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# Civil society, third sector, and healthcare: The case of social cooperatives in Italy

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ABSTRACT

In many European countries, the third sector is considered an actor able to improve both the efficiency and the efficacy of public healthcare systems afflicted by the crisis of the welfare state. Attributed to third-sector organizations is the role of a hybrid actor tasked with the professional supply of services, not for profit but rather for mutualistic purposes, and to serve the public interest. However, empirical evidence on the capacity of the third sector to pursue objectives of social inclusion in a phase of withdrawal by the public sector is almost entirely lacking in the European countries. The article describes the results of research on the transformation of the Italian healthcare system and on the emergence of a new third sector in Italy. The results of the inquiry highlight the strategies, characteristics, and governance processes which enable third-sector organizations operating in the healthcare sector to pursue objectives of inclusion, and to serve the needs of disadvantaged groups by assuming the form of social enterprises.


## 1. Introduction

Since the 1980s, due to the fiscal crisis of the welfare states and the reorganization of public expenditure, the provision of welfare and healthcare services in many European countries has undergone important changes. While the public supply of services has been increasingly unable to meet the growing needs of the population, more and more third-sector organizations (TSOs) have been created in order to deliver welfare and healthcare services (Defourny and Nyssens, 2010; Thomson et al., 2009). This evolution has been supported by the conviction that transferring power and service production to various forms of TSOS (such as charities and social enterprises) could not only help reduce public expenditure but also better reach and serve people in need. This conviction is exemplified by the Big Society approach in the UK, which sees TSOs as the remedy for all government failures in this field and their expanding role as the main justification for additional cuts to public expenditure (Ashton, 2010).

Given this evolution and its political implications, questions relative to the third sector's role have become increasingly pressing.

The rationale for the increasing engagement of third sector organisations in the delivery of welfare and healthcare services has typically been based on the belief that, while TSOs are private organizations, they are motivated by values of justice and social inclusion. Moreover, given their concern for the needs of the most disadvantaged segments of society, they are seen as a source of additional services and a way to reach users not served by public providers. Several authors, however, maintain that this conception of the third sector is excessively simplified and idealized, and as such does not correctly portray the role and characteristics of these organisations (Ruzza, 2011). Neither side of this debate, however, is sufficiently supported by empirical evidence, and research on the real ability of the third sector to satisfy needs not met by public welfare and healthcare systems in particular is still limited (Heins et al., 2010).

The aim of this article is to contribute to filling this gap by providing some empirical evidence on the capacity of TSOS to deliver services in a context of reduced coverage by the state, while still serving the needs of the most disadvantaged individuals and groups. The analysis is based on a country case study concerning the experience of Italian social cooperatives, leading private providers of social and healthcare services created by Italian civil society during the 1980s and institutionalised at the beginning of the 1990s.

After summarising the debate on the role of TSOs in the first section, the paper describes in the second section the characteristics of the Italian healthcare system and the emergence of TSOs – focusing in particular on social cooperatives – as service deliverers. The third section then reports the results of an empirical survey conducted in order to investigate the cultures, characteristics and

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behaviours of a sample of social cooperatives, as well as their forms of governance and their practices concerning inclusion and social justice. The conclusions draw some more general considerations concerning the potential role of the third sector in the transformation of the European welfare and healthcare systems.

## 2. Can the third sector improve the performance of public healthcare systems?

The provision of universalist healthcare services is deemed to be one of the pillars of public welfare systems and the necessary condition for guaranteeing equity and social justice. Nevertheless, because healthcare is also one of the main sources of government expenditure, the fiscal crisis of welfare systems has called its sustainability into question. Moreover, increased demand for more personalized services consequential on the diversification of needs has highlighted the limitations of an often centralized and bureaucratic organization of services. Numerous governments have therefore undertaken various reforms aimed at both the containment of expenditure – also through cutbacks in services – and the decentralization, liberalization, and privatization of the supply (Halsall et al., 2014). These latter actions have also increasingly involved TSOs and civil society organizations in general, in the conviction that they can contribute to a reduction of costs and to a broader coverage of needs, particularly those of persons belonging to the most vulnerable social groups often not reached by the public supply (North, 2011).

The contribution of the TSOs to costs reduction, it is argued, derives from their greater organizational and payroll flexibility. Their contribution to the pursuit of greater social justice is ensured by their particular nature as organizations driven by ideal objectives, not by profit and the relative regulation. They are thus physiologically able to respond to the problems of justice and equity, thereby contributing to the system's sustainability and to broader coverage of healthcare needs.

However, this conception appears highly reductive. According to the main theoretical criticism brought against the notion of the third sector as an 'agent of social justice', this manner of conceiving the role of TSOs derives from the conviction that the constitutive features of these organizations have an 'ontological' basis (Corry 2010).

According to the ontological approach, TSOs share a number of distinctive characteristics stable in time and space and which give them a specific nature independently of the context in which they operate, and from the incentives and motivations that induce their constitution and management.

However, the empirical evidence in support of this thesis is fragmented and anything but decisive (Pestoff and Brandsen, 2009). The literature has instead shown that TSOs, also since their involvement in the services delivery system, have assumed very different characteristics, both among welfare systems and within them (Kerlin, 2010).

In order to interpret the differences among systems and among organizations, it is more fruitful to take a more 'epistemological' approach to the study of TSOs.

The epistemological approach considers third sector as a societal process which historically and spatially stem from structural conditions, negotiations, and specific communicative processes.

The 'processual' nature of the third sector entails that its possible contribution to the reorganization of healthcare delivery cannot be theorized only in relation to ascriptive features. On the contrary, changing contextual conditions and the processes that connect them with the other political and social spheres are decisive in furnishing greater knowledge on the third sector's possible role in the current reorganization of the supply of social-healthcare services.

The research question that should be answered to determine whether the third sector can make an autonomous contribution to the reorganization of public healthcare systems to the benefit of the most vulnerable social groups is therefore as follows: in its various forms, is the third sector really concerned to respond to the needs of marginal social groups according to principles of j equity and social justice? A further question is whether this concern is apparent in all third-sector organizations or only some of them; and investigation should be made of the organizational characteristics and conditions that favour the assumption and maintenance of this attitude.

## 3. The case of social cooperatives in Italy

The Italian case is of particular interest for empirical verification of the third sector's role in the reorganization of healthcare services.

Italy's national health service (Servizio Sanitario Nazionale, SSN) was instituted in 1978. The SSN provides universal coverage and is financed out of taxation. All citizens can in principle access services without private insurance.

The SSN has ensured the ample coverage of healthcare needs but not of numerous social welfare ones, so that at the end of the 1980s Italy was one of the European countries with the lowest coverage of demand for social-welfare services. In response to these unsatisfied needs, in those same years and mainly on the initiative of civil society, numerous TSOs were created and consolidated. Thereafter, during the 1990s their function was recognized, and their activity, to a large extent previously supported by private contributions and by voluntary work, was directly financed with public resources and then by competitive tendering (Borzaga and Fazzi, 2011). Thus created was a broad supply of services managed by TSOs, but in large part financed by the national health system or other public institutions.

In this process, the form of TSO which has undergone greatest development has been that of the social cooperative (Borzaga and Fazzi, 2011). These TSOs, recognized as legal entities in 1991, are organizations that according to the law should pursue the general interest of the community and the social integration of citizens through the provision of social, educational or health services and the organization of work–integration activities (Thomas, 2004).

The law does not require cooperatives to adopt a particular form of governance. They can be governed either in mixed form by workers and members of civil society or only by workers. They may have volunteers in their memberships, but only up to 50% of the total.

Social cooperatives today respond to needs that the state would find difficult to satisfy owing to the high costs and low flexibility of the public services especially in the sectors of disability, mental illness, and elderly care. They have thus become an integral part of the Italian welfare system, while the public administrations are their principal financiers. Currently, social cooperatives in Italy number more than 12,000, they have around 350,000 employees, and record an overall turnover of more than ten billion euros.

However, the professionalization and organizational structuration of social cooperatives, and their close dependence on public resources, have loosened their relationships with civil society. Alongside organizations still rooted in the community, others have arisen with predominantly entrepreneurial purposes (Ascoli et al., 2002).

Since 2008 the economic-financial crisis and the subsequent speculative attack on the Italian debt have imposed further rationalization on public expenditure – and on healthcare expenditure in particular.