The morphogenesis of disability policies and the personalisation of social services. A case study from Italy.

Riccardo Prandini and Matteo Orlandini

University of Bologna, Nonantola, Mo, Italy

Abstract

Across Europe, and particularly since the 2008 Financial Crisis, new demands for tailor-made services came from different actors and perspectives: user-led organizations, intellectuals, policy makers, social workers, advocacy organizations, which call for a new way of programming, realizing and evaluating social policies. Personalization became a relevant part of the so called 'welfare innovation narrative', which concerns – to name but a few – English personalization agenda, Scottish self-directed support, Finnish education system, Norwegian cash-for-care policies. Even the European Commission is addressing new social services, reshaped through users' capabilities. The aim of this paper is to critically explain, through a case study focused on the Sardinian disability policy, how social policy's morphogenetic cycles influence the governance of personalized disability plans and, consequently, the possibility of their implementation.

1. Introduction

European Welfare states are facing a growing demand for personalized social services, due to – among many reasons – the de-standardization and heterogeneity of individual needs (Valkenburg, 2007) which give room to the dramatic rise of new (Taylor-Gooby, 2005) and non-actuarial societal risks (Sabel, 2012): harms whose incidence is so unpredictable that it is impossible for those at risk to create an insurance pool sufficient to indemnify those who incur losses. These changes make unsuitable the 'one-size-fits-all' services designed to serve the 'average client' typical to traditional forms of welfare state (Rosanvallon, 2000).

Across Europe, and particularly since the 2008 Financial Crisis, new demands for tailor-made services came from different actors and perspectives: user-led organizations, intellectuals, policy makers, social workers, advocacy organizations, which call for a new way of programming, realizing and evaluating social policies. Personalization became a relevant part of the so called 'welfare innovation narrative' (Needham, 2011), which concerns – to name but a few – English personalization agenda (HM, 2007), Scottish selfdirected support (Scottish Government, 2010), Finnish education system (FNBE, 2010), Norwegian cash-for-care policies (Christensen, 2012). Even the European Commission (2013) is addressing new social services, reshaped through users' capabilities.

Personalization has been basically conceived as: a very ambivalent reflexive narrative (Needham & Glasby, 2014); something 'in flux, making it difficult to identify a stable core' (Needham, 2011, p. 157); being simultaneously liberal and conservative (Ferguson, 2007); for independence/self-sufficiency and in favour of retrenchment (Power, 2014); for citizenship rights protection and for families and communities activation (Glasby, Duffy,

& Needham, 2011). In a nutshell, personalization is generally observed as a 'powerful hybridization' (Ferguson, 2012) between market consumerism and social rights discourse, giving rise to a social policy mix constituted of counterposed values like deep citizenship and consumerism, community support and individual choice (Mladenov, Owens, & Cribb, 2015). This ambiguity becomes a key element of its success because different actors and services users perceive personalization differently, so that it can be extensively accepted as an actual option by the political system (Beresford, 2014): personalization become 'varieties of personalisation' and it is framed differently in various national welfare regimes (Christensen & Pilling, 2014; Needham & Dickinson, 2017).

Scientific literature and case studies have not yet fully explored the social mechanisms that allow personalization to work properly (Reeve & Cooper, 2016). In particular, the relation between personalization and its governance – which is one of the cornerstones leading to the discourse – is poorly developed (Duffy, 2010). An adequate account on how the personalization of social services has to be governed has not yet been elaborated.

The aim of this paper is to explain, through a case study focused on the Sardinian disability policy, how social policy's morphogenetic cycles (Archer, 1995) influence their governance and, consequently, the possibility of implementing 'personalization'.

The paper is structured in the following way. In Section 2 we clarify the difference between personalized and individualized social services; then (Section 3), we argue our hypothesis, methodology and research outline; in Section 4 we present our research on Sardinia personalized plans. In Section 5 we try to identify the morphogenetic cycle observed in the Sardinia case, to show how varieties of governance are linked to different ways of personalization. In Section 6 we briefly comment on the results, pointing out the critical, controversial and contradictory aspects of Sardinian personalization policy.

2. The conceptual difference between personalization and individualization

For policy makers, personalization is a specific and innovative way of designing, delivering, financing and evaluating social services (Glasby & Littlechild, 2009). Personalized social services are targeted and tailored on individual needs and aspirations, supporting and enabling citizens in realizing autonomously their life-projects (Duffy, 2008). Personalization means that social services should be de-standardized, adapted and tailored to the individual characteristics and their 'circumstances in order to increase their effectiveness' (van Berkel & Valkenburg, 2007, p. 3).

Three drivers enhance personalization processes within social policies, especially as far as social care is concerned. The first driver involves the historical breakdown of the Principal-Agent model, which has been typical of welfare states after the Second World War (Sabel, 2013). The second driver concerns the crisis of the compensatory social insurance model of welfare, which has already been replaced by a social investment and inclusive growth paradigm, triggered by a service-based welfare system (Hemerijck, 2012). The last driver pertains to co-production of services, which 'deeply' include specific ways of articulating users needs.

(a) Postwar welfare states and their governance were characterized by the Principal Agent (P/A) model. In a nutshell, Principal – i.e. a national government – appoints some

Agents – i.e. local public authorities – to implement previously defined collective goals. In other words, general programmes and reforms – elaborated by the Principal – are translated, through a bureaucratic 'chain of command', into specific actions and policies by the Agents. Literature revealed many structural, non-contingent reasons for the failure of the P/A model: (1) the Principal should know 'what he wants' ex ante, but actually this is not usually possible, since contingencies pervade the whole process; (2) the Principal is supposed to be able to identify all tasks of Agents: as a matter of fact, it rather coordinates many Agents, whose interaction gives rise to new emerging problems (and subsequent new tasks); (3) the distinction between means (enforced by the Agents: policy implementation) and ends (enacted by the Principal: policy making) is no longer clear, neither materially, nor socially and temporally; (4) social issues are always contextual and mutable so that it is no longer possible to design long-term and 'one size fits all' social services; (5) goods and services are often de facto co-produced with users-customers-citizens: therefore, the distinction between active-agents-professionals and passive-ignorant-citizens is unbearable; (6) it is not useful to adopt simple rules because if they are too general, an interpretation is needed, which generates conflicts that cannot be solved hierarchically; (7) Principals and Agents are increasingly conceived as 'search networks', which horizontally collaborate to solve part of the problem they face; (8) those Agents who should implement Principal decisions often aim to protect their own interests and not the Principal one; (9) recruitment procedures are less and less suitable for selecting the 'best' opportunities (under which respect Agent) and some rules (i.e. 'the lowest price') are often useless for the purposes of services' implementation.

(b) The second driver concerns a conceptual change, pointing at the emergence of the socalled 'new social risks'. These new risks are increasingly complex and unpredictable (Taylor-Gooby, 2005). Old welfare risks were coupled with standard insurance calculated on an actuarial basis, with a focus on a typical male citizen, full-time employed, holding a steady job position that was maintained throughout the entire career; job interruption was mainly contingent upon sickness or unemployment (which were correlated to predictable economic cycles). These risks have completely changed. To differentiate people included or excluded from the labour market has become more difficult because of the proliferation and fragmentation of new employment contracts. Moreover, categories of people previously excluded from the labour market – e.g. women, disabled people, single mothers, elderly – have become more and more included, while, on the other side, other categories who were included – e.g. young people – have gradually been more and more excluded (Annesley, 2007). Old welfare systems were also founded on a tacit intergenerational solidarity pact – involving working and retired people –, which operated with a passive financial redistribution mechanism. On the contrary, nowadays, risks that need to be insured against are less and less estimable on an actuarial basis (Luhmann, 2013). Such risks are so unpredictable that it is impossible both to say 'who', 'when' and 'how much' should be paid, and to generate an amount of insurance sufficient to really compensate those who suffer a loss. This new welfare constellation drives towards the notion of social investment where costs are conceived as tools for creation of human, social and economic capital. Instead of passive financial compensations (i.e. old-fashioned social assistance), now capacitation and active policies are new keywords. Since risks

aggregation fails, new social services are needed to help individuals and families to self-insure against risks, making them able to develop, throughout their life course, skills and capabilities to tackle ever changing problems (Crosby & Duffy, 2008).

(c) The third driver is connected with the importance to capacitate people by means ofsocial services, thus transforming their abilities into positive resources. In order to generate a cohesive and dynamic society, welfare systems have to organize personalized services so that the increased human and social capital can tackle 'dependence trap' and social isolation (Castel, 1995; Ehrenberg, 2009). The efficiency of personalized services depends on users' collaboration and response: users have to personally engage in order to thrive. Activating people's potentialities is a condition of possibility to discover and meet unmet needs: our hypothesis is that this process can take place only through a personalized services co-production.

These three drivers permitted and enhanced a new culture of personalization within social policies. Though within the concept of personalization are conflated two very different ways of thinking and designing social services. Given this conflation we need to distinguish personalization from individualization to frame our research project. These are two very different logics of delivering social services, usually conflated in literature.

We define individualized social service (ISS) as a top-down example of policy making, aimed at offering a standardized and specified provision of social services, which could be better defined as 'customization' of services. Goods and services are pre-arranged and planned by professional experts and policy-makers: the whole range of customized services is available in a 'package' ready to be delivered. 'In many situations this more individual approach is combined with a primarily top-down approach, in which the political process has already defined the problems that have to be solved and the ways in which this should be done' (Valkenburg, 2007, p. 38). In ISS the designer defines the clients' needs and decides how to deal with their context, shaping a diverse but standardized caseload. That is why the clients are not real co-producers: they can only decide how to utilize the resources previously arranged by services designers. Individualization – as a 'set menu' service – can reach remarkable levels of precision, differentiation and tailoring, but it cannot develop real processes of co-design and co-production because the client, by definition, is limited to a passive role. They are a target defined by an 'expert system' which holds the powers and knowledge to decide 'what is the case' and 'who is in charge'. The client is made passive because they have no real power to co-produce/deliver/evaluate what they need: 'because service users and carers were excluded from directly contributing to the original policy problem formulation, they could not influence the proposed solutions' (Carr, 2014, p. 30).

We can give some examples based on English personal budget and self-directed support scheme, exactly to underline the case for 'individualization without personalization'. Slasberg and Beresford pointed out how need assessment, that formerly was divided into a need evaluation (with the client) and a decision concerning which needs to meet, has become a single process: 'the imperative for Councils became to constrain assessments to affordable need only. Thus "need" was always seen through the prism of resources' (2015, p. 480). The person-centred approach has turned into a resource-driven approach. Series (2014) with Clemence (Series & Clemence, 2013) showed the failure based on RAS

(Resource Allocation System) – computer algorithms used by Local Authorities to calculate an amount for a personal budget, which service users and care practitioners may use to start planning their support. The attempt at achieving a fairer distribution of resources based on a mathematical model – less subject to arbitrary professional judgement (Duffy, 2005), more transparent and less bureaucratic – failed because RAS has become a 'back-office' way of spending cuts excluding the possibility for users to know the available amount of resources (Forder et al., 2012; Slasberg, Beresford, & Schofield, 2012). Without co-design and co-production of services, i.e. the inclusion and activation of users and clients into the service, personalization became mere (standardized) individualization. At the end of the day, many scholars pointed out that ISS is not a real revolution in social care: on the contrary the old system 'reinvents itself under the guise of the new language and, in an era of austerity, leaving us with a shadow, a pale imitation or possibly even a parody of what personalisation could be' (Needham & Glasby, 2014, 188). The alleged 'personal' revolution – which was supposed to envisage a new paradigm beyond neo-liberalism – could turn out to be a victorious resistance of the old system.

Personalized social service (PSS) shows a completely different logic. PSS empowers users who are directly involved and included in defining their needs and aspirations, as well as in designing the toolkit to achieve them. What distinguishes PSS from ISS does not concern what is the service, but how it is designed-delivered-evaluated. Differently from ISS, PSS logic includes at least three levels: (a) listening to peoples' definition of their situations; (b) sharing information and resources; (c) capacitating and empowering the co-design and co-production of services in order to make it possible for users to autonomously lead their life. Users are not conceived as a passive target of a ready-made standard service, designed by an expert system, but as active subjects of co-design. Experts, personal advisers and professionals become 'reflective coaches' able to start up processes of user empowerment. To realize PSS it is necessary that users: (1) must 'make their voices heard'. Users are conceived as social actors with specific capabilities and functioning, useful to discover personal needs, to gain autonomy and elaborate personalized solutions. PSS is based on a deep listening of users' aspirations and needs; (2) collaborate in designing and co-producing services. Each and every solution has to be shared and decided together with case managers, personal advisers, users and others responsible for the service. This concept of co-production goes back to Elinor Ostrom's work (a process by which 'inputs from individuals who are not "in" the same organisation are transformed into goods and services' 1996, p. 1073) and it is connected to policies governance (as co-creation, codesign, co-planning, co-management and co-assessment Pestoff, Brandsen, & Verscheure, 2012). To conclude, in PSS persons are conceived as the medium of new social services. PSS converts personal potentialities and powers in actual functioning, prompt to catch on-going social opportunities. As Sabel demonstrated, the new welfare regimes will be based on 'capacitating social services' (Sabel, Zeitlin, & Quack, 2017). Here social solidarity means helping people to clarify, identify, organize and control what they need, as well as to tailor welfare services on their specific life-projects (Hemerijck, 2017).

3. Hypothesis, methodology and research outline

The research aims to identify the morphogenetic cycles of a Sardinian social policy which, structuring different 'situational logics', influence different forms of personalization. We will focus our analysis on the (macro) condition of possibility (or impossibility) for personalization, including the morphogenesis of the social policy administration's regime (at regional level), its influence on different forms of governance which frame the (micro) organization of services, especially the interaction between social workers, users and their supportive networks (Figure 1).

The first hypothesis concerns the relationship between social policies governance and care services personalization. We try to establish, through what Hedström and Swedberg called 'situational mechanisms' (1998), how macro-level conditions affect the street-level practices of social care. We assume that the more social policies governance is pluralistic and participatory, the more care services can generate the possibility for the development of personalization. Governance is more pluralistic when it is open to the largest number of actors: users and their families, users' associations, for-profit or non-profit service providers, public administrations. On the contrary, monistic governance tends to include the minimum number of actors. Governance is more participatory when action plan design involves users and subsidiary support planners, while it is less participatory when, being professional-oriented, the plan design is strongly delegated to professional experts (Sabel & Zeitlin, 2012).

The second hypothesis deals directly with the street-level functioning of services, i.e. how interactions between users, social workers and assistants take place, the frontline units of the service. We want to verify how the actors enact the governance rules, what Hedström and Swedberg called 'action-formation mechanism' (1998). We assume that, in cases where care services are actually 'co-produced', personalization lead to a flourishing of users and does not turn out to be a mere standardized individualization.

To verify these hypotheses we need to frame forms of governance into the so called morphogenesis of social policies administration. Methodologically, we use two different sociological approaches: Archer's morphogenetic theory[1] (1995) and Hedström's social mechanism theory (Hedström & Swedberg, 1998). We try to include within the morphogenetic approach the so-called 'Coleman boat' to show how changes over time at different policies layers, can influence personalization (or not) (Figure 2). At T^1, we observe macro social situation (social structuration – Nodes A) that figure as explanantia. 'Basically, A's are extra-individual social factors that might be cited as causes of social phenomena and that might influence individuals' (Ylikoski, 2016, p. 5). Between T^2 and T^3, we refer to the

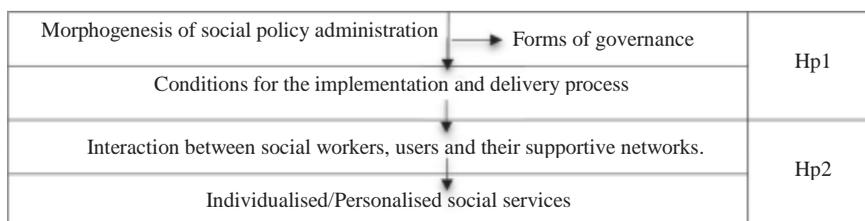|		
Morphogenesis of social policy administration → Forms of governance		Hp1
Conditions for the implementation and delivery process		
Interaction between social workers, users and their supportive networks.		Hp2
Individualised/Personalised social services		

Figure 1. The research design (arrows represent the possibilities to influence different factors).

properties of agents and their situations, like values, opportunities or interests (Node B) and to behavioural outcomes, like choices, behaviours, or actions (Node C). At T^4, we take macro social facts as our sociological explananda (Node D). The arrows are to be interpreted in the light of social mechanisms: 'one should identify the situational mechanisms by which social structures constrain individuals' action and cultural environments shape their desires and beliefs (arrow 1), describe the action-formation mechanisms linking individuals' desires, beliefs, etc., to their actions (arrow 2), and specify the transformational mechanisms by which individuals, through their actions and interactions, generate various intended and unintended social outcomes (arrow 3)' (Hedström & Ylikoski, 2010, p. 59). Finally, there is arrow 4, which is sometimes absent from Coleman's own diagrams. 'It is the starting point of the analysis that employs the diagram. It might be a correlation between A- and D variables, or it could be a hypothetical causal connection between these variables' (Ylikoski, 2016, p. 8).

In order to verify our hypothesis, we have chosen a case study dealing with a well-recognised Italian social policy relating to disability: the Sardinian personalized plans (ANED, 2009). After having analysed the available documentation,[2] we interviewed 16 key informants selected from politicians, medical staff, social enterprises managers, social workers and members of users-led-organizations (Table 1). Then we reconstructed and analysed 41 personalized action plans, interviewing users, their families, personal assistants and social workers.

The interviews with key informants have been divided into four parts: (1) how they got in touch with personalized plan; (2) what users needs are, what services are offered, and what services are requested; (3) what changes are taking place through personalized plans and what processes are driving these changes; (4) a final evaluation of what favoured or hindered the personalization processes.
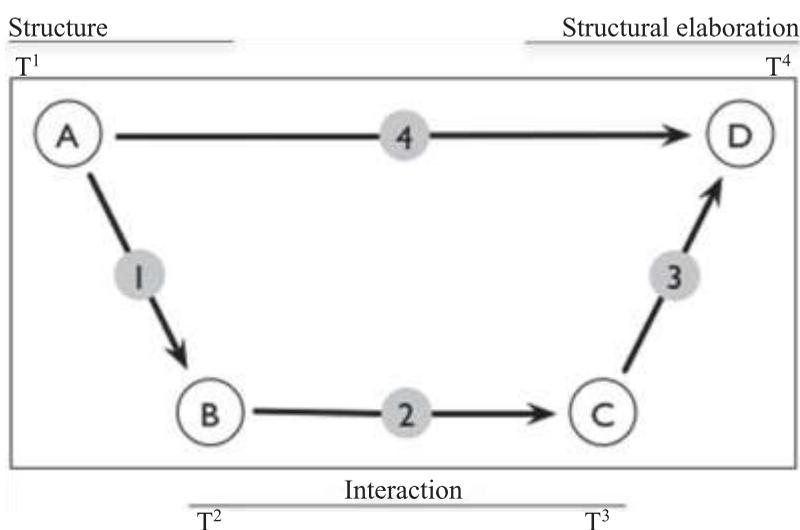

Figure 2. The Coleman diagram combined with morphogenetic sequences. Source: Elaboration by Ylikoski (2016) and Archer (1995).

Table 1. Key informant interviews.

N.	Roles	Position, Organizations
1	Politician	Councillor for Social Care, Local Authority
2	Politician	Councillor for Social Care, Local Authority
3	Specialist	Head Physician, Intensive Care, Cagliari
4	Specialist	Social worker, Association
5	Specialist	Social worker, Local Authority
6	Specialist	Director, Regional commission for the revision of the Fund for non-self-sufficiency
7	Service provider	Manager, Social enterprise
8	Service provider	Manager, Non-profit
9	Stakeholder	President, Italian Children's Brain Injury Association
10	Stakeholder	Manager, Sardinia Children's Brain Injury Association
11	Stakeholder	President, Users and Families Led Organisation
12	Stakeholder	President, Users and Families Led Organisation
13	Stakeholder	President, Users and Families Led Organisation
14	Stakeholder	Member, Users and Families Led Organisation
15	Stakeholder	Member, Users and Families Led Organisation
16	Monitoring	University

Interviewing users, family members, and relevant social workers have carried out the analysis of personalized plans. Users and family members have been asked to focus on: their life stories; reasons leading to request a personalized support; how the plan was designed; what people they have cooperated with; what changes have occurred and a general evaluation. On average, each interview lasted 90 minutes. Social workers have been asked to focus on their job, and personalization and co-designing strategies activated with users and family members.

4. The case study: Sardinian personalized plans

The Italian welfare state is a well-recognised example of a Southern European welfare model (Ferrera, 1996). This model emphasizes a passive subsidiarity (Kazepov, 2010): the care for disabled or dependent persons rests on families, in an institutional context mainly characterized by cash benefits. Characteristic of the Italian long-term care system is a strong territorial differentiation: the Centre-North has a higher care coverage and higher development of services than the South (Arlotti, 2015). Even in disability policies, the Southern European countries are characterized by under-developed policies with respect to the activation and integration dimension. In the last years, they have carried out reforms to reduce the generosity of their social protection system, but there have been fewer efforts at implementing changes to support employment and prevent permanent disability (Böheim & Leoni, 2016).

The Italian disability policy rests on three levels: the State regulates and (partially) finances; Regions specify programmes and (in most cases) finance; Municipalities implement policies (ANED, 2016). As regards disability services, Italy regulates the domestic assistance through a national framework law on disability (Art. 9 of Law 104/92) and delegates powers to Regions in order to decide what services are offered and the eligibility criteria for accessing them. A national independent living legislation was

approved in the 1998 (Law 162/1998), but only some Regions have defined a specific programme for it (especially Piedmont, Tuscany, Veneto and Sardinia). A series of national funds finance the disability policies (Fund for Social Policies, Childhood and Adolescence Fund, Equal Opportunities Policy, Fund for dependent persons, Fund for the Family), but Regions and Municipalities actually take charge of the main part of policies' functioning and financing.

In this very fragmented picture the Sardinian disability policy stands out for three main reasons. (1) From a regional social expenditure analysis, Sardinia Region is the second main national 'spender': in the period between 2004 and 2012 it dramatically increased its investment in disability policies.[3] (2) During the last decades, Sardinia has moved from residential care and institutionalization to home care and free choice of disabled persons, especially through personalization. (3) The policy of personalized plans has increased steadily since 2000 to date, involving a growing number of users and families. In 2015, there were about 39,000 people who could take advantage of the personalized plans, on a computable target population of at least 106,500 persons (Figure 3).

The female population, in addition to being more substantial, also requires a higher number of plans (23,693 vs. 14,819; 28.26 plans vs. 18.48 plans per 1000 inhabitants) (Table 2). The distribution in relation to the age group highlights the strong presence of children between 4 and 17 years old and seniors over 65 years, both in absolute terms and in relation to the population of the age group. Over-65s indeed record an incidence of 71.24 customized plans for every 1000 inhabitants: from this figure you can see how the addition of non-self-sufficient 65 years-old people has made the policy into something different from what it was in the early 2000s (Table 3).

Personalized plans represent the Sardinian regional enforcement of National Law 162/ 1998 and are a new way to improve the disabled people's quality of life through tailored

Figure 3. The extent of the phenomenon. Source: sardegnasociale.it (our elaboration).

Table 2. Gender distribution.

	Plans (Number)	%	Population (01.01.2013)	Per 1000 inhabitants
Male	14,819	38.48	801,849	18.48
Female	23,693	61.52	838,530	28.26
Sardinia Region	38,512	100.00	1,640,379	23.48

services, co-decided by professionals and users, and with the involvement of both families and community resources. The service user goes through a process of person-centred planning, steered by her family members and social workers (Box 1) by which service users design personalized plans for the kinds of services they want to use. Personalized plans are discussed and collectively assessed. Once the plan is accepted by Local Authorities, the user starts to arrange the services using her budget. The policy is designed, managed and measured by a mix of actors. Each actor in the network (Region, Local Authorities, Third Sector organizations, families) develops specific tasks and responsibilities. The Region finances and controls the implementation of the policy; the Municipality assess needs and sign the plan with the users and their families; users and families codesign and co-produce the plan by choosing personal assistants and services; user-lead organizations support families and disabled people in designing and managing the plan; third sector organizations and private personal assistants provide services.

Box 1.   Five steps to personalize disability plans

Step 1: Needs assessment. The first step is to evaluate social and health situation, needs and resources concerning service users, their families and friends. Disabled people and their family submit their situation to a double evaluation process: (1) 'health card', i.e. how serious disabled health conditions are; (2) 'social card', i.e. user needs along with their assistance plan, from a social, educational, working and family point of view. Resulting score determines action plan scope and needs, later assigned to a specific budget approved by the Region.

Step 2: Individual budget. The second step is to find out how much money service users can get to spend on support: people should be able to find out quickly how much money they will have for support.

Step 3: Co-planning. The plan says how users will spend the money on their support. A support plan, written together with social workers, enlists: desires, activities fitting their goals, how they will spend personal budget.

Step 4 – Organize the support. There are two ways to manage the personal budget and the plan: (a) direct management (the Municipalities organize and spend the budget assuring social services people have decided); (b) indirect management (families have the responsibility to organize and purchase services, and the Region, through the Municipalities, pays a refund after documentary presentation (receipts, payrolls, passes, etc.)).

Step 5 – Enact the plan. The personalized plans may include: home care, day care centres, educational services, sports and socializing services.

Source: Our elaboration by administrative materials.

5. The morphogenesis of the Sardinian social policy: from personalizationto professional individualization.

5.1. The four phases of the process: situational, actional and transformational social mechanism

In identifying the development of the policy governance and its street-level functioning, we have observed a morphogenetic cycle composed by four different phases (Table 4): (1) the period since the Regional enforcement of the law 1682/98 (before 2000); (2) the period covering the start-up and the institutionalization of services (between 2000 and

Table 3. Age distribution.

	Plans (Number)	%	Population (01.01.2013)	Per 1000 inhabitants
0–3	253	0.66	51,396	4.92
4–17	2843	7.38	190,935	14.89
18–35	2608	6.77	341,601	7.63
36–64	8714	22.63	718,261	12.13
>65	24,094	62.56	338,186	71.24
Sardinia Region	38,512	100	1,640,379	23.48

Table 4. Nodes and arrows in the Coleman diagram (see Figure 2).

Nodes and arrows (Coleman Boat)	First phase	Second phase	Third phase	Fourth phase
A. Explanantia	Standard individualized services	Personalized plans	Co-produced personalization	Personalization via suspension
1. Situational mechanism	The Law 162/98 creates the opportunity to change disability policies	The Sardinian enforcement of Law 162/98 leave room for new relationships in social services.	The logic of opportunity creates the possibility for new actors and users to enter the system.	The logic of compromise generates a safeguard of the status quo
B. Properties of Agents	Social workers: institutionalizing procedures; ULO: home care	Region: plans as a communication tool; Users: choose and check care services	Unions and non-selfsufficient users can use personalized plans	Region: critical review of personalized plans ULO and union: defence of social expenditure
2. Actionformation mechanism	The agents capturing the change promote a strategy for the utilization of experimental funds	The agents capturing the change promote coproduction.	The agents expanding the system suspend the co-production	The agents struggle for and against the cuts
C. Behavioural outcome	Region: open to the experiment	Users and their families 'make their voices heard'; dignity back to users and families; collaborative designing of personalized plans.	ULO and unions: defensive and advocacy role; Region: extension strategy; Social workers: overwork	Region: like a Principal; Local Authorities: like Agents;
3. Transformational mechanism	Creating a public space for dialogue between institutions and civil society	Creating a plural and participatory governance	Creating a political defensive coalition	Creating a command & control governance
D. Explananda	Personalized plans	Co-produced personalization	Privatization of personalization	Technical and professional individualization
4. Situational logics	Protection	Opportunity	Correction	Elimination

2007); (3) the scaling-up phase (2007–2010); (4) the period of the reform (2010-up today).[4] We sketch a synthetic picture of these phases.

First phase (1990s–2000). Personalized plans emerged within a pre-existent social and political context, transforming it in the process. (A) Before 2000s, disability policy system was structured by: – different sectorial laws (laws for people with kidney disease,

thalassaemia and haemophilia); – few big private organizations delivering highly institutionalized treatment. Child psychiatry, physiotherapy and specialised treatment for intellectual disabilities were underdeveloped and basically supplied by a low-quality private sector (Siza, 2012). Disability policies operated within the so-called situational logic of protection (Archer, 1995): i.e. for profit companies delivering services had no interest in change, so that they act to maintain and reproduce the context.

> There were no effective rehabilitation methods. It was very interesting. [...] The rehabilitation was offered institutional or at home but very ... Some professionals theorized that rehabilitation hurt, 'if you treat her more than three half-hours a week, then you keep hurting her.' These are all things that over time ... These are all nonsense. (Interview no. 9)

(1) The Law 162/98 introduced at the regional level the possibility to design and to publicly fund personalized plans for disabled people. For the first time the logic of protection was affected from the outside. (B) On the one side, Sardinia Region had difficulties to spend these additional funds, even because social workers treated disabled users with standardized and institutionalizing procedures. On the other, during the '90s, user-led organizations, which are used to organize home care for disabled people, adopted an independent living and de-institutionalizing culture. (2) Some actors, those interested in leading this change, promoted a strategy for the utilization of experimental funds with personalized plans. (C) Region turned from hindering to facilitating the emergence of personalized plans; social workers began to exploit new opportunities to upgrade their skills; user-led organizations were summoned by the Region to discuss how to spend the experimental funds, and families supported those organizations. (3) The Region created an Advisory Commission for elaborating on 'Law 162/98'. The Commission became the interface between civil society and political institutions, i.e. the place where personalized plans criteria could be discussed, reviewed and reconsidered on the basis of experience.

The officials of the Commission that always set the rules were supporting us. And clearly people are important. The politics followed because of external convincement. The Sardinia model was really born from the bottom, from the users. [...] Technicians supported. (Interview no. 9)

(D) The care system changed in many ways: the funding strategy moved from a mutual public-private arrangement, to direct families' reimbursements (according to eligible costs of personalized plans); the topic of social policies changed as well, from standard treatments based on experts' knowledge to care services chosen and controlled by users.

Second phase (2000–2007). Between 2000 and 2007 – the period covering the start-up and the institutionalization of services – regional policies were especially connected with families and user-led associations. (A) Already in 2002, 266 municipalities, 70.5% of the municipalities of Sardinia, had presented at least one personalized plan in favour of residents with severe disabilities. (1) The Sardinian enforcement of Law 162/98 left room for new relationships in social services. (B) Sardinia introduced personalized plans as a tool useful for welfare organizations in order to meet users' needs along different life course transitions. Users-led associations were constantly in touch with local authorities, monitoring the implementation of personalized plans. Local City Council and Health Authorities staff members (councillors, social workers, psychologists, doctors, etc.) invited citizens to apply for personalized plans. Users and family members had the power to choose and check care services available on quasi-markets. (2) Actors interested in the

change, promoted co-production of services for disabled people entitled to cash-forcare. User led organizations supported families in designing their own plans, sustaining the relationship with social workers and personal assistants, influencing mass media conceived as a sounding board for requesting support to personalized plans. The Region decided to regulate its own decision-making process towards a non-commanding approach. Local Councils changed their previous bureaucratic management. Each personalized plan derived from specific needs and resources assessment, designed jointly by professional staff and users. Hospital, service centres, local health units, public or private assistants recognized the plans as a shared product, in agreement with the users engaged. (3) This plural and participatory governance gave room to three different and parallel arrangements: hierarchy, co-production and market. These new possibilities disclosed new opportunities for the actors involved. The outcome was the situational logic of mutual opportunities (Archer, 1995), where groups characterized by very different interests could operate together. When properly exploited, these compatibilities lead towards the socalled co-produced personalization.

Third phase (2007–2010). At the beginning of this phase, users and their families begun to interact with local social workers in order to co-produce their plan. (A) They could define with social workers their care needs, and they could be supported to find adequate solutions. (1) The situational logic of opportunity, within which the production of personalized plans was governed, created the possibility for new actors and users to enter the policies system. The broadening of services to elderly and non-self-sufficient people began from the middle of the 2000s (Regional Law n. 2/2007) and called for the inclusion of unions in a new coalition of interests. (B) The Region included new actors (unions) and users in the system. Unions supported the entry of elderly and non-self-sufficient people in the system. Users-led-organizations pushed to expand the system to institutionalized people (in social and health residential structures) or at high risk of hospitalization: the Region approved the Back Home programme for home care. (2) Actors entering and sustaining this system expansion started to disinvest in co-production because it was too complex and resources spending. (C) Due to the dramatic boost of plans, social workers were flooded with requests so that they began to accept them, without being able to design, monitor and evaluate the services in a proper way. Users accepted that co-production was activated only by personal assistants and without the public monitoring and assessment. User-led organizations were pushed to accentuate their defensive and advocacy role to the detriment of their previous proactive and supportive role. Last but not least the Region, overwhelmed by applications, reacted by renewing ex officio personalized plans for a few months instead of investing in the new assessment programme. (3) The ultimate outcome of this situation was the emergence of a new political defensive coalition composed by very different actors and contradictory logics. Unions entered the system and increased their power to negotiate with regional politicians; disability-led organizations limited their role to advocacy but decreased their ability to give voice to the disabled; social workers gave up designing plans in a creative way. Public opinion only focused on the defense of included people. Moreover, because of the widening of beneficiaries, the social policy became more inconsistent. It had to combine services to capacitate disabled people with services dedicated to non-self-sufficient people – normally assisted by very low-quality home care work ('badantato') – which is less interested in developing the 'high quality' services requested by personalization. (D) The interactions between users, families and

social workers become very ambivalent: plan designs and their implementation were fully delegated to families and personal assistants with social workers limited to the paper compliance of bureaucratic rules. The final outcome was what we can call a sort of 'privatized personalisation'.

Fourth phase (2010–2016). (A) 'Privatized personalisation' means that co-production collapsed but, at the same time, is balanced out on a different level: the plan designs and implementation shifted to users, families and their networks. At the vertical level, a compromise between politicians, unions and civil society organizations governed the social policy. (1) The situation logic of correction (Archer, 1995), based on compromise among actors, generated the containment of the status quo. (B) Social workers become simply policy's 'verifiers': entangled and overburdened in daily work, they could not really follow and evaluate cases. Users and families complained about the end of the co-design process: every year they received only some communications about plans renewal. Userled organizations and unions defended the amount of social expenditure reserved for disability and long-term care because it gave them power to negotiate. Since 2010 the Region, after changing political leadership, already in the shadow of the austerity period, began a critical review of personalized plans especially on three points.

Since 2010 the Region, after changing political leadership, began already in the shadow of the austerity period, a critical review of personalized plans especially on three points: the overlap between non-self-sufficiency and disability; the exclusive choice of home care and the lack of assessment tools. (2) This new configuration gave rise to a polarized struggle between agents protecting the policy system and agents trying to reform it but only through cuts of budget. (C) The Region perceived personalized plans as discretional, ineffective and exposed to moral hazard (Deliberation 34/30, 2010). An ongoing reform reestablished a hierarchical governance (Deliberation 33/12, 2015). Nowadays the Region is trying to transform the personal plan policy into an austerity one, in order to control social expenditure. Plans are processed on the basis of an explicit and detailed legal procedure. The bureaucratic logic of this decision is that re-introduced and personalized plans are now at risk of restricting themselves as individualized and standardized services. Municipalities and Local Health Units start to rule a new assessment procedure with little or no relationship with users. Users and families continue to design personalized plans but only with personal assistants.

> A new form of opportunistic behaviour is now developing, especially in some areas of Sardinia, where the pressure to have a household income in order to participate in consumption is very strong. In certain areas where occurred industrial, agricultural or pastoralism crisis, people want to maintain the level of income. Somehow they benefit from the care system in replacement terms. (Interview no. 6)

(3) These new configurations lead to a command and control governance. The logics of opportunity and of correction have gradually weakened, leaving room to a logic where the public administration tends to eliminate the previous plurality of the actor and brings back the governance to something like a Principal-Agent model, i.e. a hierarchy (Sabel, 2013). (D) In September 2014, a new technical working group was established. After several months of work, it produced new guidelines for the multidimensional evaluation, financing and monitoring of personalized plans. These guidelines consist of three steps: (1) administration evaluates the personal and specific conditions of dependency, identifying the appropriate health and social care services to deliver; (2) it assigns to the services a

'rank' so to determine the funding available for the implementation of measures; (3) finally the system proceeds to the operational design of the most appropriate objectives and actions, based on the total available resources. The assessment is entrusted to a Territorial Assessment Unit and to the municipal social workers, in accordance with the beneficiary and/or their family. This configures a more technical and professional process than the original one, where the role of the users and their families become subordinate because the focus is on an ex-ante non-self-sufficiency evaluation.

The current scientific twist is due to the scientific evaluation: if there is a mess, we have to validate things scientifically. You don't care about all the personalized process. It remains personalized, but about all the participatory process where the choice is made … You aim to have just a technical report that defines how high is your seriousness level and how much money and then they will explain you how to spend them … If they will arrive to these conclusions, we will say nooo! (Interview no. 4)

5.2. Interactions through personalized plans: 'misunderstanding' and coproduction

The other focus of our analysis concerns interactions taking place between users, their families, social workers, personal assistants and professionals. These interactions are now very ambivalent: in a certain sense, plan designs and their implementation are fully delegated to users and families, but this 'devolution' gives rise to a reaction that, paradoxically, generates a more bureaucratic procedure. The final outcome is what we call a 'creative misunderstanding'. This means that the collaboration between users, families and social workers collapses; but, at the same time, the absence and the breakdown of this institutional collaboration is balanced out on a different level: the design and implementation shift to users, families and their networks. Social workers and public officers simply limit their role and action to validate autonomized personalized plans.

5.2.1. The interaction between social workers and users and families: a 'creative misunderstanding'

Users and their families begin to interact with local social workers in order to co-produce their plan. They can express to the social worker their care needs, and then they can be supported and given some solutions. As a personal assistant underlined: 'Expressed needs carry a solution with them'.

Within this context, after plan design there is no further substantial support to users. Every year, families have to submit the action plan documents to the Local Council, but they limit themselves to submit the same project. After the first agreement with the social worker, users and families give up the idea of adopting the plan as a tool to improve their condition and as an interface to record their improvement within the care system. For 10 years, families using the personalized plan complain about the end of the co-design process: basically, every year they only receive communications about plans renewal. While, in the early years, families experienced collaborations with social workers – collaborations resulting in detailed plans – today the feedback with local social services units is almost absent. Social assistants have become simply 'verifiers': entangled and overburdened in daily work, they cannot follow cases. Thus, it is not possible to describe these procedures as case management practice.

Interviewer: And your relationship with the City?

Father: The help from the City was almost zero [...] we talk about co-design to enhance the municipal assistance. All projects, however, pass through the will of the family, in my experience. In fact, over the last 10 years there is no longer co-design. There is only the communication: 'It has been extended the plan for another 6 months, for another 5 months.' Our project works, if we insert in other requests we would not be able to handle it, because now L. has a full life. There is nothing that can improve the life of L. [...] A basic level. They have to manage 2,400 personalized plans with only two social workers. Everyone complains that they would not be able to design a plan. I wish that our plan would not be changed, because it is a good plan that we wrote 10 years ago.

I.: Have you done a work on the plan with the City?

F.: No, it fails for lack of people. P.T. is a good Municipality: accurate, on time. Knowing the whole situation in Sardinia, it is not like other Municipalities. It is a professional one.

I.: And the role of associations?

F.: The associations are the basis for parents, for the training of parents in order to live with a disability.

I.: And the personalized plan?

F.: I did submit plans to the other families, I was the expert on the 162, we pass down the idea of plans design to other families. We were planning into my house. P. and R. "What can we do?" We were the means to impart the idea. They told me: "Can we put the horse riding? What can we do? The pool?". We gave input.

(Story of personalization, no. 1)

Interviewed social workers report that personalized plans are still able to meet families' requirement for care, but also report that support, monitoring and evaluation activities are not really carried out. Co-production is thus suspended, and users and families have to manage their relationship with personal assistants autonomously. In a sense, the process of co-production is creatively 'misunderstood' because care services become dependent on the family ability to operate on their own. At the same time and paradoxically, users, their families and the chosen staff are included in the care system because they are necessary for the daily workability of the system. Arbitrariness and freedom to design the plans autonomously are thus traded off for a restricted and limited co-production of services.

5.3. Interactions between users and personal assistants: three steps towards coproduction

Information collected by interviews and regional databases clearly point out that a large part of the available budget is spent on home assistance provided by personal assistants or healthcare professionals. Sardinia is characterized by a widespread cultural and institutional tradition of domiciliary care, which led to a huge dissemination of domiciliary policies. This means that personal assistants and social carers are the pleasure and pain of the system.

Some stories of personalization tell of a human development towards autonomy (Box 2), but interviews also highlight at least two problems: the first concerns training of specialised staff – in particular regarding autism – and the second is the particularly high turnover. These problematics affect the role identity and career of personal assistants and professionals. At the beginning of their career, they are really motivated and engaged in their work; but then, when they acquired professional skills, their job become monotonous. They become expert but low-paid employees, losing their personal engagement in activities.

Box 2. – Two example of autonomy

F. is asking for more and more autonomy and that is absolutely fine with me. He asks me to go on errands, of course within two hundred metres around the house, but still in the territory. He goes, buys pizzas, newspapers, buys something, goes back home. At this point, I have begun, being on special leave and doing lunch for him each day, to let him prepare the pasta. He makes her bed. He knows how to wash a pair of underwear, how to clean the kitchen, how to wash the dishes.

(Autobiographic story, no. 8)

Already changing coaches is a thing I did not think he could do so fast, but the personal assistant, after two days M. took the coach alone for the first time, he told me: 'Tomorrow M. will come directly to Colle San Michele', I said: 'But R., what are you saying? Look, it is just two days he is taking the bus,' 'He can do that, he can do it' 'R., he hasn't learnt that,' 'Do not worry, he could get it.' After two days he has done it, he has seen twice what it had to do, and M. made no mistake. I cannot ask him to do different routes if someone does not see him, but he has stored those.
(Autobiographic story, no. 5)

We can now highlight three specific dynamics within the interaction between users, families and personal assistants:

(1) Users and their families can 'make their voices heard'. Several personalization cases (stories 1, 7 and 11) report positive changes if users can express and communicate their needs. A peculiar ability to communicate is necessary in order to run a social service. Users and families have to be trained. Personalized plans are useful exactly for this: family members can discover how the disabled communicate or can create new channels for communication (e.g. using a computer, their eyes, moving their hands, etc.). Users then start to make themselves understood by gestures: they start to recognize their unmet needs and how to articulate them in a creative way. Personal assistants often become their interpreters (Box 3).

Box 3. – The graduation of L.

The story of L. changes when – thanks to 'facilitated communication' – he ceases to be the 'janitors' boy' and starts to actively partake in the classroom learning processes. L. has succeeded in accomplishing Primary, Junior High, High School and a University degree. When he was 10, L. dreamed of 'tità' (i.e. 'Università'). Since 2000, his educational projects have always been co-designed and financed with Law 162/98. Educational assistance has been provided in every school attended. A team, involving his primary school teacher, a high school professor, an educational assistant, and university staff, has projected university itinerary. L. has one of the largest personalized plans: 24 hours per week, supported by two personal assistants.

(Story of personalization, no. 1)

It is exactly here that we can see the difference between personalization and standardized services: users and families are not seen as mere passive targets, but as real

proposers, people with competencies and capacities useful to elaborate solutions. In their actions they represent the precondition for the existence of personalized services.

'Interviewer:	You have to teach the knowledge of G. to the personal assistants. Can you make sure that they understand these characteristics of G., to work better?
Mother:	Yes, but it took time, indeed we have two personal assistants, but we took some years so that G. accepted them and they were able to understand these things. At the beginning, G. seems to be a girl who does not understand anything, because she does not give adequate answers, then it happens that we talk about one thing and she anticipates the action and she does it. That means that she has followed, understood and then she does it. Then one realizes and says: 'What, it seems she does not understand, instead think the smart thing she did! [...]'
I.:	When it is not required to be in the conversation, can she demonstrate to understand?
M.:	Yes. But interactions are often verbal, this is a limitation, because she does not communicate verbally.
We have two assistants:	one in the morning, a girl, 5 days in a week for 3 hours. Practically, she takes her to do physical activities four times a week, because two days a week she goes to the pool and two days a week she runs and goes to the gym. Always with the same teacher, very good'.

(Story of personalization, no. 11)

(2) 'Giving heed' and dignity back to users and families.

When interviewed and asked to describe their experiences, personal assistants often use expressions like 'we develop together what she prefers' (story no. 3), 'her needs are now met' (story no. 2), 'we work on her skills and her desires' (story no. 4). Assistant's empathy and understanding are increased by two factors: the presence of a caring and collaborative family, and the possibility of a fruitful dialogue with other professionals (see Box 4 and 5). This process makes personalization different from 'expertocracy': professionals and assistants acquire coaching, facilitating and mentoring skills.

(3) Collaborative designing of personalized plans, involving users, professionals and personal assistants.

(4)

Box 4. – The double experience of I.

I. is a psychologist who has worked on personalized plans for 10 years. She came in contact with disability during University years: her first experience was about supporting C. (seriously brain-damaged), whose family was very supportive and could rely on a solid network of volunteers. The objective was to support C.'s attitudes and passions during the daily activities, mitigating the family care burden. I. faced this first experience as a freelance, while next experiences were carried out within a social enterprise working on disabilities. In this new context, she can discuss frequently with other assistants, can rely on several professionals in order to design each specific plan and can learn how to support disabled people in a very personal way.

(Story of personalization no. 9)

Box 5. – The work with F.

My experience with F.: I met him 14 years ago. I studied pedagogy and I'm a personal assistant of the 162. I would like to highlight that the assistant is always a bit precarious but I never felt insecure because I was supported by F.'s family. The goal was the autonomy and the important thing was not to have limits. We worked on some useful activities but that F. might also like. And then we worked on advanced autonomies such as money management. I felt the need to be supported in my work by an association. With the aim of the family, we formed an association for the promotion and social inclusion, which concerns minors who got out of the community.
I noticed that working with the two categories together there was harmony and we have seen that this report was very positive, there was synergy and these guys acted as positive role models for him.
So we started to raise money and we realized projects they saw F. together with these guys that get out of the community. What we tried to do in this path, with failures and mistakes, was something F. might like. We tried nondefined training paths that F. liked: for example, we contacted an online magazine called 'S. D.' and we offered a training course for F. and two other boys for photo storage tasks'.

(Autobiographic story, no. 18)

Interviewed families underline how the services are personalized and co-produced together with professionals involved. Personalized plans usually pertain to four operative areas: the first concerns daily routine activities decided with users and families; the second is about educational activities (e.g. school attendance, homework and learning experiences); the third area, the less developed, concerns working activities like work inclusion, training and apprenticeship; the last area regards community life (e.g. partaking some workshops with other disabled people, sport activities, attending same-age groups, volunteering, etc.) (Box 6). Personalized and co-designed services are really different from participative practises because they support users in need assessment, in designing and enforcing the plan (Box 7 and 8).

Box 6. – Filippide Project

Several young people with personalized plans use part of their budgets for carrying out some sport activities together with their personal assistants. Athletics, swimming and horse riding are the most commonly practised activities. Learning by doing helps users acquire basic skills. Filippide Project, an association that organizes sport activities for disabled, represents one example.

Box 7. – The creation of social enterprises

The Social Enterprise C. provides a set of integrated support for the co-production of personalized plans. The first support is represented by a social secretariat, where social workers help users and their families to get information about their relevant rights and local policies. A multidisciplinary team of professional workers gives the second help. The third support consists of the creation of a personalized plan covering three thematic areas (achieving autonomy; developing interactions; enabling communication). Finally, users begin to work with trained professionals operating in overlapping networks, which are monitored by peer reviews on a monthly basis.

6. Conclusions

The Sardinia personalized plans, framed into disabled social policy, develop into phases of morphostasis and morphogenesis. The first phase is patterned by the situational logic of protection (Table 5) and it is morphostatic. Here the most traditional culture of (Italian) social policies – based on the so-called 'institutionalization' – is reproduced and the existing array of providers is mutually and highly integrated. Before 2000, social policies

---

Box 8. – Network between different actors

After a year, I can tell you that one of the most significant aspects was a visit to the Hospital at C., because after the annual visit to the child, the neuropsychiatry took the parents aside and asked them: 'Tell me what happened in the meantime, this year, the child has changed tremendously.' She did not recognize that child who she had seen a year and a half ago. What happened? We did network. We just built a personalized plan, and this project was entirely shared by the family, and coordinated by the neuropsychiatry of G. and planned with social workers of the Local Council of G. We only tried to focus on the child and the communication between these four parts (family, neuropsychiatry, personal assistant, social workers) has been fundamental and important; there was really a continuous exchange of information, all were very willing, perhaps even outside the usual rules. It was definitely important to follow the advice of the psychiatrist because she has clarified to the family the importance of early age intervention. Together with the neuropsychiatry, we tried to stimulate the vision of the family: the child is also the adult of tomorrow, so the family has to think about how their child will be in 15 years. The matter related to parental education was very important. We shared all our activities and in the whole process I have always explained why it was done and the goal we wanted to achieve. I think that in our work we should never create a dependency on the professional. An assistant can work with a child in a family from 6 to 10 hours maximum per week, but for the rest of the hours the parents and other figures around the family have to take care of them. Therefore, a great family formation that favours the context around is needed. I think it is important to reiterate the crucial role of communication in a network composed by health system, Municipality and social services but also school. (Autobiographic story, no. 10)

---

in Sardinia are very coherent, but then a new national law intervenes creating new possibilities. This development generates a second phase where actors are still very integrated (the Advisory Commission, for example, guarantees a common political vision), but they begin to specialize and differentiate. Evidence shows that in this second phase (between 2000 and 2007, the time interval covering the start-up and the implementation of services), regional policies were newly related to families and to user driven associations. These strong connections have built up an open and participatory governance, particularly suitable for supporting personalization services. In this morphogenetic phase, the situational logic of opportunity emerges, allowing different users (the elderly and the disabled at risk of hospitalization), actors (unions) and providers (private in-home assistants and migrant caregivers) to be included in the policy system. It is worth saying that two types of opposing policies – co-produced personalization and individualized welfarism – begin to coexist. The first requires high specialization and management quality; the second calls for low professionalism and management proceduralism. The emerging situational logic is now that of correction where private in-home care, being more standardized, tends to crowd out personalization. With austerity – and this is the last phase – policy makers begin to think that personalization could be eliminated because of its management complexity and high resource spending. Institutional actors gain power, while user-led organizations are marginalized. The governance has been reconfigured into a more command and control system managed by professionals and experts. The logic of opportunity has gradually weakened, leaving room for a logic where the public administration tends to eliminate the previous plurality of actors, bringing back the

Table 5. Cultural and structural morphogenesis/morphostasis.

	Contradictions		Complementarities	
	Necessary	Contingent	Necessary	Contingent
Situational logic	Correction	Elimination	Protection	Opportunism
Cultural level	Syncretism	Cleavage	Systematization	Specialization
Structural level	Compromise	Competition	Integration	Diversification
Social Configurations	Morphostasis	Morphogenesis	Morphostasis	Morphogenesis

Source: Elaboration by Archer (1995, p. 303).

governance to something like the Principal/ Agent model. Our research shows that this governance is more linked to individualization than personalization, so that the risk would be the creation of a system based on marketization, re-familization and de-qualification of social services.

Regarding our second hypothesis, our research revealed that personalization actually implies two different and intertwined social mechanisms, which apparently seem contradictory. The first mechanism shows that social workers leave room to users and families for independent action. Social workers suspend their monitoring and evaluative tasks, typical of their bureaucratic and institutional role, reporting and accounting only with respect to the economic dimension of plans. In a sense, they leave families alone, neither interfering nor supporting them, to produce services. Co-production is really suspended at an administrative level and activated only through daily interactions between users, families and assistants. It is here that we can observe a second social mechanism. It involves users, their families and (street level) workers. At this level, real innovations are observable but only produced by the informal actors sustained by personal assistants. In that sense, we cannot talk about a full-fledged co-production because the institutional level is almost absent. It is apparent that this specific configuration leads to huge problems, since evaluation processes are left to field experimentation, without any co-production protocol implemented between public authority and users. The risk should be the creation of a system based on marketization, re-familization and de-qualification. Families would have to deal with a quasi-market of social services that they don't know (i.e. information asymmetry); paradoxically, a P/A model should reappear, where families are the Principal and assistants are the Agent (i.e. re-familization); finally, the system should be based on paper compliance, without a real process of monitoring and evaluation (i.e. dequalification).

In conclusion, we can point out further aspects to be elaborate on, in future research: the connection between leading actors, external/internal social powers and the morphogenetic cycle. In morphogenetic cycles – characterized by the logics of opportunity and elimination – the leading actors are user-led organizations and the policy makers. Here external forces have a significant influence. In the logic of opportunity (phase 2), the national law guarantees new funds and so opens new possibilities for different entering actors. In the logic of elimination (phase 4) the demand for cuts in social spending creates an austerity policy and consequently closes opportunities reducing the number of possible active actors. In the morphostatic logic of protection (phase 1), the policy system is steered by agreements between regional policy makers and big for-profit providers, immunizing themselves from external events and from the entries of new possible actors. Within the logic of correction (phase 3) unions, private in-home assistants and migrant caregivers

emerge as leading actors. Here, the internal agreements between the Region, private entrepreneurs and trade unions dictate the agenda of social policy through robust processes of political negotiations.

Notes

Disclosure statement

Funding

Notes on contributor

Riccardo Prandini is Full professor at the University of Bologna, Department of Political and social sciences.

Matteo Orlandini, Ph.D in Sociology and Social Research, Alma Mater Studiorum - Università di Bologna.

ORCID

Riccardo Prandini   http://orcid.org/0000-0002-2581-3476

References

ANED. (2009). ANED Country report on the implementation of policies supporting independent living for disabled people. Italy. Retrieved from www.disability-europe.net

ANED. (2016). ANED country report on social protection and article 28. Italy. Retrieved from www.disability-europe.net

Annesley C. (2007). Lisbon and social Europe: Towards a European "adult worker model" welfare system. Journal of European Social Policy, 17(4), 195–205.

Archer M. (1995). Realist social theory. The morphogenetic approach. Cambridge: Cambridge

University Press.

Arlotti, M. (2015). The role of regions and municipalities in the Italian multilevel governance of eldercare: recent trends in a context of increasing needs and budgetary constraints. Paper presented at ESPAnet Spain 2015.

Beresford, P. (2014). Personalisation. Bristol: Policy Press.

Böheim, R., & Leoni, T. (2016). Disability policies: Reform strategies in a comparative perspective. Working paper, National Bureau of Economic Research.

Carr, S. (2014). Personalisation, participation and policy construction: A critique of influences and understandings. In P. Beresford (Ed.), Personalisation. Bristol: Policy Press.

Castel, R. (1995). Les metamorphoses de la question sociale : une chronique du salariat. Paris: Fayard.

Christensen, K. (2012). Towards a mixed economy of long-term care in Norway?. Critical Social Policy, 32(4), 577–596.

Christensen, K., & Pilling, D. (2014). Policies of personalisation in Norway and England: On the impact of political context. Journal of Social Policy, 43(3), 479–496.

Crosby, N., & Duffy, S. (2008). A whole life approach to personalisation. London, In Control.

Duffy, S. (2005). Individual budgets: Transforming the allocation of resources for care. Journal of Integrated Care, 13(1), 8–16.

Duffy, S. (2008). Smart commissioning. Retrieved from www.in-control.org.uk

Duffy, S. (2010). The future of personalisation. Sheffield: The Centre for Social Reform.

Ehrenberg, A. (2009). The weariness of the self. Montreal & Kingston: Diagnosing the History of Depression in the Contemporary Age, Mc-Gill-Queen's University Press.

European Commission. (2013). Towards social investment for growth and cohesion – Including implementing the European Social Fund 2014-2020, COM(2013) 83 final, Brussels.

Ferguson, I. (2007). Increasing user choice or privatizing risk? The antinomies of personalization. British Journal of Social Work, 37(3), 387–403.

Ferguson, I. (2012). Personalisation, social justice and social work: A reply to Simon Duffy. Journal of Social Work Practice, 26(1), 55–73.

Ferrera, M. (1996). The southern model of welfare in social Europe. Journal of European Social Policy, 6, 17–37.

Finnish National Board of Education. (2010). Special education support. Retrtieved from http://www.oph.fi/english/education/special_educatioal_support

Forder, J., Jones, K, Glendinning, C., Caiels, J., Welch, E., Baxter, K., ... Dolan, P. (2012). Evaluation of the personal health budget pilot programme. Canterbury: PSSRU University of Kent.

Glasby, J., Duffy, S., & Needham, C. (2011). Debate: A Beveridge report for the 21st century? The implications of self-directed support for future welfare reform. Policy and Politics, 39(4), 613–621.

Glasby, J., & Littlechild, R. (2009). Direct payments and personal budgets. Bristol: Policy Press.

Hedström, P., & Swedberg, R. (Eds.) (1998). Social mechanisms: An analytical approach to social theory. Cambridge: Cambridge University Press.

Hedström, P., & Ylikoski, P. (2010). Causal mechanisms in the social sciences. Annual Review of Sociology, 36, 49–67.

Hemerijck, A. (2012). Changing welfare states. Oxford: Oxford U.P.

Hemerijck, A. (ed.) (2017). The uses of social investment. Oxford: Oxford University Press.

HM Government. (2007). Putting people first: A shared vision and commitment to the transformation of adult social care. Retrieved from webarchive.nationalarchives.gov.uk

ISTAT. (2009). La disabilità in Italia. Il quadro della statistica ufficiale. Retrieved from www.istat.it

ISTAT. (2015a). Social inclusion of people with functional limitations, impairments or severe chronic diseases. Retrieved from www.istat.it

ISTAT. (2015b). Residential care facilities. Retrieved from www.istat.it

Kazepov, Y. (Ed.) (2010). Rescaling social policies: Towards multilevel governance in Europe. Surrey: Ashgate.

Luhmann, N. (2013). Il rischio dell'assicurazione contro i pericoli. Roma: Armando.

Mladenov, T., Owens, J., & Cribb, A. (2015). Personalisation in disability services and healthcare: A critical comparative analysis. Critical Social Policy, 35(3), 307–326.

Needham, C. (2011). Personalising public services. Understanding the personalisation narrative. Bristol: Policy Press.

Needham, C., & Dickinson, H. (2017). "Any one of us could be among that number": Comparing the policy narratives for individualized disability funding in Australia and England. Social Policy & Administration. doi:10.1111/spol.12320

Needham, C., & Glasby, J. (Eds.). (2014). Debates in personalisation. Bristol: Policy Press.

Ostrom, E. (1996). Crossing the great divide: Co-production, synergy and development. World Development, 24(6), 1073–1087.

Pestoff, V., Brandsen, T., e Verscheure, B. (Eds.). (2012). New public governance, Co-production and third sector services. London: Routledge.

Power, A. (2014). Personalisation and austerity in the crosshairs: Government perspectives on the remaking of adult social care. Journal of Social Policy, 43(4), 829–846.

Reeve, J., & Cooper, L. (2016). Rethinking how we understand individual healthcare needs for people living with long-term conditions: A qualitative study. Health and Social Care in the Community, 24(1), 27–38.

Rosanvallon, P. (2000). The new social question. Rethinking the welfare. Princeton: Princeton University Press.

Sabel, C. (2012). Individualised service provision and the new welfare state: Are there lessons from Northern Europe for developing countries? In L. de Mello & M. A. Dutz (Eds.), Promoting inclusive growth, challenges and policies. OECD Publishing.

Sabel, C. (2013). Esperimenti di nuova democrazia tra globalizzazione e localizzazione. Roma: Armando.

Sabel, C., & Zeitlin, J. (2012). Experimentalist governance. In D. Levi-Faur (Ed.), The Oxford handbook of governance. Oxford: Oxford University Press.

Sabel, C., Zeitlin, J., & Quack, S. (2017). Capacitating services and the bottom-Up approach to social investment. In A. Hemerijck (Ed.), The uses of social investment (pp. 140–149). Oxford: Oxford University Press.

Scottish Government. (2010). Self-directed support: A national strategy for Scotland: Consultation. Edinburgh: Scottish Government.

Series, L. (2014). Resource allocation system: Complex and counterproductive? In C. Needham & J. Glasby (Eds.), Debates in personalisation (pp. 37–43). Bristol: Policy Press.

Series, L., & Clemence, L. (2013). Putting the cart before the horse: Resource allocation systems and community care. Journal of Social Welfare and Family Law, 35(2), 207–226.

Siza, R. (2012). I fragile equilibri. Rapporto sulle politiche sociali in Sardegna. Cagliari: CUEC.

Slasberg, C., & Beresford, P. (2015). Building on the original strengths of direct payments to create a better future for social care. Disability and Society, 30(3), 479–483.

Slasberg, C., Beresford, P., & Schofield, P. (2012). How self directed support is failing to deliver personal budgets and personalisation. Research, 29(3), 161–177.

Taylor-Gooby, P. (2005). New risks, new welfare. Cambridge: Cambridge University Press.

Valkenburg, B. (2007). Individualising activation services: Thrashing out an ambiguous concept. In R. van Berkel & B. Valkenburg (Eds.), Making it personal. Individualising activation services in the EU (pp. 25–43). Bristol: Policy Press.

van Berkel, R., & Valkenburg, B. (2007). Making it personal. Individualising activation services in the EU. Bristol: Policy Press.

Ylikoski, P. (2016). Thinking with the Coleman Boat. The Institute for Analytical Sociology Working Paper Series, 1.