations of the third sector together with public and private organizations, and the term co-governance for situations where organizations of the third sector together with public and private organizations take part in the decisional process and the planning of services.

So, both the concepts of social innovation and co-production share the dimension of governance, that is the relationships developed among all the subjects that at different levels of responsibilities and government (Tsaruis, Kazepov, Boczy, 2019) are involved in their activation and implementation. Governance is connected to three crucial aspects: the individuation of the actors who are legitimated to participate in the process, each one with their own interests and responsibilities; the relationships that develop among

them; the result of these relations which needs to be significant for all the actors and legitimated by them (Kazepov, Colombo, Tsaruis, 2020).

Results

At the time the research was carried out, twelve projects were operational among which seven were carried on by one provider, two by another provider and the others respectively by another provider. As we can see, one provider carries on the most part of the projects.

Considering the location, the majority of the projects (seven) are located in Trieste, which is the county seat of the FVG Region, whereas the others were located in little rural municipalities always in FVG.

The oldest projects are the ones who were in Trieste and dated back to 2015 in one case and to 2016 in two cases. The latest project has been activated in 2021. The remaining date back to 2017 in four cases, to 2018 in other four cases and to 2019 in one case.

All the projects are in buildings which are integrated with the context, easy to reach and well connected to services. Many of the buildings are flats, which are in urban centres or independent residential buildings located in rural centres. The available bedrooms for each project range from two to twenty: the majority of the projects (6) have five bedrooms and three projects have ten bedrooms.

Many of the buildings are rented by the providers and only in three cases they are their property.

The providers are five not for profit organizations: two social cooperatives, one association, one ecclesiastical organization and one is an ASP. Each of the two cooperatives manages respectively five and two projects while each of the other providers manages only one project.

As above said, the peculiarity of these projects is that elderly are not considered as guests who stay in this residential services for a limited although very long period, but as owners of the house that can stay there for an unlimited time. So, they may consider their permanence in the residence like their real home and remain there until their death.

Considering the contract the elderly stipulate with the provider, there are a rental agreement for the location and a supply contract for welfare, food, transport to services. Additional feeds are required for more intensive assistance and for extra intervention of accompanying. In general, there are permanent contracts and only two projects are fixed-term contracts.

We can see that in two projects there is a peculiar model in which one caregiver takes care for all the elderly who live together. The elderly stipulates a pact of cohabitation, an instrument that allows people who live together without being a family unit to share the same caregiver, although

only one of them stipulates the contract with him/her. The elderly who do not stipulate the contract with the caregiver can benefit from his interventions and reciprocate by paying other costs and expenditures.

Service delivery is organized in the following ways: in seven projects the provider supplies directly the interventions; in one project the provider supplies interventions insourcing by own caregivers and professionals and part outsourcing by another provider that is a social cooperative; in one project the interventions are supplied outsourcing; in three projects the provider collaborate with a voluntary association formed of elderly relatives and specifically settled to employing caregivers. These latter, in fact, in all the provider organizations are not qualified operators and Italian legislation states that they can be directly employed only by the person they have to take care for. Hence, in three projects, all managed by the same provider, the elderly select the caregiver and directly employ him/her while in the other projects caregivers are chosen and employed by the provider. In three projects the provider had settled a voluntary association formed by elderly's relatives to employ the caregivers. Moreover, in these three projects caregivers are selected by the provider from women who live in the neighbourhood of the residential service in order to promote the integration with the local community. They are also employed part time to assure more flexible and continuous interventions. All the projects also involve some qualified caregivers, charged to supervise the activity of not qualified caregivers and have a coordinator of all the qualified and not qualified caregivers. In one project the coordinator is a social worker, in six projects she/he is an expert not qualified operator, and in three projects she is an educator. None of these projects recruit nurses because, as above said, these residential services are not considered a health residential service but as a private house and health assistance is assured by Health District nurses. Hence, health assistance and in particular pharmacological therapy and intensive therapy are very thorny and contentious issues. The crucial question here is if not qualified caregiver can deliver pharmacological therapy on behalf of nurse. When elderly people with health needs are at their home, pharmacological therapy is managed by their caregiver, who may be a relative or a private caregiver, also without an appropriate qualification. In these residential services where the caregiver is not qualified and is not an elderly' relative it is not clear for providers as well as for health care managers if not qualified caregiver can administer pharmacological therapy on behalf of nurse. So, Healthcare Districts as well as the providers adopt different modalities to address this issue. In six projects, which were managed by the same provider and located in the territory of the same healthcare district, the nurse of the Health District delegates pharmacological treatment to not qualified caregivers. The other providers, on the contrary, consider not possible for their caregivers to

assume the responsibility to administer pharmacological therapy, as well as the other healthcare district managers consider not possible for their nurses to delegate therapy administration. The question, for them, is that in these projects elder-caregiver ratio is not 1:1 as at home because for one elder there are four caregivers, so it is not clear who is the effective caregiver to whom delegate therapy administration. Hence, in one project there are two hours weekly supervision of a nurse whereas in the other projects elderly who need intensive pharmacological treatments are discharged and transferred in residential health services for elderly.

In accordance with the Regional Guidelines, most of them are partially autonomous who can live with other people and do not need intensive medical assistance. Only in one project they are in prevalence autonomous (profile E of the Valgraf). Two projects, moreover, are qualified by accommodating not autonomous elderly people affected by dementia, although in forms that do not preclude living together with other people and in one project also in forms that do not need to keep an eye on somebody during the night.

Considering the service delivery, it is possible to identify two models: the first one is based on the traditional work shift of the caregivers and the second one is based on the cohabitation of the caregivers. In the traditional model there are three work shifts – morning, afternoon, and night – followed by a holiday shift, and caregivers alternate. This model implies a considerable number of caregivers who take turns. In the other model, instead, two caregivers each one lives with the elderly for a continuous period, which is fifteen days or a month: one caregiver takes the other place, and a third caregiver covers them for the daily rest. So, in this model there are only three caregivers involved in the same project.

In all the projects elderly relatives have free access to the structure and can remain inside it as long as they want, collaborating in preparing foods, taking care for their relative, talking with him/her and keeping him/her company. They are active and collaborative but in some cases, they need to be solicited by providers because they tend to delegate to care givers every activity related to their relative. Providers solicit them to follow aspects and activities related to their relative's health, such as relations with his/her doctor and decisions regarding therapy and medical and nursing interventions.

To assure a tailored assistance in all the projects service organization is not standardized and based on scheduled and fixed activities, but it is flexible. Daily activities such as waking up, breakfast, lunch and dinner are not strictly fixed and follow elderly desires and rhythms, as well as entertainment activities. All the providers emphasize that they do not measure time they have spent with the elderly because they have any standard of time to respect, such as in traditional residential care. Hence, their care givers have no time constraints and can respect elderly rhythms as well as wait for them.

Interventions and activities are not scheduled but are decided day by day and based on the desires of each service user in order to enhance his/her sense of identity, self-esteem and sense of belonging to the structure, and their development follows each user's pace. They are always tailored on the real abilities of each service user and follow his/her pace to empower them most possible. Great attention, moreover, is paid to maintain service users' relationship with relatives, parents, friends, and neighbours, and many activities consist in going out to stroll with them or to visit them.

Elderly participation consists in realizing simple daily activities such as collaborating in preparing foods, making their bed, tiding up their bedroom or kitchen, gardening or doing simple maintenance works.

104 elderly have been accommodated in these structures during the three years of the experimentation, aged from 81 to 83 in average. Most part of them, before accessing the structure, were resident in the municipality where the structure is located.

Discussion

In this paragraph the results described previously will be discussed through the processes of governance, namely the relationships developed between the different levels of responsibility and government of the various actors involved in the realization of the experimentation.

They are exemplified by the Region at the macro level, the Health Service Departments and Social Service Management Entities at the medium level, and the public and non-profit organizations that are in charge of the experimental projects at the micro level.

Considering the Regional Guidelines' principles, first evidence detected by the analysis is that every project has interpreted the same principles and objectives in different ways. As described in previous paragraph, several types of services are indicated with the same denomination of "Abitare Inclusivo". The rules and concepts specified by the Region were operationally and organizationally interpreted by the project owners, who also defined the projects and carried them out. As a result, the experimentation took on many forms in each project, and these various forms had a variety of effects on both service delivery and cost. This is a consequence of the lack of providers and service users' participation in planning and designing this experimentation and the experimental projects. This also shows how social innovation promoted at the beginning at a central level can later develop from the bottom to the top fostered by the existing relationships between local actors (Eizaguirre et al., 2012).

From the standpoint of service delivery, two organizational configurations can be found: one, which allows for the traditional eight-hour rotation

of operators, and the other, which allows for the continuity of the same operators achieved in one project by the presence of two-family caregivers/operators who alternate weekly and/or biweekly, and in two other projects by the co-residency family caregiver with the elder. The experimentation's goal of personalisation and co-production appears to be best met by this latter configuration whereas the other appears to mirror the more rigid and standardised arrangement that is more typical of residential services. Hence, what emerges is the difficulty of these organizations to innovate and modify their structure and ways of functioning by introducing new ways of planning and delivering service in response to external influences such as experimentation (Schein, 1990, 2000).

At this level, the crucial role of governance appears in relation to the two typologies of organizational models adopted for delivering the service, the one in which the older user employs the caregiver directly and the one in which the association of the relatives employs them. These are two organizational configurations that represent an example of the transition from a bureaucratic model to a participative model based on co-production.

If we consider coproduction from the New Public Management approach, we can say that the most part of the experimental projects have not realized it. NPM approach in fact is preoccupied with how service user participation can be "added into" the process of service planning and production to improve the quality of these services, so co-production can only occur at the behest of, and controlled by, service professionals (Brandsen & Pestoff 2006). As Osborne et al. (2013) highlights, although NPM approach regard co-production has evolved, portraying service users as co-producers in different guises – as citizens/clients, consumers, customers – and latterly simply as co-producers, the most recent literature, maintains the enduring perspective of public administration upon co-production as an optional element of the service delivery process, arguing that "service users and their communities can – and often should – be part of service planning and delivery (Bovaird, 2007, p. 846) and considers co-production as a normative, voluntary, good that should add value to the public service production process, but that is not intrinsic to it. Our analysis has shown that this approach has oriented providers and social services and health district managers interpretation of coproduction.

If we assume the service management approach «*co-production is an essential and inalienable core component of service delivery: you cannot have service delivery without co-production.* It occurs whether service users choose to or not, whether they are aware of it or not, and whether the public service encounter is coerced or not. *Co-production thus comprises the intrinsic process of interaction between any service organization and the service user at the point of delivery of a service – what Normann (1991) has termed "the moment*

of truth" in service provision. […] Unlike much current public management literature, therefore, the service management literature emphasizes the interactive interactions between the service producer and the service user in the co-production of public services and the interdependency between these two at operational level. The user's contribution as a co-producer during service production is not only unavoidable (and can be unconscious or coerced) but is also crucial to the performance of a service. *Such co-production leads to the co-creation of value for the service user*, […]» (Osborne et al., 2016, pp. 19-20). According to this approach, all the experimental projects realized co-production. Co-production, in fact, «is being considered as the involvement of citizens in the (co-)implementation of public services» and «is perceived as a value in itself, which is also supported by the observation that several authors addressed the increase of citizen involvement as an objective to be met» (Voorberg *et al.,* 2015 p. 1347). These types of services, as the health care system, are by "nature" a co-producing system where providers and patients perform their functions in an integrated way and share information, competences, and skills to co-create value (Palumbo, 2016). Moreover, codesign and co-delivery health care services to be especially fitting to home-care where health care professionals are hosted by patients within their daily context of life (Palumbo, 2016). Hence, they appear to be appropriate to this type of service, which is aimed at reproducing home setting. If we go into depth and consider the use of co-production during the phases of the service cycle, that are commissioning, design, delivery, and assessment (Nabatchi et al. 2017), our analysis shows that it is limited to delivery. In the phases of commissioning and design there has been no involvement of service users and their relatives. But both are crucial: co-commissioning is useful to identify and prioritize needed public services, outcomes and users, and co-design enable public actors to better understand how public services could be designed to be of greatest use and benefit for individuals and communities.

Moreover, it is evident from the point of view of service delivery that drug therapy administration and intense nursing care are managed in different ways on the basis of the various relationships developed between the providers of the projects and their respective Health District. Regarding this aspect, what emerges is not only the importance of the organizational aspects such as the availability of nurses, but also of the organizational culture (Schein 1999, 2000) which seems more oriented to bureaucratic approaches in most parts of the Health Districts and more open to the community in others. However, because only the elderly people who are partially non-self-sufficient and have a specific level of autonomy and residual competence are eligible to use this service, it really introduces into the experimental projects a mechanism of adverse selection of the elderly. This illustrates that the ser-

vice only partially satisfies the demands of the older population, which is at medium-high levels of non-self-sufficiency. The elderly with greater levels of non-self-sufficiency remain excluded from this programme. The Health Service Districts that represent the intermediate level of governance, have demonstrated an inability to contrast efficaciously the effects of path dependence and to address these challenges uniformly, thus reinforcing the unevenness of the system. For the population, these organizational inequalities and service heterogeneity represent manifestations of inequality that must be eliminated. As a result, it is necessary for the Region to take regulatory action to define and explain the duties, responsibilities, and connections between the many levels and individuals participating in the caregiving process.

The way the personal budget is currently set up creates a further barrier to using this service (Castegnaro, Cicoletti, 2017; Carnevali, 2021). The personal budget, used to pay for the costs of caregiving projects for all elderly people with Val. Graf type B and C profiles, is the financial support made up of a health-related component that constitutes an essential level of assistance (LEA) to cover health expenses and a social relevance component that is funded through the FAP to cover welfare expenses.

In this regard, both project managers and social service managers draw attention to the fact that the amount of FAP supplied for the elderly is minimal and that it frequently falls short of covering their costs, particularly when they have a low need profile. The elderly would therefore forsake this service, unless certain family members were able to cover the expenditure, and choose a typical residential facility where they might benefit from the subsidies to lower the cost of the fees, because it is only applicable to residential care and not home care, according to the regulations in effect today. It follows that low-income and partially dependent elderly persons continue to be denied access to this type of assistance.

As a result, there is inequality on this dimension as well that needs to be removed. Therefore, regional regulatory action is required to implement financial assistance for people who choose this service, in the same way as for those who opt for a residential home.

The set of regulations governing the connection between the Region and project holders also needs to be revised. Project holders are also ineligible for a wide number of supports, particularly financial ones, from which residential facility owners benefit when they provide a service that qualifies as a home-based service. However, the facility where the service is delivered is either their own or is given to them on loan, and it comes with several responsibilities that home care does not, associating them instead with the proprietors of the residential facilities that allow for the lodging of a huge number of people thereby benefitting from some economies of scale as op-

posed to the facilities in the experimentation that due to limited accommodation potential, are impeded from developing such economies.

These services, which already struggle to cover fixed costs when all available places are filled, are likely to experience a particularly significant shortfall because of the length of the waiting period for the UVM assessment, which delays the prompt filling of any available vacancies. As a result, there is a type of inequality with respect to the owners of these services when compared to the owners of residential services. There is therefore a need for extra regulatory action on the side of the Region which would grant compensation for the additional expenditures and lost revenue associated thereto, by acknowledging the added value delivered to the service by the modest size of these facilities.

In accordance with Sorrentino and colleagues (2018) the results confirm that, although co-production is based on the critique of hierarchical service delivery models, the fundamental role of central administrations is confirmed, both as promoters of interaction between the actors involved and as facilitators of the distribution of resources available to the various policy arenas involved.

The crucial issue is the way in which governance is realized. In fact, it should be able to balance adequately the necessity to guarantee equity with the necessity to safeguard the peculiarity of social innovation and co-production which, as described previously, are characterized by the strict adherence to the local context and to its specific needs and resources. In order to achieve this, it is fundamental that governance assumes a participative configuration which may find in ongoing evaluation a useful instrument for recognizing the adjustments necessary for the process underway through the participation of all the actors involved. The application of these adjustments may then be realized by guidelines that, though presenting a binding feature, allow a margin of discretion for intervention useful to accepting the specificity of singular contexts.

Conclusion

The paper has an empirical context because it is grounded in the experience of a regional experimentation. However, we argue that its results and analysis are not bounded in this geographic locus and they can be useful also for policy makers and practitioners in other contexts.

The evaluation research has highlighted the crucial role that the *governance* plays in developing and sustaining innovation experiences. On the one hand, in fact, what has become apparent is the decisive function exerted by the governance system existing at the micro level in inducing the path dependence effects, upon which the many and distinctive declinations

assumed by the same innovation depend. On the other hand, it has been demonstrated that, to prevent these factors from having distorting effects in terms of disparities regarding the access to services and treatment for citizens, the intermediate level of the governance system is fundamental and, in particular, that central institutions monitor and evaluate the progress of promoted innovations in order to implement those adjustments that make it possible to avoid the potential negative effects that even the innovation itself can have.

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