



CIVIL SOCIETY IN THE ITALIAN REFORMED HEALTHCARE SYSTEM: A ROLE OR RESPONSIBILITY?

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At the turn of the new millennium the European Union (EU) catapulted into a new economic era. The golden period of the welfare state, as a solution to social inequity, started to lose ground especially in countries traditionally considered as having conservative-corporatist welfare regimes. Gradually the economic burden the welfare state had transformed itself into became too conspicuous for governments to conceal from other EU member states, the global economic scenario, the sharp eyes of the media and community at large. Due to austerity measures, the guarantee of universal access to healthcare which civil society had gained in exchange of votes started to crumble and, as public debts become more grievous, citizens have started giving up hope on politicians' promises of finding solutions.

In this article we pose the question as to whether civil society can merely be acknowledged as playing a role in healthcare, or if the reform measures adopted are demanding that civil society shoulders the responsibility which states seem unable to handle any longer. In the first part of the article the healthcare system in Italy, the third largest economy in the Euro-zone and a welfare system based on solidarity, is presented as a case study of how the principle of universal healthcare has slowly been nibbled at since the 90s. In the second part we argue that Italian civil society, despite a period characterised by a long transition of administrative and healthcare reforms, plays more than a key role in guaranteeing community wellbeing.

Keywords: Civil Society, Healthcare Systems, Community Empowerment, Health Promotion, Critical Pedagogy

La società civile nel sistema sanitaria italiano riformato: ruolo o responsabilità?¹

Emiliana Mangone, Erika Marie Pace

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Nel nuovo millennio l'Unione Europea è catapultata in una nuova era economica. Il periodo d'oro del welfare state, come soluzione alla disuguaglianza sociale, inizia a perdere terreno soprattutto in paesi considerati a regimi di welfare conservatore-corporativo. A poco a poco il peso economico dello Stato sociale diviene troppo evidente tanto che i governi tendono a nascondere agli altri Stati membri dell'UE, agli occhi dei media e della comunità in generale. A causa di misure di austerità, la garanzia di accesso universale all'assistenza sanitaria che la società civile aveva guadagnato in cambio di voti ha iniziato a sgretolarsi e contemporaneamente il peso del debito pubblico diventa più grave, tanto che i cittadini iniziano a rinunciare alla speranza di trovare soluzioni politiche.

In questo articolo si pone la questione se la società civile possa essere riconosciuta solo per il ruolo nell'ambito della sanità, o se le misure di riforma adottate inducano la società civile ad accollarsi la responsabilità che i governi sembrano non essere in grado di supportare. Nella

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prima parte dell'articolo si riflette sul sistema sanitario in Italia, terza potenza economia della zona euro con un sistema di welfare solidaristico, presentato come un caso di studio per spiegare come il principio dell'assistenza sanitaria universale sia stato eroso a partire dagli anni '90. Nella seconda parte si sostiene che la società civile italiana, nonostante un periodo caratterizzato da una lunga transizione di riforme amministrative e sanitarie, gioca molto più che un ruolo nel garantire il benessere della comunità.

Parole chiave: Società civile, Sistema sanitaria, Empowerment comunitario, Promozione della salute, Pedagogia critica

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Indice

Introduction	5
1. The Italian healthcare system and its reform in principles and practice	5
2. The Italian civil society in healthcare	8
3. The future of civil society: A mere role or responsibility?	11
Conclusions	15
References	17

Introduction

In today's society researchers reflecting on the goal of health for all are undoubtedly driven to search for an all-inclusive perspective on the relationship among the stakeholders involved in the processes that guarantee wellbeing. This article examines the role which civil society is increasingly playing in newly-reformed healthcare systems both at governance and service provision levels. The Italian scenario is taken as a case study; the country being the third-largest economy of the Euro-zone, yet currently scarred by a negative growth rate since 2011 (ISTAT 2013a), an unemployment rate of 11.5% in 2013 and the second largest debt load in Europe after Greece (ISTAT 2013b), that is forcing drastic cuts on public expenditure including healthcare.

The second part is dedicated to the organisation and involvement of civil society in Italy and the challenges it is facing to provide an adequate response in the provision of health and social care services. Before concluding, we argue how various advocates from different professional fields and schools of thought, mainly the health promotion movement as well as organisational theorists and critical pedagogists, have long been arguing that communities have more than a role to play. They are the protagonists in reaching their own goal of wellbeing. We also present evidence of policies and actions which not only acknowledge civil society's indispensable cooperation, but recognise the need to invest in civil society to shoulder the responsibility universal healthcare systems, aren't able to provide for any longer. Our final paragraphs propose an accountable and sustainable reorganisation of civil society within this new healthcare system.

In the absence of a common agreement in international literature on the definitions of Civil Society Organisations, the third sector and civil society, our understanding of the definition of Civil Society Organisations is that proposed by Salamon (2010), which characterises the key criteria of Civil Society Organisations (CSOs) as being: (i) self-governing; (ii) not profit-distributing; (iii) private; and (iv) voluntary. Thus the term refers to a set of private organisations acting for social and collective needs. These can be distinguished from commercial companies because they lack profit purpose, and they are very relevant as they have a strong involvement in the implementation of public welfare.

In comparison to the above classification, the European definition of the third sector encompasses social enterprises, cooperatives and mutual aid societies (Evers et al. 2004) and covers the intermediary space between the market and the state (Johnso, Prakash 2007). With the term civil society within a healthcare perspective, we call on all of the above key players as well as individual citizens who may consider themselves spectators. Nevertheless, in reality they are actors because they are not only health service users but also contributors to healthcare provision, financially and through informal family and community life (World Health Organisation [WHO] 2001).

1. The Italian healthcare system and its reform in principles and practice

In 1997, Ardigò affirmed that in the third millennium many countries would have had to deal with a paradox in healthcare: the uncertainty of guaranteeing a continuing universal healthcare system (Ardigò 1997), while witnessing giant leaps in progress in the healthcare field, which would bring forth state-of-the-art public health systems in the western world (Freeman 2000;

Giarelli 2004). Today Ardigò's predictions have become hard facts, including in Italy. The current systems are the result of several reforms which were necessary in an arduous attempt to find a balance between the increase in medical care costs, the rightful expectations of the population to wellbeing and equitable access to health, but, more importantly, the illogical decrease in financial resources to sustain the whole framework.

In the last decade governments of western countries have been rethinking the general principles of welfare and healthcare systems placing us in the midst of "yet another historical regime shift" (Esping-Andersen 2002, 2). Recent literature shows that defining Italy's welfare state regime is not so straightforward. In 1990, Esping-Andersen classified the country within the conservative-corporatist welfare state regime, since it matched the characteristics of a moderate level of decommodification, low-female participation, reliance upon social contributions instead of taxes, moderate income redistributions, and rather high levels of unemployment (Esping-Andersen 1990; Fenger 2007). However, as outlined by Fenger (2007), other classifications articulated by various authors, each based upon different indicators, categorised Italy, Spain, Portugal, Greece and France within a Southern European or Latin Rim type which could be considered a sub type of the conservative-corporatist regime. What distinguishes these countries from Esping-Andersen's classification, according to Fenger citing Leibfried (1992), "is the lack of an articulated social minimum and the right to welfare" (Fenger 2007, 7).

The present Italian healthcare system is not a result of the 70s model inspired by the British National Health Service, and the progressive transformations through the 90s, but is the outcome of a collaboration between different levels of responsibility. On a national level it guarantees equitable assistance among all the territories; whereas locally it puts value to the regional planning and production responsibilities of tailor-made services that meet the needs of the specific territory. In brief the Italian healthcare system was and, up to a certain extent, still is, inspired by the fundamental principles of universal healthcare. These principles are universal access, equal access to a wide spectrum of uniformly-distributed services, and a shared financial risk. In principle, Italy has and continues to embrace Sen's belief that the funding by general taxation; the distribution of services based on equity; and a system that must ensure that the individual financial contribution is exclusively determined by the ability to pay, rather than morbidity and/or services received, are the three conditions necessary, although not sufficient, to prevent financial, social or territorial barriers from hindering the effective enjoyment of the right to health (Sen 1995; 1999).

In the 90s the need to identify models that could more suitably reflect the increasing expectations of the population, who were dissatisfied by the system, and to reach cost-effective standards imposed by measures to cut public expenditure, gave rise to a succession of reforms in the Italian National Health Service. Originally, the Legislative Decrees n. 502/92 and n.517/93 attempted to find a balance between the citizen's right to free choice of seeking public or private healthcare and, on the other hand, the identification of indispensable healthcare services which it had the responsibility to cater for. Successively, the Legislative Decree 229/99 introduced the concept of essential and uniform levels of assistance and the identification of financial resources. This specification introduced a government-funded service for medical emergencies,

but left room for the private sector to provide healthcare services, with the aim of reducing public expenditure. As a result it also brought about a partial shift in methods from universal healthcare to a selective form of income-tested assistance and age stratification in relation to the reimbursement criteria for prescribed pharmaceuticals, routine checkups, palliative care, and specialist physician care, among others.

Meanwhile the demographic changes and the evolution into a more loosely-knit and complex social context have enhanced the need for a welfare regime based on solidarity beyond kinship ties. The need of a commitment for mutual responsibility by all the public and private institutions as well as all the other stakeholders was felt because it had become clear that health outcomes do not depend on the technical quality of performance alone, but are more deeply rooted in the empowerment of individuals. It is now being acknowledged that, in terms of rights and duties, citizens need to take direct personal responsibility and gain consciousness of their and other people's physical, mental and social wellbeing, by using all the available structures of participation and engaging in consultation regarding territorial management. It is now recognised that healthcare develops within the public and private spheres since wellbeing is understood to be the capacity to manage one's own state of health with the resources and challenges of the surrounding environment. The adoption of the principle of subsidiarity in the new political welfare system at the territorial level meant that the main aim of the local administrators is to help people to remain active and productive members of society, rather than guaranteeing the cure. As a result, in defining the delivery of healthcare services, administrators have to identify the role that citizens can have as active productive partners rather than passive receivers of benefits and services.

This development process is being brought about through the new health and social policies that involves, on the one hand, the central government entrusted with supporting the general strategies for modernisation and, on the other hand, the re-organisation and management of the new territorial systems of regional and local governments, through the ongoing proposed process of economic federalism and the gradual administrative decentralisation on the basis of the principle of vertical and horizontal subsidiarity. As a consequence, the organic framework of the Health Institutions has been redefined in relation to the roles of the central government, the regional and local administrators and citizens' rights, and with respect to the types of social security of citizens' health (Barbieri, Mangone 2009).

In line with other authors (Gori, Pasini 2001), and in view of these reforms in principles and practice, we can therefore confirm that the country tends towards a welfare state and healthcare system based on solidarity where people's rights depend on their circumstances, work record and family relationships, not on general rights protected by the state. Nevertheless, this model is the expression of a perspective which promotes new initiatives and mobilisation of resources through participatory planning and which brings together the government, private institutions and civil society. With regards to healthcare provision, the focus is redirected to a system that has the capacity to provide social responses to the real needs of the citizens and one that is especially able to combine resources and aim for quality standards, while extending the right to health to that of wellbeing through mutual responsibility and support.

2. The Italian civil society in healthcare

According to the latest census published by ISTAT (2013c), as at December 2011 the number of active non-profit organisations (NGOs) in Italy was 301,191, a 28% increase over 2001. The workforce constituted 5.7 million people, and volunteers widely outnumbered paid staff (83.3%). Full-time workers accounted for 11.9%, followed by outsourced workers (4.7%) and part-time workers (0.1%). The social and health services sectors, although not the prevalent sectors, together constituted 13.7% (8.3% and 5.4% respectively) of the NGOs. What is more significant is that within these sectors the number of NGOs exceeded both the number of public institutions and private companies offering medical and paramedical services, and these NGOs, as highlighted above, relied mainly on volunteers (ISTAT 2013c, 48-57).

With regards to revenue, Italian CSOs rely heavily on fees (61%), which includes service charges and relating government subsidies and public reimbursements. Government funding provides 36% of the revenue. This is very low when compared to other countries that, according to Desse (2012), fall within the same welfare partnership (Western European) model such as Ireland where government funding accounts for 74% of the revenue, in Germany 65%, and in the Netherlands 63%. Philanthropy, which only accounts for the remaining 3%, includes donations from individuals, businesses and foundations, but this figure does not reflect fairly the hours of work and invaluable dedication which volunteers put into the organisations (Salamon, Sokolowski, Associates 2010 as cited in Desse 2012, 27).

Although this data shows that civil society is a key player in guaranteeing healthcare and in containing costs, and despite the reforms acknowledging its role, the devolution of administrative roles from the central government to the authorities and entities, set in motion by the Legislative Decree 59/1997, is still in transition.

So far, the application of Article 14 of Legislative Decree No. 502/1992, bearing the title “Participation and Protection of Citizens’ Rights”, has been the first concrete commitment of the state towards attributing civil society its due role and acknowledgment in healthcare. At a national level the Ministry of Health is required to engage in consultation to establish the indicators and assess the quality of health services from the beneficiary’s perspective. At the regional level civil society is to be consulted in the planning and evaluation of health policies and formal structures are set up to facilitate cooperation between the two. Other initiatives include the organisation of an annual Health Service Conference to gauge the levels of patient satisfaction; specific training activities for caregivers working in direct contact with the public; and the publication and dissemination of a Health Service Charter by each healthcare provider, be it public or private.

Meanwhile the relationship between central and local governments, and the roles of the latter related to citizens’ rights and duties in practice haven’t been defined yet. This postponement, which is distinctive of Italy mainly due to its unstable political system, results in a relationship between civil society and public institutions that does not follow any model (Ranci 1999). The current Italian scenario seems to be characterised by contradictory elements: a strong task interdependence in the absence of effective coordination; a highly autonomous management of CSOs in the absence of legislation that would separate them from the state and prevent them from being affected by commercial interests; and the tendency to delegate public liabilities in a

polity characterised by patronage systems and particularism. Furthermore another paradox related to civil society participation is that at present citizens are unable to participate unless they are part of an officially recognised third sector organisation. That results in the exclusion of a considerable number of CSOs, and demotivates citizens who might be interested in participating on an individual level.

On a positive note, once federalism and decentralisation become effective, civil society will gain a much more distinctive role. This is because the reform is based on the principle of subsidiarity, both vertically and horizontally and thus will require its participation at various levels from advocacy to governance and service provision.

This means that a number of changes need to take place at administrative levels even if this process may seem difficult and/or inconclusive in practice. Administrative procedures will need to be modified to allow the continuous involvement of civil society. A lot of collaboration and negotiation will be required to efficiently identify the needs and the related decision making processes, as well as the implementation of interventions which would need consent, sharing and collaboration between the different actors within the territory. In such a situation we are faced with what Altieri (2002) called macro dimensions of political participation. This happens when the citizens (or their representing agents or associations) intervene, directly or with a process of indirect influence, on the choices related to the definition of standards. Civil society will try to influence the decisions about the localisation of the resources, will propose new services or interventions to improve the services, and will engage in practices such as monitoring, vindication and negotiations. Colozzi (2002), considers such involvement at administrative levels as both a development tool and a tight, somewhat restricting, bond. He argues that if civil society is responsible with public institutions for the satisfaction of social needs, it will utilise most of its energy in management and bureaucratic responsibilities, and risks losing its main objective of creating new forms of solidarity and social capital.

The most meaningful change that must be fulfilled is in the relationship between institutions and citizens, and consequently in the relationship between participation and institutions. The passage from viewing participation as an ideology to participating based on objectives is the first step for the administrations. It will therefore be necessary to predict structures and procedures with the aim of identifying and choosing the institutional objectives and rethink participation processes in function of the proximity of the territory and the principles of equity and quality. The administrations will have to categorically guarantee citizens the right to be heard, to be informed and to active citizenship by allowing them to be direct protagonists and taking on responsibility. The new political scene in the territory will not only have to give life to a strong partnership institution, but will also have to have a strong research method, using new tools to account for its legitimacy which represent the overall bases for the re-launching of the programming of the political welfare in different sectors.

In this projected administrative organisation, the definition of governance can be that proposed by Bovaird and Löffler (2002): a system of formal and informal rules, structures and processes that define the ways in which individuals and organisations can exercise power over the decisions (by other stakeholders) which affect their welfare and quality of life. In other words, governance indicates the changeover from programming systems based on hierarchical

models and policy making direction, to programming systems based on the principle of subsidiarity (vertical and horizontal) and cooperation between public and civil society.

Nonetheless this reform does not demand changes from the administrative side alone. Civil society in Italy has not yet taken the lead as a promoter and enabler of change the way it could. At present it is still aiming for a role, rather than taking responsibility. Participation does not take place in governance processes but mostly at service provision levels. This is not only due to a lack of a common agreement regarding the direction to take, but also because these organisations cannot find and attribute the right value to two important resources: *trust*, that can be defined as the actor's expectation of a positive experience (Mutti 1994), and *knowledge*, seen as the construction and research of meanings and interpretations worked out and assigned to situations and contexts in the daily life and not as a simple transmission of information. This in turn is due to the lack of involvement in the setting in which citizens live, which would otherwise have allowed the establishment and intensification of relationships with the main supporters of social and institutional change; with those social actors who are able to provide innovative contributions in the form of new organisational and behavioural dynamics (Manfredi 2003a).

For this system to work, many more citizens need to have the willpower to build the capacities needed for political, civil and economic participation, acquire the basic knowledge regarding the mechanism of the institutions and society, be able to identify one's interests and weigh out the options, and plan and implement courses of action with the aim of responding to collective needs. As Manfredi (2003a; 2003b) argues, there needs to be a complete cultural revolution; changes in the behaviours and attitudes among citizens, and better dialogue among all those involved within the same context to manage micro-conflicts. This means that social actors will have to face the future through new organisation models focusing on two key factors: innovation and experimentation. The former is based on three strategic factors: (i) the capacity of involvement within the surrounding environment; (ii) orientation to internal and external interests; and (iii) the ability to create relationships for a strong and long-lasting collaboration. On the other hand experimentation is required to build new development processes, such as activities, projects and actions with a highly-flexible management system (Manfredi 2003a).

Leaders of CSOs, third sector organisations and the public sector need to facilitate this transition. Otherwise we face the risk that CSOs would tend towards a logic of appropriation (of spaces and positions) rather than that of solidarity and outreach. The problems that can arise are: i) lack of inter-organisational cooperation and common action with many micro-conflict situations and inefficient use of resources; ii) excessive search of a role focused on the organisations' survival; and iii) scanty use and development of intangible resources such as trust and knowledge.

While in the next few years we will witness highly competitive dynamics because of the progressive growth of social enterprises, civil society needs to adopt a strategy to occupy the centre stage within governance and implementation processes. But in order to achieve this aim, civil society must take a direction that points towards:

- the shift from an *appropriation logic* to a *solidarity logic*, which entails being fully aware of the limitations of individual action, fight against the feelings of insecurity and

- fear elicited by contemporary society, and give rise to new cooperation and forms of social solidarity, viewed as joint and organised risk offsetting (Zoll 2000);
- the integration between the role civil society has already been able to design for itself, and the responsibility it has as a form of expression of collective needs. Civil society should be aware of the impact it has on the political agenda and on the new alliances between autonomous and specific parties at play on the political and social level;
 - the enhancement of knowledge and trust as resources that allow a full and widespread involvement with the surrounding environment, starting from the stimulus provided by the latter for the improvement of individual, organisational and collective knowledge.

3. The future of civil society: A mere role or responsibility?

The call on civil society to take on a more significant role and be an active player has long been encouraged internationally, even before the economic downturn and the subsequent ripple effect on welfare systems. A brief historical overview of the identification of strategic priorities to achieve health for all and reflections from various schools of thought will help us explain how civil society action on all fronts, and the goal of wellbeing are inextricably linked and could be better defined as a responsibility rather than a role.

The health promotion movement, in itself an example of a social movement born in the late 70s and which is now, as argued by Labonte, a “professional and bureaucratic response to the new knowledge challenges of social movements” (1994, 253), was one of the pioneers in stressing the responsibility which civil society has in guaranteeing community wellbeing through its participation in healthcare systems reform and beyond. In a time when Organisation for Economic Cooperation Development (OECD) countries were characterised by a growing consensus on the importance of universal education, a strong welfare system, high employment and free health services for all, it was clear that the creation of health depended heavily on social, economic and environmental determinants and not on advances in medical technology alone (Baum, Ollila, Pena 2013).

This awareness, together with the influence of Antonovsky’s salutogenic approach to health (Kickbusch 1996), paved the way for the focus of a series of health promotion conferences and thirty years of global initiatives, during which health promotion action was defined, the determinants of health were recognised and revised, strategies for action were set and implemented, and evidence of health promotion effectiveness was established. Throughout these years many socio-economic determinants were identified, such as *the need for social security, sustainable resource use* and *respect for human rights* (WHO 1997). New key areas needing immediate action were highlighted at each conference, confirming the scope and relevance of health promotion action beyond direct action on healthcare reform. Some examples are *the re-channelling of resources* (WHO 1991), *bridging the equity gap* (WHO 2000) and *global governance to address harmful impact of trade, products, services and marketing strategies* (WHO 2005). Through the successive WHO conferences, meetings and published documents since the Alma Ata Declaration in 1978, two prevailing courses of action have been endorsed to deal with these issues: advocating for health in all policies and guaranteeing health for all

through community empowerment (Baum, Ollila, Pena 2013); both of which heavily rely on a key player - civil society.

Whereas both paths emphasise the importance of an integrated multi-strategic approach where people are the primary foci in the process, the first course of action concentrates more on governance and requires capacities in advocacy, enabling and mediation. Meanwhile the second course of action requires additional skills for community organisation and the implementation of health promotion practice models adapted to local needs and possibilities and based on the prevailing physical, social, cultural and economic environments. Although these two paths will be further discussed separately in order to outline the multi-faceted role of civil society, it is important to keep in mind that they are intertwined and interdependent and cannot reach their maximum efficiency and effectiveness if each one of the paths doesn't reach out to the other.

The Health in All Policies (HiAP) approach is defined as “an approach to public policies across sectors that systematically takes into account the health and health systems implications of decisions, seeks synergies, and avoids harmful health impacts, in order to improve population health and health equity” (Ollila, Baum, Pena 2013, 6). A term coined in the 1990s, HiAP “places more stress on the multilevel policy-making reality of today's globalised world” and “is most typically facilitated from the health sector which then involves other sectors” (Baum, Ollila, Pena 2013, 32).

The book “Health in All Policies. seizing opportunities, implementing policies” (Leppo, Ollila, Pena, Wismar, Cook 2013) presents various examples of how civil society has been active in policy-making in a number of areas such as nutrition, tobacco, alcohol and physical environments conducive for physical activity as well as the fight against non-communicable diseases. In summary, drawing from the list of civil society roles identified by the World Economic Forum (World Economic Forum [WEF] 2013), in a HiAP approach, civil society acts as a “*watchdog*” to guarantee accountability and promote transparency; is an “*expert*”, an “*advocate*” of societal issues and a “*representative*” of the marginalized or under-represented population; is a “*solidarity supporter*” to promote fundamental and universal values; and a “*definer of standards*” by creating norms that shape state activity.

Nevertheless, it is at practice levels where civil society is gradually being asked to shoulder more and more responsibility to provide the support and the services which up to a decade ago were the responsibility of the state. During the first international conference on health promotion way back in 1986, the movement had already identified the five fields of action, which are even more relevant today than they were at the time. These are: build healthy public policy, discussed earlier, create supportive environments, strengthen community action, develop personal skills and reorient health services (WHO 1986). The rising cost of healthcare provision, the austerity measures witnessed in the last decade due to the worldwide economic crisis and as “government, donor and foundation funding comes under greater pressure than ever before” (Russell, ABCD Institute and Nurture Development 2009) governments and policy-makers are now motivated to start giving more value to these fields of action in order to face the ever-increasing needs of the present society characterised by high unemployment rates among youths, a rise in poverty rates, health inequities between and within countries, immigration and social exclusion, among other social and health issues.

In summary, as affirmed throughout all these years, “needs-based or funding-led strategies need to be replaced by approaches that promote citizen-led initiatives” (Russell et al. 2009) where communities are supported to “apply their skills and resources in collective efforts to address health priorities and meet their respective health needs” (WHO 1998); in other words create the conditions for community empowerment. However, as Russell et al. (2009) argue, this social services model relegated “citizens and communities to a position of passive recipients of state funded services, creating more dependency than empowerment”. It follows that the challenge is now to arouse that sense of ownership and the willingness to participate needed to find meaning and regain trust in one’s own abilities and resources to bring about change.

Over the years many community-based approaches have been developed, borrowing their underlying principles from both behaviour-oriented and environment-oriented theories (Bartholomew, Parcel, Kok, Gottlieb, Fernandez 2011). Two of the emerging theories and models that are worth mentioning and comparing are the Community Coalition Action Theory (CCAT) (Butterfoss, Kegler 2009) and the Asset-Based Community Development model (ABCD) (McKnight 1993). Both models are characterised by formal, multipurpose and long-term alliances but whereas the former is a structured arrangement for collaboration between existing organisations, the latter starts from the citizens of a community and creates alliances with existing organisations and institutions. Another significant difference which makes ABCD worth mentioning is that people are brought together by their assets rather than needs. Community organising takes a whole different perspective, concentrating on existing reinforcing and enabling factors, building “on the skills of local residents, the power of local associations, and the supportive functions of local institutions” (www.abcdinstitute.org). The focus is not on what is missing but on what is available to create a sustainable, resilient and empowered community.

Referring back to the roles identified by the World Economic Forum (WEF 2013), the roles of civil society at practice levels are not only those previously outlined for HiAP but also of a “*capacity builder*” by providing the education and training to impart the necessary skills and abilities, a “*service provider*” of services required to meet societal needs such as education and healthcare, an “*incubator*” of solutions that may require a long gestation or payback period and a “*citizen champion*”, encouraging citizen engagement and supporting the rights of citizens.

The health promotion movement therefore needs civil society actors to proceed from playing a role in healthcare systems reform, to embarking on a shared responsibility with public institutions and the private sector to reform the whole of public policy. It is not simply a *player* but a *dealer*, a powerful negotiator whose successes or mishaps are as influential as those of policy-makers or multinationals. It is an invitation to stop pointing fingers at who’s to blame for ill-health and work together to create health and wellbeing.

An encouraging point is that the health promotion movement has definitely not been the only advocate. Other influential actors in public policy have recognised that civil society has more than a mere role in facing this new economic era. It is not by chance that in the preface of the Europe 2020 document Barroso calls for a “coordinated European response including... social partners and civil society... to come out of the crisis stronger” (European Commission 2010, preface). Neither is it a coincidence that the World Economic Forum launched a project in 2012

“to explore the rapidly evolving space in which civil society actors operate” (WEF 2013, 3). According to the report “civil society should not be viewed as a third sector; rather, civil society should be the glue that binds public and private activity in such a way as to strengthen the common good” (WEF 2013, 5). It acknowledged a paradigm shift in sector roles among businesses, governments and societies in which they are no longer three separate sectors primarily acting within their own spheres with independently defined roles and with little degree of interaction. On the other hand, in these three sectors there is now a greater degree of activity to address societal challenges within each sector, and more integration across a shared space. Due to this overlap the traditional roles have become blurred, bringing about new frameworks for collaboration, partnership and innovation. There are evidence and examples of hybrid organisations emerging such as businesses with social purpose and civil society as market actors (WEF 2013).

A good example of the result of this blurring of roles is corporate social responsibility (CSR). Although it is arguable that CSR programmes are more of benefit to a business’s image than to the community (Newell 2005), these have introduced a positive collaborative approach between civil society actors and powerful multinationals. The mobilisation of private sector capital towards the common good has become a resource for civil society to invest in social and environmental objectives. In this way the community’s needs are the focus, encouraging positive participation of the community while “introducing a set of leaders from the corporate sector committed to driving broad societal change” (WEF 2013, 10). As a result the corporate sector and the community view each other as a powerful coalition of actors in raising issues on the agenda, rather than two separate, often rival, sectors with very different hidden or manifest agendas.

From a sociological and economic perspective civil society has also been viewed as a creator of social capital. Whether looked at from Bourdieu’s sociological perspective as the sum of resources by virtue of possessing a durable network of relationships of mutual acquaintance (Bourdieu, Wacquant 1992); or Coleman’s view of it being a resource based on trust and shared values developed from the weaving-together of people in communities (Coleman 1988), social capital is the outcome of civil society action. More importantly, as Putnam (1993) affirms, a well-functioning economic system and a high level of political integration are the result of the successful accumulation of social capital and not vice versa. Besides, as Woolcock remarked “the well-connected are more likely to be hired, housed, healthy and happy” (2001, 12).

One cannot talk about civil society and its responsibility without dedicating a few lines to two great inspirers of community empowerment. As Mayo argues “social movements focusing on social justice issues can easily draw inspiration from Paolo Freire ... and Gramsci” (2013, chap. 4). More so in the case of the health promotion movement, when considering the underlying theories and philosophy outlined earlier.

Freire and Gramsci, exponents of critical pedagogy (Mayo 2013), both considered the community as the driving force to change. Educating the community to become a critical thinker and not merely a passive recipient of knowledge (Freire 1997) was seen by both thinkers as the competence necessary to be able to engage in dialogical encounters, which nowadays would be with policy-makers and the business sector. In other words, they both embraced the

Aristotelian notion of praxis: “a pedagogy of transformative change, or liberation education, ... located in educational sites of resistance, for example, community work, youth work, social work, community education, adult education and schooling” (Ledwith 2001, 171). It is a form of education involving reflection upon action for transformative action where the struggle to social change does not stop at raising consciousness, but must aim at transforming consciousness. For this role in society Gramsci identified the *organic intellectuals*: a group of intellectuals that have developed organically alongside the ruling class (in our case the community) and function for the benefit of the ruling class (Burke 1999; 2005). A role that could be attributed to health promoters but also to the leaders from businesses who are interested in social change or simply leaders of CSOs, community or youth organisations where community work becomes “critical pedagogy, located as it is, in the very essence of people's lives, at the interface of *liberation* and *domination*” (Ledwith 2001, 171).

It comes as a long-awaited strategy at this point that the European Reference Framework recommends “social and civic competencies” as one of the eight key competencies for lifelong learning where the skills identified include the ability to:

- engage effectively in the public domain;
- display solidarity and interest in solving problems affecting the local and wider community;
- undertake critical and creative reflection and constructive participation in community and neighbourhood activities as well as decision making at all levels (European Communities 2006).

To conclude, as the Danish sociologist Esping-Andersen postulates the “flagship policies are now training and lifelong learning”. Rather than taming, regulating or marginalising markets so as to ensure human welfare, one of the strategies should be “to adapt and empower citizens so that they may be far better equipped to satisfy their welfare needs within the market. At its core it is a supply-driven policy attempting to furnish citizens with the requisites needed for individual success” (Esping-Andersen 2002, 5).

Conclusions

As stated at the beginning, reflecting on the goal of health for all undoubtedly drives researchers to search for an all-inclusive perspective on the relationship among the actors involved in the processes to guarantee wellbeing. Throughout our reflection we have attempted to outline how solutions can be found starting from the most valuable resource every country has available, that is human capital, within today's economic scenario.

Health is not the responsibility of the healthcare sector alone, but it is the result of a tightly woven fabric of citizens' priorities, corporate policies and distributive, regulatory, economic, health, social and environmental policies of the state. Civil society, including both formal and informal CSOs, the third sector, and all the individuals providing services and shouldering responsibilities within their immediate environment, is the solution for the reawakening.

The processes of federalism and decentralisation based on the principle of vertical and horizontal subsidiarity are the initial steps which acknowledge the role of civil society. However, without running the risk of creating too rigid a framework, there needs to be a

structure that guarantees accountability, evidence-based practice and cost-effective long-term action. This is a fundamental criterion since the social capital and community empowerment generated from civil society action is fundamentally based on trust which civil society, as opposed to the political system, can still claim to have among the community. Therefore the administrators need to take on two roles: (i) a regulatory role that ensures accountability and transparency; and (ii) a facilitating role which, through their expertise would:

- create bonds between different groups of civil society, and with the private sector and the public service sector;
- build bridges as an outreach towards the community with the aim of creating a type of ‘organic territorial political welfare’; and
- aid communities to identify their assets, think critically, and plan their pathways to wellbeing.

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