

CHAPTER 5

**CO-PRODUCTION PARADIGM:
THREAT OR OPPORTUNITY FOR
SOCIAL ECONOMY?**

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Part of *New perspectives in the co-production of public policies, public services and common goods* by Philippe BANCE, Marie J. BOUCHARD & Dorothea GREILING (eds), 2022

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This publication has been peer-reviewed.

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BASSI, Andrea and FABBRI, Alessandro. “Co-production paradigm: Threat or Opportunity for Social Economy? / Chapter 5”. In: BANCE, Philippe, BOUCHARD, Marie-J. and GREILING, Dorothea (eds). *New perspectives in the co-production of public policies, public services and common goods*. Liège: CIRIEC, 2022. (CIRIEC Studies Series; 3), pp. 99-123. <https://doi.org/10.25518/ciriec.css3chap5>

This publication is indexed and available in [RePEc](#)

Co-production paradigm: Threat or Opportunity for Social Economy?* / Chapter 5

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Abstract

The aim of this contribution is to examine the “co-production” paradigm, focused on the cooperation between public services and their users, and its connections with the role of the social economy organizations, or Civil Society/Third Sector Organizations. Firstly, the paradigm itself and all the related concepts, such as co-creation, co-design, co-governance and so on, are deeply analyzed through a review of the scientific literature.

Secondly, the authors take into consideration the “dark side” of the paradigm, i.e. its negative effects and implications, such as the risk of neglecting the importance of the Public Administration professionals’ contribution, and the underestimation of the Civil Society/Third Sector Organizations, which instead are primary stakeholders, especially in Europe. This strong collaboration between Public Administration and Third Sector Organizations is a peculiar form of co-production called “joint production”.

Two empirical case studies of joint production are taken from the Italian context and are examined in order to identify the structural elements that can facilitate or hinder the different phases of the co-creation/co-production process. They belong to the fields of *emergency* and *healthcare services*, in both of them the Third Sector Organizations historically played a primary role and are still playing it. This collaboration has strongly contributed to the high performances of the Italian health care system.

In the final section the authors illustrate the factors that boosted the joint production of public services in these fields, either by the public sector side and by the Third Sector side.

Keywords: Co-production, Co-creation, Joint production, Public Administration, Third Sector Organizations, Civil Society, Health care, Emergency

JEL-Codes: I18

* While the contribution is the result of the joint effort of the authors, Andrea Bassi has written the Introduction and Sections 1 and 2; Alessandro Fabbri has written Sections 3, 4 and the Conclusions.

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Introduction

Recently (in the last decade) the concept of *co-production* (and related terms: co-creation; co-design; co-governance; co-planning; etc.) became a central reference of public policy reform in western societies.

The supporters of this approach claim that it has positive effects towards the planning and delivery of effective public services; particularly we mentioned: the possibility of being a response to the *democratic deficit* and a route to *active citizenship* and active communities; a means by which to reap additional resources to public services delivery. Unfortunately, very few evidence based research have been realized in order to demonstrate the above mentioned outcomes and impacts.

Adopting a more theoretical sociological approach, we argue that the concept itself is neither a positive or negative one therefore, in order to understand (measure) the real contribution that co-creation might bring about in the specific system of services delivering (field of action) it is applied, it must be contextualized and specified further. Meaning, it is necessary to clarify who are the actors implied by the “co” and what is(are) the object(s) of the “production” or “design” or “planning”.

We stress the risk linked to a naïve adoption of a co-design/co-production framework. In particular we highlight the possibility that the focus on the “activation” or “involvement” of the final users (or beneficiaries) of a service at individual level, could have the effect of “ruling out” the intermediary bodies – that historically have played a crucial “mediation role” between citizens and the public administration officers and agencies – such as social economy organizations: associations (parents; disabled; mentally ill persons; the elderly; other disadvantaged groups; etc.), social enterprises, voluntary organizations, etc.

Therefore, we opt for the term of “*joint production*” and we agreed about the proposal to move from PPP – Public-private-partnerships towards PSEP – Public-social economy partnerships (Bance, 2018), as the key aim of a new welfare policies configuration.

1. Co-production: blurring boundaries and intertwined concepts

First of all, it is necessary to clarify the meaning of the concept used, highlighting that we follow the management literature approach. However, inside this approach, there is a difference between two meanings of “co-production”.

The first one is more limiting: Osborne et al. consider co-production as “the voluntary or involuntary involvement of public services *users* in any of the design, management, delivery and/or evaluation of public services” (Osborne et al., 2016: 640).

The second one instead is more inclusive: Howlett et al. consider the definition coined by John Alford in 1998, that is, “co-production” as the “«involvement of *citizens*, clients, consumers, volunteers and/or community organizations in producing public services» in addition to consuming or otherwise benefiting from them (Alford, 1998, p. 128)” (Howlett et al., 2017: 2). Subsequently they develop their own definition:

Although co-production emerged and developed as a concept that emphasized citizens’ engagement in policy delivery, however, its meaning has evolved in recent years to include both individuals (i.e. citizens and quasi-professionals) and organizations (citizen groups, associations, non-profit organizations) collaborating with government agencies in both the design and management of services as well as their delivery (Alford 1998; Poocharoen and Ting 2015) (*ibidem*).

In greater detail, we could find in the scientific literature three main traditions of research/approaches concerning co-creation/co-production:

- a) Management literature (Osborne and Strokosch, 2013) and (Osborne, Radnor, Strokosch, 2016);
- b) Civil society, democracy, social movements studies (Pestoff, 2014);
- c) Urban renewal, local development, social planning (Brandesen et al., 2018).

A first step in defining an analytical framework in order to identify conceptual sub-dimensions of the co-production semantic field, is the typology elaborated by Brandesen and Pestoff (2006). The authors recognize three different levels of relationship between citizens and public sector: co-governance, co-management and co-production:

- *Co-governance* (macro-level) refers to an arrangement in which citizens’ associations participate in the planning and delivery of public services. The focus in co-governance is primarily on policy formulation.
- *Co-management* (meso-level) describes a configuration in which citizens’ associations produce services in collaboration with the public sector. Co-management refers primarily to interactions between organizations. Its focus is primarily on policy implementation.
- *Co-production* (micro-level) represents a situation where citizens (through associations) produce their own services at least in part. Its focus is primarily on services delivering.

Adopting a micro level of analysis, Bason (2010) analyses several examples and case studies from the private and the public sector. From this study the author identifies four distinct roles for citizens in the co-creation process:

- as *explorer*: citizens can identify, discover, and define emerging and existing problems in public services;
- as *ideator*: citizens can conceptualize novel solutions to well-defined problems in public services;

as *designer*: citizens can design and/or develop implementable solutions to well-defined problems in public services;

as *diffuser*: citizens can directly support or facilitate the adoption and diffusion of public service innovations and solutions among well-defined target populations.

Others (Voorberg et al., 2015) have described three roles of citizens in the co-creation process:

- citizen as *co-implementer* of public policy: where citizens participate in delivering a service;
- citizen as *co-designer*: often, the initiative lies within the public organisation, but citizens decide how the service delivery is to be designed;
- citizen as *co-initiator*: where the public body follows.

Taking into consideration two dimensions of the service implementation process: a) who is (what actors are) responsible for the service design; b) who is (what actors are) responsible for the service delivery, Bovaird (2007) develops a typology of co-production along two axes (see Figure 1). Depending on the extent of *professional* versus *user* involvement in planning the service and delivering the service it is possible to identify nine configurations. Moving from the top left cell of the matrix to the bottom right cell we can shift from a “pure public services model” to a “typical voluntary/community sector” model, having the highest form of co-creation and co-design in the middle of the nine cells table.

Figure 1. User and professional roles in the design and delivery of services (Boyle et al., 2009, p. 16).

Figure 1: User and professional roles in the design and delivery of services

		Responsibility for design of services		
		Professionals as sole service planner	Professionals and service users/ community as co-planners	No professional input into service planning
Responsibility for delivery of services	Professionals as sole service deliverers	Traditional professional service provision	Professional service provision but users/communities involved in planning and design	Professionals as sole service deliverers
	Professionals and users/communities as co-deliverers	User co-delivery of professionally designed services	Full co-production	User/community delivery of services with little formal/professional
	Users/communities as sole deliverers	User/community delivery of professionally planned services	User/community delivery of co-planned or co-designed services	Self-organised community provision

Source: Adapted from Carnegie Trust (2006). 'Commission for Rural Community Development – Beyond Engagement and participation, user and community co-production of services.' By Tony Bovaird, Carnegie Trust.

In synthesis, in our opinion, it is possible to identify the following analytical distinctions of the group of policies that have been defined through the “co-” suffix.

On a first instance (at the highest level of the “abstraction ladder”) we have the term *co-creation* that encompasses all the others. It refers to an arrangement where there is a certain level of collaboration between the “producer” and the “user” of a good or service. In the field of business the phenomenon has been denominated *prosumer* meaning the crisis of producer and consumer roles.

Inside the co-creation process we can find several phases or levels (degrees) of collaboration moving from a macro to a micro level of analysis through the meso level.

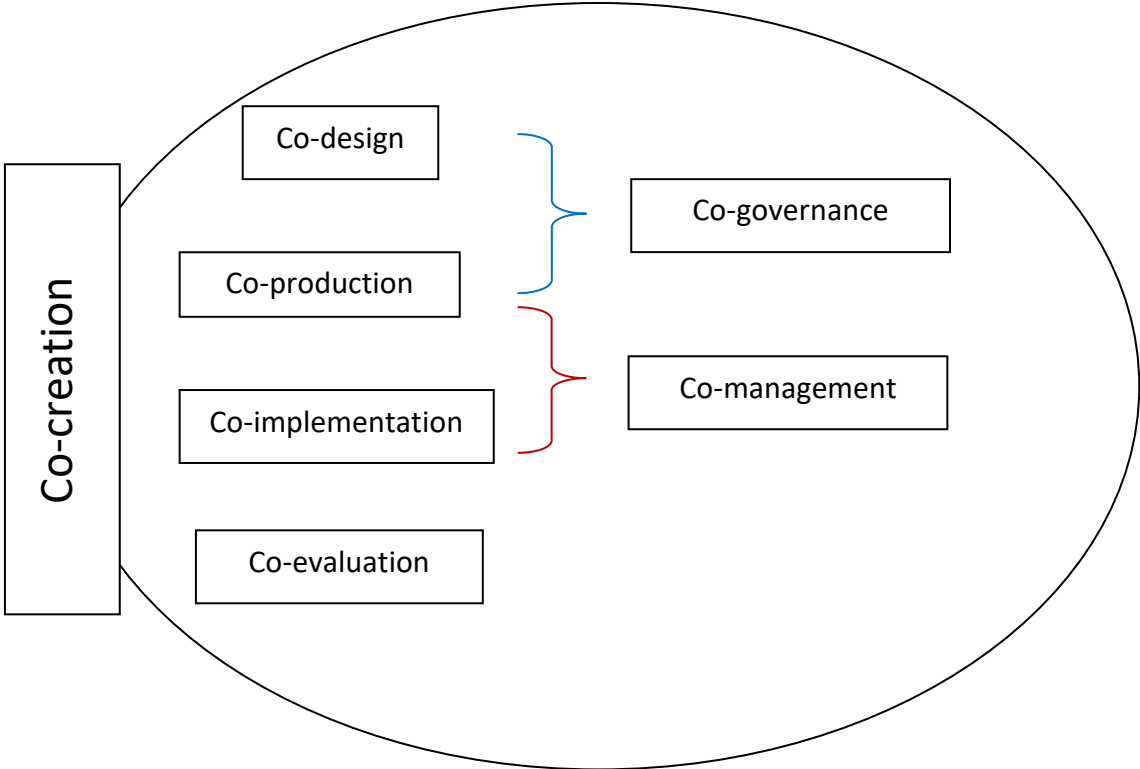
The first step is the *co-design* (or *co-governance*) phase where the professional and the beneficiaries plan together the service’s configuration.

The second step is the *co-production* phase, where the front-line professional and the users collaborate somehow in the service delivering.

The third step is the *co-implementation* (*co-management*) phase, where the professional and the users decide together how to maintain the service provision.

The fourth step is the *co-evaluation* phase, where the different stakeholders involved provide suggestions for the service’s improvement and innovation.

Figure 2. The internal dimensions of the co-creation process



Assuming the above-mentioned categorizations and typologies of the co-creation/co-production process, we will analyse two case studies in the field of *emergency and healthcare services*, in order to identify the structural elements that can boost or hinder the different phases of the co-creation/co-production process.

2. The dark side of co-production

Despite the fact that many of the authors underline the “positive” effects of policies fostering co-creation/co-production practices (among others: Delivering better outcomes; Preventing problems; Bringing in more human resources; Encouraging self-help and behavior change; Supporting better use of scarce resources; Growing in social networks to support resilience; Improving well-being), there are several possible “negative” (unexpected) effects to be taken into consideration.

Among these risks/backlash we can mention in first instance the recognition that the co-creation/co-production process is a high “time consuming” one. Which implies the difficulty to keep the participants (both users and professionals) involved for a long period of time. Moreover, given the fact that the users of a service change over time and it is necessary to involve the newcomers, in order to maintain a sufficient level of participation.

Secondly, often the users/clients that do participate are those in better socio-economic conditions (middle-class), with high level of education, so the co-creation/co-production process can exclude (instead of including) the so called “hard-to reach” users.

Thirdly the public administration officers are usually not very willing to adopt innovation in their working procedures, and often enact strategies in order to keep “business as usual” practices. They are well aware that any innovation entails “winners” and “losers” and in particular in a framework such as the co-creation/co-production one that implies a deep mind-set change from the professionals. So often the public administration body reacts to these policies merely in a “formal” way, adopting the rhetoric of co-production but practically trying to carry out their activities as usual.

The success or failure of a policy fostering co-creation/co-production is very hard to verify and it depends on several factors among which the most important one is the purpose of the policy. What is the main aim of the innovation? To increase the responsibility of the users/clients? Or their participation? To enhance the efficiency (cost reduction) of the public administration? Or the effectiveness (quality) of the service delivering process?

A final point on this topic concerns the complexity of the public administration system, with its hierarchical model of decision-making, and with the separation between the political role and the managerial one.

In order to be sustainable and scalable a co-creation/co-production innovation-experimentation must involve the entire public administration body, from the politicians, the top-managers and below, down until the so-called street-level professional. But needless to say that these actors (roles and positions) they all have different aims (and incentive rewards systems), so it is very difficult to find an equilibrium among the often conflicting interests. Taking into consideration that in any co-creation-co-production practice there are, at least, three conflicting logics acting in the field: a) Professional/expert logic vs. citizens/lay logic; b) Service logic vs. workers union (corporative) logic; c) Public administration logics vs. third sector/civil society logics.

2.1. Value co-creation implies a re-thinking of the relationship between the professionals and the services' beneficiaries

The scientific literature on co-creation/co-production is usually oriented to the role of users/clients in the process of service design (the first one) and service delivering *stricto sensu* (the second one). The authors (Pestoff, 2014; Brandsen et al., 2018) stress the necessity to involve the citizen as beneficiary in one or more of the several phases that characterized the co-creation/co-production process. Numerous researches identify a set of tools or mechanisms in order to promote, increase and boost the contribution of the citizen as “active co-producer” (prosumer) of the services rather than a passive recipient (Brandsen, Pestoff, 2006).

As Osborne and Stokosch state (2013) there is a systematic underestimation of the role, tasks and responsibilities of professionals in the co-creation process and even more in the co-production process. The involvement and the contribution of professionals are often “taken for granted”, and it represents, in Osborne’s view, one of the main weaknesses of the scientific studies on co-production.

As a matter of fact, the role of professionals at any Public Administration (PA) level – politicians, top-management, mid-management, low-management, front-line, street level professionals – is instead a key one, with the possibility of influencing (effecting) the success or failure of a co-creation/co-production initiative.

In fact, professionals follow standards, deontological statements/assumptions, world-wide established protocols, and are very skeptical against the introduction of any changes in their “ways of work” and procedures. The first reaction toward the innovation in PA is usually resistance or hostility versus the “new”. PA agencies, more than any other kind of organizations, manifest a very high level of *inertia*, especially towards the programs that are imposed from above, following a “top-down” logic.

This is true in all levels of PA structure and fields of activities, but it is particularly strong in some stream of services – those with a high level of technical knowledge,

such as: health, education and some kind of social services. Physicians, nurses, teachers, social workers, pedagogists, psychologists, etc. are depositary of a set of standardized knowledge that apply at each individual case. They operate following what has been defined as “inward look” (Boyle, Harris, 2009) and they have difficulties in adopting an “outward look”, meaning recognizing the “lay knowledge” and “resources” of people in caring about themselves and the others they are related with.

In order to fill this gap in the scientific literature on co-creation/co-production, there is the need to dedicate a specific attention to analyze the contribution of professionals in the realization of co-production processes, as well as new type of interactions emerging among the professionals (new professionals ties). In particular it would be very useful to highlight the structural elements that can boost or hinder the active involvement of professional in the different phases of the co-creation/co-production process. This will allow, eventually, to identify the kind of skills (Paskaleva, Cooper, 2018) professionals need to develop to guarantee a more pro-active and open-minded attitude toward the contribution of the beneficiaries in the service planning and delivering. The change of professional “mind-set” is one of the main challenges any project of co-creation/co-production has to deal with, in order to be not only successful but, even more important, sustainable in the long run.

2.2. Value co-creation implies a re-thinking of the relationship between the public administration and the third sector (civil society) organizations

The co-creation framework implies a series of challenges for the civil society organizations (CSOs). Given its stress on active direct participation of citizens as “end users” co-creation might underestimate the role and contribution of CSOs in the process of services’ implementation.

In many European countries there is a strong tradition of involvement and collaboration between the CSOs and the Public Administration Agencies – at different governance levels: local, province/district, regional, national. This collaboration is intensely visible in the planning, delivering and monitoring of public services provisions. Some authors define that as “joint production” (Bance, 2018) or partnership (Boccacin, 2014).

Therefore, it is necessary to distinguish what co-creation is and what is not. For instance, co-creation is not: information, consultation, advocacy, users’ associations lobbying, and other traditional tools and mechanisms of CSOs organizations’ influence in the decision-making process concerning welfare policies.

Since co-creation entails direct “end users” involvement on a single base, this may have significant consequences from the point of view of democracy, access, equality and equity, given the uneven distribution of skills and capabilities among the population.

In the framework of the classical “stakeholder theory (Freeman, 1984; Freeman et al., 2010)¹ the co-creation approach (or paradigm) requires a complete revision of the role of the various stakeholders involved in a service or project or program. The boundaries between what constitute the environment (external) and the core (internal) of a service provision are blurred. In a certain way the co-creation/co-production approach implies the fact that the “external” is somehow incorporated internally by the service deliverer. That process can increase, instead of decrease, the inequality among the service’ users given the unequal power of the different stakeholders involved.

Often the final beneficiaries of a welfare provision belong to marginalized groups, such as low income, underclass population, and different kinds of disadvantaged individuals. These targets are in that situation exactly because they do not have the set of resources/capabilities (cultural capital and social capital) that allow them to be fully included citizens in the social fabric. Because of this, among the dark side effects of co-creation, we mention the risk of reproducing and reinforcing the divide among the “well-off” (included) and those “in need” (excluded).

This is especially true in those fields of public service delivering where there is a huge gap in terms of knowledge between the professionals and the recipients, such as health, education and other social services (for disabled, elderly, not self-sufficient/autonomous people, multi-problematic families, adult hardship).

For these reasons the research must recognize the function, role and contribution provided by the CSOs-Third Sector Organizations in the different phases of the co-creation process: *co-design*, *co-implementation*, *co-delivering*, *co-monitoring* and eventually *co-evaluation*. Because often the “end-users” are not in the position to give an active contribution to the service planning, in order to overcome that, it is needed a direct involvement of Third Sector Organizations in creating a “sensitive” institutional environment through the settlement of a concrete *co-governance* service configuration fostering a joint-production system.

On the other hand, the co-production entails some not negligible risks for these organizations: the public sector, through its regulation, often causes typical institutional isomorphism phenomena in the CSOs, particularly of the “coercive isomorphism” typologies (DiMaggio, Powell, 1983: 150), while other “institutional-isomorphic” dynamics can be determined by imitation among CSOs, that is, “mimetic isomorphism” dynamics (ibid.: 151). These processes can be positive, if they really improve CSOs’ performances, but could also produce negative and “dark side” effects, such as bureaucratization, conformism, coercive professionalization and so on. These effects, as is known, are very dangerous for the volunteers and their dedication, that is, for the real added value of the Third Sector. Therefore, this is

¹ As it is known Freeman classical definition of stakeholder is: “any group or individual who can affect or is affected by the achievement of the organization objectives” (Freeman, 1984, p. 25).

another aspect of the co-production that social research has to take into account, as the next sections will show.

3. The *joint production* in the Italian transfusion system: a classic but involuntary example

This section describes the Italian transfusion system considering its history, its current configuration and the results achieved, in order to demonstrate that it is a classic but involuntary example of joint production, of an essential public service.

The Italian transfusion system can be considered a classic and effective example of a “joint-produced” public service. However, this is not due to precise choices made by the ruling class in distant times, but rather to a mix between the autonomous initiative of the Italian civil society and subsequent legislative interventions: this mix has created a system based on the interaction between the public sector and the nonprofit sector, with the marginalization, until now, of the for-profit sector and its entrepreneurial spirit.

To understand the current functioning of the Italian transfusion system it is necessary to summarize its evolution in the context of the Italian health system, of its historical evolution, and of its interpretation by welfare sociology. Specifically, the Italian welfare state was analyzed and ascribed to various clusters of Western countries by Italian and foreign sociologists, but it is certainly true that, at least in the health care field, and at least formally, a historical watershed between two eras was constituted by the reforms of the decade 1968-1978, and particularly by the act n. 833 of December 23, 1978, which established the Italian National Health Service, inspired by the British and Swedish models.

Before this phase, the Italian health care system was dominated by for-profit hospitals (often affiliated with health insurances), by voluntary institutions of different cultural and political inspiration, and by parastatal entities, such as the IPABs and the Italian Red Cross (CRI) (Fabbri, 2019: 165-168).

Furthermore it is necessary to consider that transfusion techniques began to develop with slow and difficult progresses at the turn of the 1st World War, and that in Italy, up until the 1920s, there was no specific legislation on this subject: blood was collected in hospitals and in some doctors’ offices, and could either be sold or donated, on an individual basis (AVIS, 1978: 7, 16-17).

Therefore, the first step towards the creation of a transfusion system was undoubtedly the foundation of the Italian Blood Volunteers Association (AVIS) in 1927, in Milan. This was due to the idea of Dr. Vittorio Formentano (1895-1977), one of the first Italian doctors specialized in hematology and transfusions (ibid.: 13-14).

He understood that the commodification of blood could have been avoided only by encouraging, promoting and even organizing a voluntary donation, free and anonymous, but also safe and planned, not dictated by the emergency of the moment (ibid.: 13, 16-17). Without rhetoric it can be said that the work of Formentano and his first 17 acolytes was egregious: AVIS donors increased along the whole country, year by year.

After the 2nd World War, the CRI began to take part more directly in the transfusion activity², but the AVIS reacted by obtaining its own legal recognition through the act n. 49 of February 20, 1950³. Of course since then the CRI has not ceased to manage directly the promotion of the blood donation and, for many years, its direct collection, having its own hospitals: blood donors were and still are one of its voluntary components, although with a reduced status (Fabbri, 2019: 231-232, 253-254).

In the following thirty years, along with scientific advances, the institutional framework was enriched and clarified. The enrichment was due to the birth of the other two nation-wide organizations that currently complete the “non-profit part” of the Italian transfusion system: the FIDAS and the Fratres.

The FIDAS, differently to AVIS, is not a single association, but a federation: the Italian Federation of Blood Donor Associations, founded in 1959⁴. Currently, as far as we know, there are neither historical studies about this TSO, nor empirical sociological studies: it is therefore impossible to make hypotheses on the causes that led to its birth, on its identity, on its peculiarity with regard to AVIS and CRI and on its relations with them.

Lastly, in 1971, twelve years later, the Fratres was born: while AVIS, CRI and FIDAS are, at least formally, apolitical and non-denominational, Fratres was and still is qualified for its denominational identity, and on its website it is proclaimed “an association of Christian inspiration (...)”⁵. Moreover, Fratres is born “by gemmation” from the Confraternities of the Misericordie, “the oldest organization of the Italian Third Sector” (Fazzi, Marocchi, 2017: 6), that operates in the fields of social assistance and health care: Fratres is still strictly bound to the Misericordie, even if it is a formally and legally autonomous organization (ibid.: 27, 48).

The clarification instead was determined from the normative point of view, because the act n. 592 of July 14, 1967, finally rearranged the transfusion sector, both at a technical and at an institutional level. This act coordinated organically the various entities that operated in the sector and began to transform them into a real system (etymologically), based, as anticipated, on the collaboration between the

² See <http://www.gazzettaufficiale.it/eli/id/1947/11/24/047U1256/sg> (last accessed: 26.09.2019).

³ See <https://www.gazzettaufficiale.it/eli/id/1950/03/11/050U0049/sg> (last accessed: 26.09.2019).

⁴ See <https://fidas.it/chi-siamo/la-storia-abbiamo-iniziato-cosi/> (last accessed: 26.09.2019).

⁵ <https://www.fratres.it/approfondimenti/la-fratres#.XR-Af1dS-1s> (last accessed: 26.09.2019).

public sector and the Third Sector. Indeed, the TSOs role was recognized (article 2) and “a Commission for the discipline and development of human blood transfusion services”⁶ was established in each Italian Province, with representatives of CRI, AVIS and FIDAS (article 3). The phenomenon of the sale of blood and blood products for profit was partially discouraged (article 12) but still tolerated: the blood sellers were institutionally recognized as “professional givers” (articles 16-19). Richard Titmuss mentioned it in his renowned study *The gift relationship* (Titmuss, 1973: 198).

The following year, the “Mariotti act” n. 132 started the hospital reform, and the creation of a universal public health service. This culminated, ten years later, in the aforementioned act n. 833, that dealt also with the transfusion system (article 4 comma 6, and article 6 comma c). For its actual implementation, on May 4, 1990, the act n. 107 was issued: it completely and organically reformed the whole sector⁷. However, this regulatory measure was not simply granted by the ruling class, but it was the outcome of long-lasting and exhausting consultations with TSOs, first of all AVIS. This was remembered, still seven years later, by many AVIS managers during an empirical study conducted by the sociologist Lucia Boccacin: “The act was wanted by AVIS who had to put a lot of pressure to have it issued” (Boccacin, Tamanza, 1997: 79; *ibid.*, 78, 80-82).

The act supported even more the cooperation between the public sector and the nonprofit sector, both by reaffirming the central role of the latter, founded on the principles of volunteering and gratuitousness (article 1, comma 2), and by forbidding once and for all the sale of blood and blood derivatives (comma 4)⁸. However, this did not mean at all an overload of the nonprofit sector: instead, the Italian National Health Service took up the exclusive task of carrying out the transfusion activity, in the strictest sense of the word (article 19) (Boccacin, Tamanza, 1997: 45, 66). The donor associations were left with the faculty to carry out the collection of donations in their own facilities and with their own staff, as is the case today. It is noteworthy that this major direct intervention of the public sector was not deprecated by the key informants interviewed seven years later: their judgments on the act were actually positive (*ibid.*: 46, 80).

A final overall reorganization of the transfusion system took place with the act n. 219 of October 21, 2005: its essential articles are 6, 7 and 12, because they reiterate the collaboration between the public sector and the nonprofit sector. Article 7 indeed reaffirms that “the State recognizes the civic and social function and the human and solidarity values that are expressed in the voluntary, periodic, responsible, anonymous and free donation of blood and its components”⁹. Article 6 is instead relevant from a practical point of view, i.e. organizational and operational, because

⁶ <https://www.gazzettaufficiale.it/eli/id/1967/07/31/067U0592/sg> (last accessed: 27.09.2019).

⁷ See <https://www.gazzettaufficiale.it/eli/id/1990/05/11/090G0150/sg> (last accessed: 27.09.2019).

⁸ See *Ibidem*.

⁹ <https://www.centronazionalesangue.it/sites/default/files/LEGGE%2021%20ottobre%202005%20n.%20219%20con%20commenti.pdf> (last accessed: 27.09.2019).

“a standard scheme is adopted for the stipulation of agreements with associations and federations of blood donors to allow their participation in transfusion activities”¹⁰. However, article 12 is even more relevant, because it establishes an authority for the coordination of the transfusion activity, the National Blood Center (CNS): it is located in Rome, but it has its own branches in each Region, namely the Regional Blood Centers (CRSes), as stated in article 6, comma 1, letter A. Although created within the Istituto Superiore di Sanità, it is not a mere emanation of the state authority, or more precisely of the Ministry of Health, but it is an institutional center in which the nonprofit sector has a concrete role: in fact, at its summit there is a Steering Committee, which also includes “a representation of associations and federations of voluntary blood donors (...)”¹¹. Finally, article 13 establishes the Technical Permanent Council for the Transfusion System: its aim is to be a technical adviser for the Ministry, and it is composed, among others, by representatives not only of the four aforementioned NPOs, but also of the associations of patients who need blood transfusion¹².

Moreover, in view of the issuing of this act and of the creation of the CNS, in March of that same year 2005, AVIS, CRI, FIDAS and Fratres established their own coordinating centre, a real “umbrella organization”: the Interassociative Committee of the Italian Volunteer of Blood, or CIVIS, embryonically founded already in 1995 and endowed with its regional and provincial articulations¹³. Unfortunately, we are not aware of the existence of empirical studies dealing with the satisfaction, the eventual criticism, or even only the impressions of the members of these TSOs for this act and for its results.

Therefore, since 2005 till now the main stakeholders of the Italian transfusion system have been the following: the national government; the Regions; the TSOs.

By the side of the public sector, the *national government* and the *Regions* agree upon a standard regulation (periodically updated) of the relationship between the same Regions and the four aforementioned TSOs for the provision of blood and blood products, and upon standard national tariffs for the reimbursement of the TSOs contribution¹⁴.

Then each Region, being autonomous in the management of its health care service, makes conventions with the TSOs, according to these standards, and fixes together with them the targets for the blood collection to reach every year. Both sides have to respect these agreements. Finally, at the local level, in each Province of the Regions

¹⁰ Ibidem.

¹¹ Ibidem.

¹² Ibidem. In 2013 this Council has been substituted by the Technical Health Committee, that encompasses a Technical Section for the Transfusion System, with the same previous members. See <https://www.centronazionaleangue.it/node/2>

¹³ See http://www.fidas.it/box_documenti/regolamento_CIVIS.pdf (last accessed: 27.09.2019).

¹⁴ Cfr. http://www.salute.gov.it/portale/news/p3_2_1_1_1.jsp?lingua=italiano&menu=notizie&p=dalministero&id=2585 (last accessed: 23.02.2020).

the single sections or committees of the TSOs interact with the single public hospital (AO) or health unit (AUSL), making further conventions.

Concretely, the TSOs can choose between sending their members to the AOs or AUSLs to donate blood (and so receiving one type of reimbursement), and collecting blood and blood products in their own facilities and sending the blood sacks to the public hospitals (and so receiving another type of reimbursement, but only AVIS has chosen this way); the CRSes supervise the good functioning of this mechanism. In some Regions only members of the TSOs are allowed to donate, while in others also non-affiliated citizens are allowed.

This complex institutional structure has recently been enriched with another component: the COBUS, “Committee for the good use of blood”. This is an entity envisaged by article 17 of the 2005 act, but it was set up only at the end of December 2017, with an agreement signed by the State-Regions Conference. Its task is precisely “To carry out control programs on the use of blood and its products (and stem cells) and to monitor transfusion requests”¹⁵. The COBUS, or the COBUSes (one for each Italian Region), are organized in two sections, dedicated to blood and stem cells. The first one includes also “a representative of the Associations / Federations of voluntary blood donors who have agreements with the Health Authority” and “a representative of patient associations”¹⁶.

In conclusion, if “effectiveness” means the “ability to produce fully the desired effect”, then it must be recognized that the Italian transfusion system, based on joint production, is fully effective with regards to the collection of whole blood, while it is remarkably but not completely effective with regards to the collection of blood products: indeed, according to CNS data, “For blood was guaranteed last year (2018) total self-sufficiency, which for plasma derivatives reaches about 70%”¹⁷. The situation was the same in 2019 and even in 2020, notwithstanding the Covid-19 pandemic. Moreover, if we consider that donors have grown globally to 1,682,724, and that “91.7% of the total is represented by donors registered with volunteer associations”¹⁸, we can have a concrete idea of the importance of the TSOs contribution to this effectiveness. Unfortunately there are no recent scientific studies on the state of satisfaction or dissatisfaction of the stakeholders concerning the functioning of this relationship. In 2018 the national government expressed great satisfaction through the Ministry of Health for the TSOs contribution to the system, and the TSOs’ presidents appreciated it, but at the various local levels it is not unlikely that there is some reciprocal discontent between public practitioners and TSOs staffs. It is certain, however, that the agreements have forced the TSOs to respect very high-quality standards: this has implied bigger expenses, the use of an increasing number

¹⁵ https://www.quotidianosanita.it/governo-e-parlamento/articolo.php?articolo_id=57304 (last accessed: 27.09.2019).

¹⁶ Ibidem.

¹⁷ <https://www.centronazionalesangue.it/node/777> (last accessed: 27.09.2019).

¹⁸ Ibidem.

of paid staff and the necessity of the volunteers' professionalization. It is thus possible to say that the structure of these TSOs, and particularly of AVIS, is resembling more and more the NHS structure, following a typical isomorphic process: therefore the risk, as usual for a TSO, is to wear out the volunteers and to lose by the roadside their precious spirit.

4. The emergency health assistance “118 Service”: an example of a successful PSEP. The public sector and the “Triple Alliance”: Italian Red Cross (CRI), Misericordie and ANPAS

Another example of successful joint production of public services is the collaboration between the public sector and the “Triple Alliance”, or, more precisely, among some branches of the State and the Italian Red Cross (CRI), the aforementioned Misericordie and the ANPAS.

The CRI was founded on June 15, 1864, in Milan, and currently is a full member of the International Red Cross and Red Crescent Movement. For most of its existence, although based on the work of volunteers, it was a public entity (“parastatale”) and became a TSO, and precisely a Voluntary Organization (OdV), only recently, with the reform started in 2012 and ended in 2017, coinciding with the TS reform (Fabbri, 2019). Nevertheless, the CRI continues to work closely with the State, particularly in the sectors of health care and humanitarian emergencies (earthquakes, floods, etc.). With regard to this, it is worth noting that until 1911 the Statute of the CRI forbade strictly any involvement in activities of health care or social assistance in time of peace: the staff, the volunteers and the resources of the CRI had to be preserved for exclusive wartime use, as it was for all the Red Cross national societies. However a huge debate arose at the turn of the XX century about this topic, so some circumscribed activities were authorized: their success and popularity definitely persuaded the CRI leaders to start operating also in these humanitarian fields (ibidem), where two main competitors were already operating.

Chronologically, the first one of them is the Confederation of the Misericordie, the aforementioned TSO that it is necessary to consider more in depth. As recent sociological studies verified (Fazzi, Marocchi, 2017), the confraternities of the Misericordie have been able to combine an ancient legacy with a great talent for adapting to changes in society. Indeed, they are perhaps the oldest TSO existing and operating in Italy (in Europe?) in the fields of social assistance and health care, because the first one was founded in Florence in 1244: Tuscany is still the Italian Region where they are most numerous, strong and developed. Their original purpose was to perform the works of mercy prescribed by the Catholic ecclesial tradition, that is, seven in the spiritual field and seven in the corporal field: among these, caring for the sick and burying the deceased (ibid.: 7).

Currently the Misericordie have become a dynamic component of the Italian TS. On the basis of official data, in fact, there are about 700 confraternities, coordinated and represented by a national Confederation, that was founded in 1899¹⁹. The absolute majority of the old confraternities operate in Central and Northern Italy: as hinted before, Tuscany alone boasts over 300 realities (ibid.: 129). Despite their antiquity, in the last two decades they have generally benefited from the dedication of a new leadership, whose members have demonstrated the capability of being “active and propositional” (ibid.: 17). On the other hand, in Southern Italy the Misericordie have been flourishing more recently, following the example provided by the volunteers who came from outside to help the victims of the last natural disasters, such as the Irpinia earthquake of 1980 (ibid.: 19).

A second and certainly secular competitor of the CRI is the National Association of Public Assistances, or ANPAS, a second-level organization, that is a sort of confederation. Like the Confederation of the Misericordie, indeed, it gathers the vast majority of existing health care organizations that operate in Italy with the name of “Public Assistance” or of “Cross”. As the historian Fulvio Conti observes, these associations were born in Italy shortly after the CRI, around the 1870s: their primary aim was carrying out social and health assistance in time of peace, both “in the case of calamitous events such as earthquakes, fires, floods, epidemics (...)”, and by providing “a daily work of assistance to the sick, the poor and the needy, guaranteeing them free transport to hospitals, the administration of medicines, the change of linen, and daytime surveillance shifts and night. They also carried out first aid operations in the event of accidents or injuries (...)” (Conti, 2004: 8).

Fundamentally, these associations occupied the space that the CRI was leaving free for its aforementioned statutory choice. Moreover, they were very interested in distinguishing themselves from the CRI also for a cultural and political reason, “because they had a marked secular connotation, to which the Masonic matrix of many leaders was not extraneous, and a progressive and leftist political orientation, though never exclusive and totalizing” (ibid.: 5). Their 4th congress, held in Spoleto in 1904, was the place of birth of the National Federation of Public Assistances, the first embryo of the ANPAS (ibid.: 3).

The coexistence between the CRI and the Public Assistances was characterized by alternate events, according to the various historical periods. At certain times, such as between the late 19th and the early 20th centuries, there were decent “good neighborly” relationships (ibid.: 77-80), and sometimes also a certain convergence of intent and action, represented plastically by the double belonging of some individuals (sometimes very renowned) of the medical milieu (ibidem). Another kind of convergence was the joint enmity towards the Misericordie: it was caused by the

¹⁹ See <https://www.misericordie.it/chi-siamo> and <https://www.misericordie.it/storia> (last accessed: December 10, 2019).

common secular and Risorgimental roots of the CRI and the Public Assistances (Campagnano and Lori, 2016: 489-497).

At other times instead, and particularly during the fascist period, there was a very strong opposition: it was motivated by different political choices, because the CRI was infiltrated by the regime, and became part of its apparatus. This opposition culminated with the Royal Decree no. 84 of February 12, 1930: it sanctioned the dissolution of all those Public Assistances that lacked legal recognition. This governmental provision was nominally aimed at the “reorganization” of the health care sector, but actually it was also originated by the desire to rid the CRI, now close to the regime, of an efficient and subversive competitor. Only those associations that had obtained the juridical personality survived during the fascist era, but they were strictly controlled (Conti, 2004: 113). The regime in 1933 dissolved also the National Federation, although it had obtained legal recognition since 1911 (ibid.: 80, 113).

It is therefore clear why after 1945, and for many subsequent decades, the relationship between the CRI and the rebuilt Public Assistances was not particularly positive. Another reason for this was the public personality of the CRI, its continuing privileged link with the State, and the consequent availability of public resources. However, despite some difficulties, the Public Assistances managed to resume their position, alongside and sometimes in opposition to the CRI and the Misericordie: even their representative organization, the National Federation, was reconstituted in 1946, and in 1987 adopted the current denomination of ANPAS (ibid.: 3, 120).

The Public Assistances have many objective similarities with the Misericordie. Historically they too spread mainly in Central and Northern Italy, and only in the last decades have developed in Southern Italy (ibid.: 5). Furthermore, the number of participating organizations is sizeable, at least according to the ANPAS website: “Nowadays 880 Public Assistances and 282 sections, present in all Regions of Italy, form part with ANPAS”²⁰.

Therefore, the ANPAS, the CRI and the Misericordie have a very similar internal structure and organization and quite similar humanitarian missions, but also very different cultural and political roots: because of these they were historically competitors in the provision of health care services. In more detail, the main field of this competition was the medical transport of patients, both in context of emergency and of non-emergency: in each Italian city the three associations competed for the assignment of this service and the related reimbursements. This struggle went on until someone thought that it was better to harmonize and coordinate all these energies and resources (and the Italian NHS’ ones) by creating a public service aimed at allocating precise areas of the cities to each association and its ambulances.

²⁰ <https://www.anpas.org/chi-siamo/le-pubbliche-assistenze.html> (last accessed: December 10, 2019).

It is still unclear where this invention took place: according to Mario Mariani, a CRI historian, one of the first cities to create this service was Milan in Lombardy already in the '80s (Mariani, 2006: 360), while other sources argue that it was established in Bologna, in 1990, during the soccer world championship²¹. However, this new service was based on an operations centre with a switchboard, and the citizens in need of help could call it by dialling the number "118", so the service took up the name of "118 service". It proved to be effective and successful, so other cities and Regions adopted it, and finally the State intervened to establish it at a national level: on March 27, 1992 the President of the Republic issued a decree in order to regulate the emergency health assistance. Article 3 was specifically devoted to the 118 service, spreading it around the country²².

This was the beginning of a more loyal and constructive relation among the three associations: it was difficult, but after two decades they started considering each other more as partners than as competitors, particularly when the Third Sector reform took place in the years 2016-2017 (the same reform that concluded the transformation of the CRI into a TSO). One of the topics treated by the legislators indeed was the medical transport service, and so the three TSOs decided to overcome their past hostility and their present competitions for the contracting of the service, in order to create a sort of "lobby" and protect their common interests, based on their similarities. The main result of this action was article 57 of the Third Sector Code (D. Lgs. 117 of July 3, 2017): it establishes that the emergency transport services can be assigned primarily to a Voluntary Organization instead of a for-profit firm, because the general interest is more protected by a TSO than by a firm, also if the latter offers a cheaper performance²³.

Currently, the Italian emergency health assistance service has the following configuration: the *national government* fixes periodically the guidelines for its management, adopting directives from the EU or issuing new acts elaborated by the Parliament. Then the *Regions* implement them in their aforementioned AOs and AUSLs and in the 118 operations centres, that are under the Regions' responsibility. The transport is concretely carried out by public staff, by staff of for profit firms, or by volunteers, both of the three major TSOs and of other smaller ones: clearly, there has been an increasing resemblance among them in training, clothing, vehicles and equipment, because of the national standard criteria adopted. It is therefore possible to consider it as another isomorphic process.

At the local level, each AUSL can sign a contract (agreement) with TSOs or private firms, checking their reliability and competence and paying them for their services. As seen, the Third Sector reform guarantees the TSOs position against the for profit firms and their dumping, but sometimes the Regions want, or are obliged to cut

²¹ See https://www.118er.it/emiliaest/video_detail.asp?id=49 (last accessed: December 13, 2019).

²² See http://www.salute.gov.it/imgs/C_17_normativa_1701_allegato.pdf (last accessed: December 13, 2019).

²³ See <https://www.gazzettaufficiale.it/eli/id/2017/08/2/17G00128/sg> (last accessed: December 13, 2019).

the costs, and so some AUSLs prefer to entrust the service to the firms. This is a problem that periodically worsens the relationship between the TSOs and the NHS at the local level. Another problem is the excess of demands (requirements) of the public sector about the standard quality of performances, that is, when the TSOs are requested too much in terms of training or equipment, whilst the reimbursement is not likewise increased. For example, in 2019, the Parliament considered a project of increase of training hours requested for the ambulance drivers: the ANPAS, the CRI and the Misericordie unanimously judged this project excessive and unaffordable for their volunteer operators and protested together against the government²⁴. However, despite this set of problems, the joint production of the emergency health assistance service contributes effectively to the performances of the Italian public health care service, which is still one of the best in the world, according to various rankings drawn up by authoritative sources (Orientale Caputo, 2017²⁵: 97-103).

Therefore, the cooperation among the public sector and the three TSOs permits them a more effective and efficient use of their human and material resources in this very important field of humanitarian action, and helped the ANPAS, the CRI and the Misericordie overcome their hostility and reach a more collaborative attitude: they now are together in the Italian Third Sector Forum²⁶, and, as seen, they sometimes demonstrate together to defend their interests²⁷. In short, they have become a “Triple Alliance”, an important partner of the public sector in the joint production of some essential services.

²⁴ See <https://www.cri.it/29-04-2019-forse-preoccupazione-di-angepas-croce-rossa-e-misericordie-sulla-proposta-relativa-alla-figura-professionale-di-autista> (last accessed: February 24, 2020).

²⁵ See also <https://www.bloomberg.com/news/articles/2018-09-19/u-s-near-bottom-of-health-index-hong-kong-and-singapore-at-top> (last accessed: February 25, 2020).

²⁶ See <https://www.forumterzosettore.it/organizzazioni/> (last accessed: December 14, 2019).

²⁷ See <https://www.cri.it/14-11-2019-emergenza-118-angepas-croce-rossa-e-misericordie-chiedono-incontro-al-governo> (last accessed: December 14, 2019).

Conclusions

In this contribution we have reviewed and clarified the different meanings assigned to the concepts of co-creation, co-production and so on by the scholars. We have seen that *co-creation* is the most general and abstract one among them and encompasses all the others: these are referred to specific phases or levels of the same co-creation of public services.

We have also seen the dark side of the co-production, that is, its negative effects: the most important ones are the opposition from the PA professionals (their role in the co-production processes is a neglected topic), and the risk of burdening the final users of the service with excessive responsibilities, particularly disadvantaged people, so creating a vicious cycle. For these reasons, our opinion is that the most successful form of implementation of the co-creation is the *joint production*, that is, a strong and consolidated collaboration between the public sector and the Third Sector at all levels of the process of providing public services.

Accordingly, we have illustrated and analyzed two important examples of joint production of public services taken from the Italian welfare system: the transfusion system and the emergency health assistance. They are two fields belonging to the health care system, that is an area of the Italian welfare system where the State intervention is historically late: therefore the civil society had to get organized and provide by itself these services, as we have seen, and this produced important results for people in need, but also disorder and rivalries among TSOs. Nevertheless, subsequently, from the 1960s onwards, the State adopted a universalistic approach and began to intervene directly and massively, neatening these fields with great reforms. These reforms did not ignore the role of the Third Sector: on the contrary, this role was recognized and fostered, at least theoretically. Practically, a satisfactory level of collaboration between the public sector and the Third Sector, and among the single TSOs, so far has been more difficult to achieve, but it has been achieved: these are some of the causes of the high performances of the Italian public health care system, still one of the best in the world.

These cases are peculiar to Italy, but Italy is not radically dissimilar to other European or Occidental countries: it is instead very similar to other Mediterranean countries, as many scholars recognized since decades (Ferrera, 1996). Therefore, we think that it is possible to draw some useful and “profitable” lessons from these two cases, isolating the factors that boosted the joint production of public services, and that potentially can repeat this positive action in other circumstances and countries.

We have isolated 11 factors, 6 by the public sector side and 5 by the Third Sector side. They are exposed in the following table:

Factors boosting the joint production of public services	
by the public sector side	by the Third Sector side
1. The willingness of the politicians to carry out a real comprehensive reform of a complex field of public services, with durable legislative provisions.	1. The willingness/capability to collaborate with the public sector, overcoming cultural, religious or political cleavages, and accepting its leading planning role in a field of the welfare system.
2. The willingness of the top management to recognize the Third Sector's contribution and expertise, and listen to it both in planning the reform and after its implementation.	
3. The attitude of the mid-management to bring on a continuous collaboration with the TSOs, without discriminating anyone of them because of its cultural, religious or political roots.	2. The willingness to collaborate with other TSOs, overcoming cultural, religious or political cleavages, and accepting suggestions (best practices) or help from them.
4. The capability of the PA to guarantee fair reimbursements for the TSOs expenses, avoiding a pure economic logic.	3. The capability to offer high skilled (qualified) human resources (both volunteers and professionals), and high standard technical resources, to deliver the public service.
5. The creation of stable organisms (Committees etc.) or forums where public sector and Third Sector representatives can meet regularly and discuss together service-related issues.	4. The willingness to actively participate in stable organisms or forums on a regular base (both among TSOs representatives and between them and public sector representatives).
6. The public sector professionals' attitude to accept suggestions (best practices) from TSO operators during the routine activity.	5. The TSO operators' willingness/capability to comply with public sector professionals' protocols and rules during the routine activity.

As can be seen, there is an almost total correspondence between each of them, because it is logical that the same aspects of the joint production have to be considered by the two perspectives. Of course, it is necessary an active role of both parts in pursuing collaboration: if one part wants only to exploit the other's resources, soon or later the collaboration breaks, with particularly negative effects for citizens. Therefore, the base for an effective collaboration is, first of all, to acknowledge that both the public sector and the Third Sector pursue the common good, although from different positions and with different obligations.

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