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Contracting for Welfare Services in Italy

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Abstract

The 1990s witnessed the spread and broadening in Europe of different types of relationships between public administration and private organisations (both for-profit and non-profit), derived from the two main categories of contracting out and accreditation. These models, linked to the process of developing new modes of governance, also focus on forms of contracting between providers and users of services. This contractual configuration of local welfare systems appears to encourage 'civil society' and recipients to play a more active role in designing interventions and putting them into practice. Nonetheless, several questions still remain to be answered, mainly concerning the different position adopted by the beneficiaries in the case of intervention theoretically aimed at ensuring or increasing their 'freedom of choice'. This article sets out to analyse these questions with specific reference to the implementation of the Italian legal reform of social services. The field of observation covers interventions based on economic benefits looking to promote recipients' independence. Our intention is to focus on whether and how the present structures incorporate and elaborate this impulse towards change, with particular reference to the new configuration of the users' own position.

Introduction

From the 1990s onwards, social policies in European countries began to show a growing reference to contractual devices in the sphere of the regulation of relationships between public administration and both for-profit and non-profit private parties. At the same time, this reference also tended to gain ground in the field of relationships with beneficiaries, consistent with the trend towards increasing their *agency* and guaranteeing their so-called 'freedom of choice'. In its simplest form, the phenomenon of social policy contracting recalls the attempts to bring together the state and the market which developed in the arena of marketisation (Crouch *et al.*, 2001), and brings to mind in particular three guidelines of the changes foreshadowed and fulfilled in this framework: (1) the separation between guidance/financing/control and provision; (2) competition between providers, both public and private; and (3) the consumer's 'freedom of choice'. Thus, the transformational processes related to marketisation affect not only *who* is involved (the public or private nature of the parties engaged), but also *how* they interact (the logics of regulation and public action). It is important

to underline that a shift has occurred in the public regulatory role, marked by surmounting the principle of authority and assuming a mediative profile for responsibility (Bifulco and de Leonardis, 2002), as well as by an institutional and organisational change based upon the introduction of management methods typical of the New Public Management into the administrative sphere (Clarke, 2004).

Nonetheless, marketisation does not constitute an exclusive or unequivocal reference with regard to emerging contractual devices in social policies. On the one hand, we are faced with different forms of contractualisation and a variety of contractual devices. On the other hand, the concrete dynamics of marketisation in European countries entail a variable degree of alternation and combination among various modes of regulation.

Mix and variety do not imply that the effective range of the contracting of social policies should be reappraised. The point at issue is that the changes involved are often ambiguous and can develop in several directions and in heterogeneous forms.

One central question regards the different position that beneficiaries – that is, users of the services – choose to adopt in the policies, above all in the case of actions which theoretically aim to ensure or increase their 'freedom of choice'. In this article we will attempt to tackle this question by focusing on the role of public administration. Our hypothesis is that the nature of this role constitutes a key variable in order to understand whether and how the position of the recipients changes.

We shall proceed as follows. First, we outline different forms and devices of contracting. Following this, by limiting our reflection to the field of the market-type contract, we concentrate on identifying the main trends in the regulation of social policies in European countries. We then present the results of a study focused upon two regional contexts in Italy. The selected territories are taken as a representation of Southern and Northern Italy, and correspond to a few areas in which contractual devices have been implemented, reconfiguring the position of users in a contractual direction. From these results, we then extract information on the institutional conditions with respect to the change in position of the beneficiaries of social policies. Finally, a few further questions concerning the regulatory role of public administration are addressed.

Various forms and devices of contractualisation

With specific reference to our area of focus and in the strictest sense of the term, contracts are formalised and restrictive tools that regulate voluntary relationships between public and private parties on the basis of the classic criteria of trade, typically between buyers and providers. However, this meaning does not prove helpful in explaining the variety of contractual systems involved in the regulatory mixes.

The point is that the social policy scene is crowded with contracts. For entirely representative purposes, we can trace this variety to the following list of types and corresponding structures:

- contracts as buy-sell transactions (market-type);
- contracts between gift and market;
- contracts as responsibilisation;
- contracts as policy-making agreements (between state and market).

The first of these coincides with the market-type contract, more directly related to commercialisation, and particularly regarding health and social care policies. Beginning with the UK reforms of the National Health System, health constitutes a privileged developmental area for managed competition and quasi-markets in Europe (Le Grand and Bartlett, 1993). With regard to social care, since the 1990s its commodification has developed significantly and in various forms, particularly with regard to residential and home-based care for the weak or frail (older people, people with disabilities, children; Ungerson, 1997). In both policy fields, marketisation breaks down into two distinct modes, depending on whether the role of purchaser is assigned to the public agency or to the citizen-consumer (Ascoli and Ranci, 2002). In parallel to this, contractual regulation can avail itself of two dissimilar devices: (a) contracting out, that is competitive tender or agreements between administrative bodies and providers (both public and private) related to a specific type of competition: competition *for* access to the market (in order to stipulate contracts with the public administration); (b) contracts based on the competitive offer among authorised providers: in this case we have competition *within* the market to attract consumers.[1]

In addition to the creation of a market of professional organisations, the commercialisation of social care may come about in the form of remuneration to informal care givers.[2] Particularly where family carers are present, the relationship between the provider and the recipient of care takes the form of a 'between gift and market' contract (Ungerson, 1997; Gori, 2003); this in fact combines the logic of commercial exchange with the actual relational aspects of care, that is being involved 'in meeting the physical and emotional requirements' of dependent people (Daly and Lewis, 2000: 283).

We find the third type of contract, which we define as '*responsibilisation*' (Saraceno, 2002), in assistance intervention for social inclusion. This is specifically to be found in policies for income support and placement (whether social or occupational) that are conditional and based on the assumption of reciprocal commitments between the recipients and the agencies. We can distinguish between two main typologies. The first, more greatly rooted in continental Europe and of which the French social integration minimum income is a good example, circles on the acceptance of *reciprocal responsibilities* between recipients and agencies, and on the mutual recognition of relational capacities (Borghi and

van Berkel, forthcoming). The second typology, which is strongly influenced by the US perspective of *workfare*, centres upon the recipient's *unilateral obligation* to conform to pre-established conduct, thus conditioning the right to receive benefits according to the fulfilment of this obligation.[3]

Not only the production of goods and services but also policy making, primarily at the local level, tend to give increasing space to contractual devices as the decision-making arena opens up to a plurality of parties and institutions, both public and private. Under the name of agreements, pacts, conventions or, more precisely, of contracts, these devices redefine the form and content of relationships between the same public administrations, with varying degrees of competence or involvement (Bovaird, 2004). Here we have a fourth type of contracting, based on *relational agreements* concerning complex problems and collective interests. Therefore, this kind of contract is, by its very nature, 'between state and market' (Bobbio, 2000).

There are many and various arenas of social policies involving both cases, such as social care in Italy, which, with the reform introduced in the year 2000, makes way for partnerships predominantly with non-profit organisations. Other areas include interventions for neighbourhoods in decline or in crisis as, for example, actions instituted for social inclusion in France and the United Kingdom, respectively in the scope of neighbourhood intervention and in programmes of urban regeneration looking to revitalise local communities (Tosi, 2004).

We thus have four different forms and devices of contractualisation. In this scenario, we can identify at least a few common elements that correspond to different transformative transitions of public action related to current reorganisations of social policies. First, there is the transition from the logics of hierarchical authority (typical of government) to those of negotiation between players and interests (typical of governance). A second transition refers to changes in the relationships among the sub-national, national and supra-national dimensions of policy making, and, in particular, to the increasing autonomy of local levels of government, an increase which is normally interwoven with the development of governance regimes (Le Galès, 2002). Lastly, we have the transition from the logic of uniform and predefined services based on universal or categorical entitlement (citizenship as status) to the logic of personalised services, be it in terms of preferences or regarding the available conditions of agency that may be enabled for the recipients (in the direction of citizenship as contract; Castel, 2003; Handler, 2003).

All of this does not as yet provide much insight into the characteristics of contractualisation, but does help to identify two important points, relative to the reach of the implied processes of change and to their lack of linearity. As the presence of hybrid forms itself indicates, the spreading of contractual forms and devices calls for the frontiers between state, market, family and so-called

civil society to be redefined; what is consequently at stake is a redefinition of the relationships between services (both public and private) and citizens. In terms of the direction and range of these processes, more than one element of ambiguity can be observed. One should bear in mind that in marketisation, regulatory forms and instruments having different 'political roots' meet, alternate and often converge. Furthermore, in specific regulatory structures, overlapping between the types we have set out above often occurs; in this respect, one example would be the increasing spread of contractual agreements in Italy between public and private actors for the provision of commercialised social assistance. This granted, in the following paragraph we shall concentrate on the market-type contract.

Regulatory mix in the contractualisation of social policy

Indeed, the main attraction of the contractual model is a basic precondition of its 'market' type: managed competition. As the term indicates, valuing the virtues of competition – that is, efficiency, the diversification of goods and services and respect for the 'freedom of choice' of the citizen-consumer – requires and presupposes the public regulation of market transactions. The idea is that a public institution can or must intervene, both on the supply side and on that of the relationship between supply and demand, with a view to meeting multiple needs: to render competition effective; to counter any barriers to market access and any trust positions, as well as to avoid the risk of situations of partiality or collusion; to remedy the informational imbalances that typically plague the trade relationship between provider and buyer; and to define and test performance standards.

From this point of view, the market is a solution to the failures of the state (inefficiency and rigidity of the offer), yet its virtues unfold only on condition of a change in public administration, involving both its regulatory role and the logics of management and organisational action. This we have mentioned earlier. More accurately, managed competition requires both the introduction of the structure of market incentives – for example, prices and tariffs – in the production of public services, as well as the introduction into public administrations of criteria and techniques typical of the New Public Management, such as results orientation, the criteria of efficiency, cost and supply control and accountability. In this perspective, the infusion of 'market' action criteria in the public sector is a central aspect.

The reform of the UK health system during the 1990s is without doubt an exemplary case of policy change oriented in this direction. But once translated into practice, the reforms and policies were rife with hybridisations (Latour, 1996; d'Albergo, 2002). Already under Thatcher, the development of competition between providers in the health quasi-markets was only partial and the weight of co-operative practices became clear: a weight backed and reinforced by the initiatives subsequently implemented by the New Labour government (Neri,

2004). Studies on the subject concur in highlighting a mix between formal and informal competition and collaboration between the parties, a mix with no lack of oligopoly or monopoly situations (Klein, 2001). The same contractual devices used are atypical as compared to the premises of the market model; they are '*soft*' contracts (Savas *et al.*, 1998) or '*relational*' contracts (Dore, 1983), and are therefore characterised by fiduciary components, as such remaining subject to the risk of situations of partiality. To complicate matters further, the influence, albeit relative, of the logic of an authoritative nature was detected.

In general, in the concrete dynamics of marketisation in European countries, rather than 'pure' and lasting creations of more or less managed competition, a variable degree of alternation and combination between the logic of authority, the logic of competition and the logic of co-operation seems to prevail (Ascoli and Ranci, 2002). With regard to health care, we found the same results in Italy with the implementation of reforms of the national health system adopted over the last decade. These reforms were also characterised by managed competition.[4] In the framework of elevated regional differentiation, a mix between top–down regulation and regulation of a co-operative nature tends to predominate (Maino, 2001).[5]

There can be no doubt that the bumpy routes of contractualisation are, to a certain extent, also linked to effects of institutional learning with regard to the problems and possibilities of the regulatory modes once they have been applied in concrete form. The problems of authority are all too familiar. Even the market does not appear entirely desirable once the results are visible, both in terms of inclusion/exclusion and in terms of public visibility and control. Similarly, co-operation presents its own problems, susceptible as it is to the risk of partial, closed and exclusive situations (Ostrom, 2005).

The main point to be made is that the processes implicated therein are not at all neutral. Even if they do not follow the linear paths pursued by the reference models, and often by the public philosophies that support them, they have been, so to speak, on the road for a long time; they have prompted changes and will continue to do so. Furthermore, there is always the risk that contractualisation would pave the way for 'hollowing out the state' and would end up creating or widening disparities in access to goods and services. There are already a few hints in this direction even in Sweden, home of the universalistic ethos (Blomqvist, 2004).

Organisational responsibility in public administration

Given this picture of the situation, we should single out certain issues regarding the position of the beneficiaries in the *contractualised* policies or measures, with particular reference to those marked by an objective to promote freedom of choice. The main questions to be posed, which are interrelated, concern the actual capacity of these policies to foster or accomplish a more active role of

TABLE 1. Administrative models.

	Bureaucratic Administration	Company Administration	Shared Administration
Evaluation Parameter (Worth) of the Administrative Action	Legitimacy	Efficiency	Participation
Type of Relationship	Dual (Public Administration – Citizen)	Triangular (Public Administration, Provider, Citizen)	Network (Public Administration, Provider, Citizen, Community)
Public Administration's Responsibility	Direct	Indirect	By Process
Recipient	User	Consumer	Active Citizenry

the citizens, and what freedom of choice effectively consists of. Our hypothesis is that in order to address these questions, it is important to focus first on how public administrations change or are susceptible to change. The tendency to take on a mediative role regarding responsibility can materialise *de facto* in a wide range of arrangements. Within this range we can find forms of responsibility sharing between different public and private players having collective goals and interests, but also forms of marked reduction in the public functions of guidance and choice (such as politics).

Regulatory mix of *marketisation*, nonetheless, involves a change in the institutional and organisational structures, which we can schematise in reference to the following types of public administration: 'bureaucratic administration', 'company administration' and 'shared administration'.

This typology allows us to reflect in detail on the main variables to be considered when analysing the transformations of the administrative action under the pressure of contractualisation.[6] As we have already stated, regulation by contracts outlines an intermediary role of the administrative responsibility, a role that is the pivot for post-bureaucratic administrative change. However, this intermediary role may have a very different premise and meaning. In 'company administration', this role is defined by the position of the public administration in relation to the citizen in a triangular scheme: the public administration responsibility is indirect, because it is mediated by private providers (Freedland, 2001). In 'shared administration', the intermediary overtone of the public administration responsibility is not the attribute of a position or of a relationship; *it is the feature of processes*: it is linked to intermediary action among various and divergent strategies, interests and justifications.

Two different contractual devices: vouchers and health care budgets

Based on the aforementioned literature, we designed comparative research to analyse the effect on recipients of the introduction of different contractual devices in social policies at the local level in Italy. To begin with, we confined the field of observation to a specific policy field: intervention for people with disabilities based on economic benefits with the goals of reintegrating the recipients in society and promoting their independence. Our aim is to focus on the question of whether and how the present structures incorporate and elaborate the impulse towards change alluded to above, with particular reference to the new configuration of the users' own position and new forms of citizenship. The research was carried out in two regional contexts in Italy: Lombardy and Campania. The territorial environments under analysis specifically pertain to the south and north of Italy, and correspond to a few areas which have already witnessed the implementation of socio-medical rehabilitation interventions based on economic transfers: vouchers in Lombardy and a health care budget in Campania. These actions, while falling under the same category of intervention called for by the social services reform law in Italy (Law 328/2000), also have significant differences both in terms of their institutional system and in terms of the specific content of the services to which they provide access.[7] They also partially trigger different relational dynamics (on two levels: both between public and private parties, and between private organisations providing the service and users) and produce different organisational forms. Given this premise, and given the centrality of the organisational dimension deriving therefrom, our intention was not to rely on tools related to the analysis of policy networks (or advocacy coalitions), nor to an analysis based solely on devices, and even less to conduct an evaluative analysis of the impact of the actions in terms of costs/benefits or to the follow-up of the users' careers. We felt it was necessary to work with an institutionalist approach in order to articulate the cognitive, normative, and regulatory dimensions, which together we believe make it possible to address the relevance of the content and the issue of the policies in the processes of institutional change.[8]

The socio-medical voucher in the region of Lombardy

Throughout the past 25 years, the region of Lombardy has experienced a low level of integration between social and medical care. Since 1986, the regional structure of health policies and that of social care policies were both planned by a single regional 'socio-medical plan'. However, the last plan in 2002 concentrated solely upon health and socio-medical services, neglecting social care. Traditionally in Lombardy, the relationship between health care needs and social care needs, as well as the management thereof, has been extremely poor. The two sectors are rigorously separated at all levels (regional, territorial and

operational), with health services given the utmost precedence and marginalising the importance of social services. In this perspective, the Region has obliged the municipalities to convert social care intervention from services into economic transfers. In fact, since 2002 the regional government has bound municipalities to spend in 'cash' (vouchers and care cheques), and not in 'social care' (services), 70 per cent of the funds coming from the National Fund for Social Policies.[9] This measure is consistent with that already applied in the health sector since the early 1990s, characterised by situations of competition *within* the market and not *for* the market (Rebba, 2002), and by a system having a pre-established tariff but without a fixed volume of maximum expenditure. Thus, in the field of health care today, we see a competitive type of regulation between providers. The Region adopted a regulatory role in the system, above all to contract and to define resources, remuneration for each service, authorisation-accreditation and consumer-satisfaction assessment. This regulation mode was further extended in 2002 to socio-medical care, particularly for intervention regarding people with limited self-sufficiency and for rehabilitation.

The socio-medical voucher is part of the reorganisation of the integrated home-based care service; it aims to 'avoid or delay the institutionalisation of non self-sufficient individuals' (institutionalisation in health residence). After a short trial period in 2002 in two limited areas, the voucher was extended to the entire regional territory in July 2003. The socio-medical voucher is defined by the Region as 'a non-cash economic contribution, in the form of a voucher, issued by the Region through the *Aziende Sanitarie Locali* (ASL: Local Health Authorities), which can be used exclusively to purchase integrated home-based socio-medical services from an accredited organisation, public or private, "profit" or "non-profit", provided by professional caregivers'. People may use the voucher to pay for rehabilitation and nursing services.[10] The voucher is received by each 'frail' person who can be assisted at home, without limits of age or income. In order to obtain this voucher, the citizen must refer to his or her GP, who may then request the authorisation of the ASL upon his own judgment and at his own discretion. As a matter of fact, in the year 2004, 2,050 people were granted the voucher, with a satisfaction rate of the requests formulated by doctors to the ASL of 88 per cent.

The introduction of the voucher represents the *de facto* consolidation of a process of externalisation, coming from afar, of integrated home-based services in favour of accredited private providers. A separation between buyers and providers of the services was introduced assigning the exclusive role of *planning, purchasing* and *control* to the local health authorities, with the consequent closure of directly managed services. Thus, a quasi-market was created in which the providers of socio-medical services compete on the basis of a pre-established fixed rate (*yardstick competition*) and attempt to attract patients. The recipients are free to choose their preferred provider, based on their 'increasingly better informed "health demand"'.

In other words, the socio-medical voucher rests upon two cornerstones: the provider's freedom of action, and the citizen's 'freedom of choice'. Declaimed in the administrative decrees, these freedoms presuppose: (1) great confidence in the efficacy of competition; and (2) the assumption that the citizen is able to make a conscious and informed choice between the various service providers (Monteleone, 2005).

The analysis of the interactions in the voucher's organisational field shows the following chief characteristics of this case: (a) decision-making interactions between public and private organisations are rather scarce: public agencies establish standards according to the pre-selected providers, with providers making their own arrangements; (b) the relationship between providers and users is characterised by the market scheme (seller-buyer); (c) the demand-driven model implies that the Region plays a strong role in regulation and planning with regard to municipalities;[11] yet, at the same time, the demand-driven model implies a weak role for the public purchaser in regulating the competition among private providers and in supporting 'freedom of choice' of the citizen-consumer; (d) public administration is closely referable to the 'company administration', characterised by indirect responsibility and a triangular form of relationships among public administration, citizen and provider (see Table 1).

The Health Care Budgets in Local Health Authority 2 in Caserta (Region of Campania)

In Campania, the regional plan governing the guidelines for social and socio-medical services (2002) has three basic characteristics. First, it offers an open description of planning, limiting itself to sketching a framework that establishes priorities and objectives, and identifies criteria and operative structures that are consistent with such criteria. However, this leaves significant margins of autonomy to other institutional parties and, in particular, to local agencies. The second characteristic is related to the weight given to the criteria of diversification within the plan; not only is economic support provided for, but it also calls for services, both home-based and territorial, and projects. This plan thus stands at the opposite end of the spectrum to the Lombard socio-medical plan; moreover, regarding the relationship with the municipal level, both the open framework of the regional plan and the criteria of diversification of the offer that characterises the plan can work in favour of innovation in the local arena. The third characteristic is that the plan explicitly targets the strengthening of the integration between health care and social care services. From an already high level of integration between the two sectors, the major objective of the plan is to drive integration not only towards hindering attempts to '*medicalise*' social services, but also to try to 'socialise' the health sector. In actual fact, in certain municipal areas of Campania, experimental programmes for individualised rehabilitation are currently underway. Such programmes aim to boost autonomy and are hinged

upon new forms of arrangement between services and monetary transfers. Public and private organisations both contribute to their planning and management.

The 'individualised rehabilitation therapy project', also known as '*care budget*', is a socio-medical type of intervention intended for people affected by social disabilities derived from psycho-organic illnesses or socio-environmental marginality;[12] current experimentation constitutes a part of the strategies for reducing committals to large clinics and medical residences, and concerns a middle-sized urban area (*Aversa*). The core concept is to convert the cost of the public expenditure for the residence of non-autonomous people into individual budgets to be spent on sustaining fundamental capabilities of the beneficiaries in relation to three basic functions: housing, work, and socialisation. In other words, the idea is to translate the cost of a bed in an in-patient institution into a budget, an individual property, which the person can then use to develop his or her living and working capabilities. However, as in the case of the voucher, the recipient does not receive cash directly; he or she receives a budget, which cannot be used by the individual. The care budget, in fact, is co-managed by a non-profit organisation and by public agents (of the municipality and the ASL).

The request to enable a care budget may be formulated either by the social services of the municipality or by the health services, and is examined by a board of the ASL. If the request is accepted, the public agent who made the request draws up an initial hypothesis of the personalised rehabilitation project in conjunction with the beneficiary him or herself. On the basis of this first project, a co-operative society capable of providing the services relative to the three areas is identified for the beneficiary citizen. Should the selected society accept the conditions of the project, a mixed team is formed composed of social workers from the ASL (with health competence), from the recipient's municipality of residence (with social competence), and from the non-profit organisation, with a view to refining the details and scope of the individual project, and to further verify the private organisation's compliance therewith.

Care budgets are regulated between the parties by a contract constituting the formal act which, under the regulations of private law, governs the relationship between the user, the public service (ASL/municipality) and the private partner. The contract is stipulated on the basis of a customised project, formulated by the referent operators, the user, and his or her family. The overall procedure of the individualised project is monitored and evaluated by the Integrated Evaluation Unit, which must be activated for each case, and which consists of operators of the corresponding service (from the ASL and the municipality of residence), family members, and the recipient of the budget. Although the operators of the non-profit organisations are involved in the Integrated Evaluation Unit in order to assess the customised projects, the end responsibility for the progress assessment regarding the relationship between beneficiary and provider remains in the hands of the public administration, and of the ASL in particular.

The maximum duration of a care budget contract is two years. The design goal engaging the various parties is the transition from higher levels to lower levels of medical aid, via processes of de-medicalisation and social inclusion centred upon the three axes already mentioned (housing, work or job training, and socialisation). The beneficiary is thereby not fragmented by multiple subjects offering specialised care, but is to be supported in his or her integrity (Monteleone, 2005), so as to incrementally obtain a higher level of 'social independence' (Castel, 2003). The reduction of the level of medical care is incentivised through a mechanism of awarding, whereby the care budget is increased by 10 per cent with each step of decreasing medical intensity (and consequently supporting the social inclusion of the beneficiary).

The contract does not therefore intervene as a device for regulating the meeting point between supply and demand, but as 'support', as a strategy to create a stronger bargaining position for 'frail' citizens, by initiating an active process of change: the beneficiary in this case is not recognised as a consumer, but as a player in his or her own individualised rehabilitation therapy plan, a player with his or her own social ties and resources.

In summary, the organisational field appears to be characterised by the following features, owing to the care budget contractual device:

- partnership-type relationships are being created between public and private organisations;
- the private organisations are involved in the decision making, thus the planning of interventions tends to be characterised by negotiation and collaboration;
- the relationships with recipients are also partnerships: the beneficiaries are involved in the planning of projects and become part of an active rehabilitation process;
- the public administration appears to adopt some features of the 'shared administration', characterised by a 'by-process' responsibility and network form of relationships; and
- a tendency emerges towards the incremental innovation of institutions, which are learning to find a means to integrate social and health care, financing and provision.[13]

The regulatory role of public administration and the position of the beneficiary

By looking at the difference between the two contractual devices described in this article, we discussed the importance of the regulatory role of public administration in creating different outcomes for the recipients. Therefore, to understand better the difference between the two devices, we shall analyse the bargaining position of the beneficiary in the two cases.

In the case of the voucher scheme, the citizen is a consumer, and is thus formally free to make a choice, but his or her 'freedom of choice' is a negative freedom, it is a freedom '*from*' (Berlin, 1958). To make reference to Hirschman's well-known typology, the citizen-consumer has the freedom of *exit* but not of *voice*: he or she can change provider but cannot contribute directly to co-defining the services received. Therefore, his or her choice is a *private* choice, supported by private networks. Sometimes, it is also a *lonely* choice, if the consumer is alone, especially without family or neighbourhood support.

In addition to this, the position of the citizen-consumer is asymmetrical to that of the provider. There is a strong disparity of power grounded in the consumer's condition of hardship, urgent need, or deprivation. Thus, the citizen-consumer is conditioned by the provider and he or she is constrained to accept services which are predetermined, which are not individualised but fixed beforehand and standardised.[14] Consumer preferences can only adapt to the context of constraints and of the offered opportunities.

Furthermore, as in every market service, the consumer's right to demand does not correspond to an obligation for the seller to provide a service. In effect, the 2003 decision instituting and regulating the socio-medical voucher in Lombardy does not call for any type of sanction for providers who refuse to assist customers, nor does it provide for any possibility of appeal for those whose requests are refused. For the citizen-consumer, the only option is to try to contact another accredited provider, who may in turn refuse to offer the service. This could foreshadow a systematic exclusion of 'difficult cases', a well-known dynamic often referred to as '*cream-skimming*' (Fazzi and Gori, 2004).[15]

Therefore, in the organisational field opened by the voucher, the sole task of the local public administration is to watch over a private transaction; this is clearly the situation theoretically corresponding to the market-type contract. Undeniably, in the ordinary practices of services we never come across a pure model, but only a wide range of practices, which can be interpreted using a combination of analytical tools. However, this case is closely referable to what we called the 'company administration', which pledges to go beyond the proven limits of the 'bureaucratic administration'. This regulation mode in fact assumes consumers' 'freedom of choice' as a premise, a precondition, and a *datum*.

The position of the recipient is completely different in the case of the voucher and in the case of the care budget. In the case of the care budget in Campania, the first difference is the configuration of the relations among public administration, non-profit provider, local community and citizen. This configuration combines elements of a network and of a hierarchy; yet, as we have already pointed out, the public administration maintains a 'by-process' responsibility. Local authorities (both ASL and municipality) 'follow' the citizen in his or her relationship with the provider; local authorities take care of problems as soon as they occur. Meanwhile, public administration obliges the private organisations to modify and to raise

the level of complexity of their services. The position of the recipient is therefore different because he or she is not alone in the contractual relations with the provider, for there is a *third party* to which he or she can appeal.

In the case of the care budget, the regulation recognises that the contract is always incomplete, and that re-negotiation devices are therefore indispensable. Consequently, the demand of the citizen can be defined – and eventually redefined – within an open process, without being entirely predetermined by the supply, but modifying the intervention over time. This is at once a sort of guarantee and a moving force for the care budget to support and develop the recipient's capabilities. More importantly, the bargaining competence (and power) of the citizen is not considered as a starting point, but as the intervention purpose. The idea is to support the ability of the 'frail' or needy citizen to make a choice with regard to the project he or she is involved in, yet without requiring that this capability should be fully developed since the beginning.

As we have already stated, it is difficult to make sense of each concrete empirical case by referring only to a single model. Hence, even if in this case the public administration seems to acquire certain characteristics of the 'shared administration', at the same time it also takes on features from the other types of administration. For example, in the case of care budgets, local authorities exert their authority to remove conditions of dependency and institutionalisation, as in the 'bureaucratic administration'. Local authorities, in any case, exert their role without abandoning the person implied, without shaping him or her as an already autonomous individual and thus planning a process. There is, as a result, a 'by-process' statute of the public responsibility, and it appears to us that this assigns objective resources to enhance the recipient's bargaining power.

Conclusion

As we have seen, vouchers and care budgets form two dissimilar frameworks of administrative responsibility to which correspond divergent definitions of citizen contractuality. Both cases entail a change in the position of the beneficiaries towards a more active role, yet there are differences in the ways in which this role actually develops.

In order to observe these differences more closely, we should briefly call to mind the consolidated structure of social policies in Italy as a whole and in the two regions studied. Italy is characterised at the national level by a framework of poor social rights and 'familism'. The regulative principle of the Italian welfare state is that the family and kinship network has the core responsibility in supporting the individual, protecting him/her from socio-economic risks (Saraceno, 1994). Regarding social care, the state has only residual tasks, with the aim of ensuring some economic transfers for persons with disabilities (the so-called *indennità di accompagnamento*). Besides, in Italy the relationship between social services and citizens is traditionally marked by two main characteristics: first, the orientation

is to fix citizens in the position of simple passive recipients; and secondly to establish the relevance of narrow prefixed categories of 'needs' (Saraceno, 2002).

Nevertheless, regional differences should be taken into consideration first, differences which are particularly evident in Italy, especially with regard to the north–south divide. Even in a context of scarce institutionalisation of rights, the region of Lombardy stands out for its wealthy endowment of social services, with innovative practices in the field of home care and offering territorial services as an alternative to institutionalisation (that is, *centri diurni integrati*, integrated daytime centres). The region of Campania, on the other hand, shows the features of a marginalised system of services: a severe lack of resources and massive recourse to the family. Secondly, it must be stressed that since the second half of the 1990s, the adoption of certain measures on a national scale has encouraged an impulse for change, introducing a universalistic perspective on social rights – although with some uncertainties and problems – and giving the greatest importance to the promotion of an active role for the user-citizen.[16] However, the measures consist of a non-legally binding regulatory framework, leaving room for regional practices with differing implementation, added to the effect of the federalist reform which was set off in the meantime in the name of devolution. Moreover, after the introduction of these measures, a change of national government and a transformation in the broader political context have favoured policies oriented at privatisation. Several different processes introducing market regulative criteria and strengthening the private sector and the family care weight have composed the privatisation. But these processes have occurred in several different ways according to the various regional contexts.

So the recipient's position changes with respect to what happened before; and it changes in a very different way in the two Regions. Both the socio-medical voucher and care budget take their place in different regulatory structures and logics, not only at the regional level but also at the national level, where public regulation of the relationship between supply and demand via the assignment of an active role and purchasing power to the recipients works in two different ways. In the case of care budgets, this regulation is directed towards the aim of triggering processes whereby the beneficiary becomes involved in determining his or her own welfare, and sets hybrid contractual forms ('*between*') as the means to achieve this objective. The case of vouchers, on the other hand, highlights a regulation committed to ensuring that there may *not* be constraints or obstructions in the free encounter between preferences and the competitive offer; as we have witnessed, the pressing adherence to the market-type contract, which is coherent with the logics we have mentioned, raises several problems regarding the non-contractual premises of the contract. In both cases, the public subject has the authority to establish the institutional frameworks of decisional processes and regulations, yet the objectives, logics and effects with respect to the recipient citizens are all different.

In conclusion, the comparative analysis of the two contractual devices provides us with some interesting indications as to a fundamental variable for understanding the efficacy of the so-called new, active and individualised social care policy: the *regulatory role of public administration*. The end of the equation between the public and the state (de Leonardis, 2001) seems to multiply the difficulties in defining the role of the public administration, often 'seduced' by a minimal model of regulatory role. It appears that the difference between the two cases we have observed reveals different kinds of regulatory roles of the public administration. Whether the public administration only checks the conditions of a private transaction, or whether it takes part in all the processes, even though without directly providing services yet taking care of the quality of organisational arrangements that support the contractual devices, makes a significant difference.

Meanwhile, we should add that the 'by-process' character of the responsibility in the case of the care budget, in principle, *could* remain too open, too contingent and perhaps uncertain. It could transform itself into a discretionary process, disconnecting the regulation from the declared aims of the intervention and making processes self-referring, or dependent on leadership. In such an environment, what happens to universalism? Yet this sort of question calls us to engage in new empirical research.

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Notes

1 One example can be seen in the welfare assurance system for non self-sufficient older people introduced in Germany in 1995 (Evers, 1998).

2 For an analysis of certain measures across several European countries, see Ungerson (2003). In some cases, beneficiaries are offered a choice between assistance provided by an informal caregiver and that of professional organisations.

3 It is necessary to keep in mind that 'workfare' and 'welfare to work' should be discussed while considering social policies as institutions embedded in diverse regulatory regimes (Barbier, 2002; Lodemel and Trickey, 2000) and at least closely related to, if not always coherent with, National Systems of Social Protection (Barbier and Théret, 2001).

4 Social care has analogous characteristics; for the German case, see Evers (1998) and for the UK case, see Taylor (2002).

5 Even if, as we shall see, there is a regional case of apparently 'pure' competition: such is the case of Lombardy (Neri, 2004).

6 The three types can be considered the extreme poles of a three-dimensional continuum, and each concrete case can be located inside the area that these demarcate.

7 The reference to the Italian social services reform is very important, because it aims to integrate various levels of government, different policy sectors and wide-ranging types of actors through contractualisation. In effect, contractualisation is considered as a tool to provide answers to problems of fragmentation of the local welfare. Since we wish to focus specifically on the outcome of the two contractual devices in terms of a changing in the position of the beneficiaries, we shall not dwell in this article on the description of the two institutional contexts in which the two cases are embedded.

8 For both contractual devices (voucher and care budgets), the organisational field comprises of six 'organisational populations' (Powell, 1991): (1) the region; (2) the local health authority; (3) the provider; (4) the second-level organisation of the providers (Consortium), which we do not introduce in this article; (5) the municipality [and the aggregations of various municipalities, called *Ambiti Territoriali* (*Territorial Domains*), in confined areas of approximately 100,000 inhabitants, as called for by Law 328/2000]; (6) the beneficiary. On the methodological front, we interviewed selected witnesses in public administration and in the third sector, we analysed documents, and worked with assessment reports commissioned by the Regions.

9 Along with the axis of economic transfers, the Lombard system heavily reinforces the residence-based axis. As noted in previous research, territorial services were sucked back into a black hole.

10 In the year 2005, the socio-medical voucher has three levels of 'intensity': the first is a basic profile, with the recipient receiving a voucher equivalent to €362 each month; the second is for a complex patient profile (€464); and the third is for a terminal patient profile (€619).

11 At the institutional level, in this case the regulation mode appears to be very centred on the Region, which operates through the ASLs, its 'Prefectures', whose managers are politically chosen by the Region itself, failing to comply with the principle of vertical subsidiarity called for by the constitutional reform of Title V and by Law 328/2000. This poses a problem of political representation.

12 Such people thus cover a wide range of sorts, varying according to degree of vulnerability and institutional dependency, such as unwanted children, abused women, people with disabilities, older people, drug addicts, psychiatric patients and AIDS sufferers.

13 In this regard, we notice the tendency of the local health authority to incrementally convert all existing fees in the socio-medical area to the individual project methodology.

14 On a larger scale, in systems which use contracting out, recipients have limited control over the commodities and services they receive (Crouch, 2001; Taylor, 2002).

15 'Difficult cases', both for reasons linked to the personal condition of the citizen-consumer and for reasons linked to his or her geographical location (as in the case of people living in mountain areas or in territories which are not easily accessible).

16 In addition to the already mentioned assistance reform launched in 2000, one important measure is the experiment regarding the social integration minimum income, introduced in 1998 (l. 449/97; DL 237/98) and now finished.

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