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Italian mutual benefit societies: an organizational social innovation in health and healthcare system

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ITALIAN MUTUAL BENEFIT SOCIETIES: AN ORGANISATIONAL SOCIAL INNOVATION IN HEALTH AND HEALTHCARE SYSTEM

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ABSTRACT

The paper aims to analyse the role covered by "Mutual Benefit Societies" (hereinafter MBSs – it. trans. "Mutue Sanitarie Integrative") in terms of "social innovation" within the on-going changing of Italian welfare system.

In fact, several of these organisations survived the last three decades despite the establishment of the National Health Service (NHS) by Italian Law no. 833/1978. The law also allowed for the possibility to supplement services provided within the public system by private insurers, including MBSs. The opportunity for MBSs to establish supplementary health funds aimed at providing supplementary coverage has been confirmed by the Legislative Decree no. 502/1992 and subsequent amendments.

As the crisis of the public welfare system, MBSs working in health and social risks areas currently deal with both challenges and opportunities. The added value of MBSs emerges especially in high level social and health content services (e.g., long term care – LTC – services). It is related to the ability in linking economic (efficiency), social (relationships network inside MBSs – both with members and staff), cultural (connected with principles and values of their mission), and institutional (in terms of generation of social capital – external relationships) sides.

MBSs are a subsidiary and supplementary tool to already existing welfare policies addressing the demand for the integration of health and welfare costs. The shared goal is to combine the universality of welfare and the economic sustainability of the system, taken from the perspective of social innovation founded in civil society involvement. As "social innovation" is the application of new ideas on a product, process, or organisational arrangements producing an outcome or a stable and positive change in the level of well-being of a society or part of it through the creation of social added value, in the case of Italian MBSs, social innovation emerges from their organisational structure through which they are able to link the demand and supply of health. MBSs are able to tackle better than other types of organisations the problems of redefining intervention policies as they can organise it in a flexible way that more closely reflects needs and desires of members.

This paper is based on data collected through the administration of a survey questionnaire sent to a sample of 20 Italian MBSs working in health and healthcare fields.

Keywords: mutual benefit society, welfare, health/healthcare, social innovation, added value

Originally Mutual Aid Societies (hereinafter MASs) had been set-up during the Industrial Revolution as the first example of working class organisations. They were composed by people who voluntarily decided to pay a contribution to set up a fund with not-for-profit aims (Marchese *et al.,* 1991). These organisations mainly pursue the provision of grants to members afflicted with frail conditions (e.g., in case of disease, accident, relatives' death, and so on).

Their economic and organisational operation is based on an insurance mechanism but, at the same time, they are able to guarantee solidarity sides to generate mechanisms in order to develop social cohesion among members. According to Tomassini (1999: 35), "the small dimension of societies, their territorial diffusion, the lightness or the flimsiness of the bureaucratic machinery, predisposed to diffused and informal social relations […]".

It is therefore possible to affirm that the diffusion of MASs allowed for the establishment of a "mutual" machinery necessary to develop a class awareness based on the assertion of a wider "solidarity culture".

The "voluntary mutuality" is based on the principle of the "allocation of a charge" of one person between all members, whom are exposed to the same risk. The "member" is the principal stakeholder of these institutions. MASs link brotherhood and responsibility through shared rules (Fimiv, 2010): the member joins to the MASs both to safeguard him/her and his/her family and to responsibly sustain the need of other members to safeguard themselves and their families through his/her contribution. The term "mutual benefit" identifies a "mutual aid action" as well as distinguishes it as one of "assistance" rather than "charity".

From a legal-tax point of view, Italian code identifies as "mutual" those actions exchanged among a group of people.

In Italy today, the redefinition of new and effective welfare policies is the main shared requirement among those institutions carrying out their activities in health and healthcare fields. Those policies must be particularly oriented to overcome the crisis of the State-market dualistic model due both to wide and general phenomena (as the globalisation) and to more specific causes (as the growing differentiation of needs). The latter made standard services supplied by the local authorities more and more ineffective (the so called "demand for a wider well-being"). In addition to the current demographic evolution, there is also a change of qualitative needs. There is particularly a bigger complexity coming out from the growing relevance of identity-making and relational dimensions of those needs.

So Mutual Benefit Societies (hereinafter MBSs) working in health and healthcare fields have a great importance in the construction of a "citizen's welfare" based on a participated social innovation, that is built on social relationships, collaboration forms, trust, and direct involvement of beneficiaries.

There are two main reasons why it is extremely necessary looking for new forms and models of integration. On the one hand, there is a growing demand of health; on the other hand, there is an increasing of problems connected to the former reason. Of course, the main reason of these changes must be look for in the growing level of instruction of the population that totally changed attitudes and expectations of Italians.

The moving to a flexibility and "risk" society has been determined by demographic changes, deeply job market transformations due to the transition to a post-industrial society, international demographic fluxes together with the creation of a more and more

multi-ethnic and multi-cultural society as well as changes in social and familiar relationships. Within this kind of society, precariousness has become a daily life element as well as new problems with which the traditional welfare model is not able to deal with because of the existence of many economic, organisational, and institutional bonds.

Starting from the art. 118 of the Italian Republic Constitution, where the subsidiarity principles is highlighted, it is necessary make a deep cultural change in order to pass to a welfare community where everyone is responsible for himself/herself as well as for the community. Therefore, only if both each citizen and the whole society are promoters of a mutual assumption of responsibility, it will be possible to increase the level of the life quality for the whole community.

Therefore the main goal of MBSs carrying out in health and healthcare fields must be to connect universality and economic sustainability of welfare system assuming a social innovation perspective.

The growing importance of these issues is also confirmed by the attention placed on them at the European level. Some European documents have recently underlined aspects strictly connected with the request of building a new welfare system and with the model based on Civil Economy institutions as a possible solution.

The first document is by the European Parliament – Committee on Employment and Social Affairs entitled "Report on Social Economy (2008/2250(INI))". Particularly, in this document the European Parliament had requested to the European Commission to recognise the different legal forms of Social Economy institutions by carrying out a European charter for associations, foundations and MBSs.

Another acknowledgement of the relevance assumed by these issues is the one contained in the "Single Market Act" of the European Commission (2010), where Social Economy institutions are described as the main element for the construction of a single market based on social and economic sustainable development. The proposals of the European Commission on this issue concern, first of all, human resources. Particularly, focusing on MBSs, in 2011, the Commission had started to research on their situation in each Member States in order to analyse their transborder-worker activities as acknowledgement of the value of MBSs system – with different weights and conditions connected to countries features.

Nowadays, in Italy the redefinition of new and effectiveness welfare policies is the main need shared by all those actors working in health and the healthcare field. In addition to the demographic evolution, there is a change in the qualitative nature of needs: it is possible to underline a high level of complexity due to the growing importance of their intangible aspects, particularly identity and relational dimension.

1. LITERATURE REVIEW

1.1. MUTUAL AID SOCIETIES IN ITALY

1.1.1. Historical notes and dimension of phenomenon

Quantitative existing data show a fast growth of MASs from the Unification of Italy on: if in 1862 they were 443, in 1885 they reached 4,896 units (+1005%) until they arrived at 6,700 units (+37%) in 1897 (Fimiv, 2008). Ministerial statistic of 1904 certified the existence of

6,535 Societies, 4,067 in Northern Italy (62,2%) and the remainder divided almost equally between the Centre and the South of Italy (Baioni, 2005). The numerical imbalance of the regional distribution was a reflection of the different conditions of development of the country. The strong presence of Societies in the North could be explained by the "creation of the Italian industrial base and its strengthening, expanding of satellite industries and increasing of production and services fringe activities" (Gheza Fabbri, 1996).

Over the course of the Twentieth Century, MASs were planted by the progressive radicalisation of social conflict, which helped to pass on to others the ability to more effectively understand workers' needs and aspirations.

Until the First World War, however, MASs grew in number and importance till the starting of the construction of what became the "welfare state", thus seeing resized and reoriented their original activity. This also led to the closure of many of them because of extinction.

The outbreak of the First World War and later the advent of Fascism meant the clear disintegration of the mutual aid movement. The management of social security was finally removed from MASs and the National Social Security Institute (Istituto Nazionale della Previdenza Sociale, or INPS) became the only reference on these issues.

After the Second World War, alive MASs faced with the resumption struggling to regain operational reasons consistent with the activities developed in the Nineteenth Century. The charitable function was reduced (Fimiv, 2008:57), while MASs continued to spread their recreational and cultural activities. From 1965 onwards it went through a chaotic phase in terms of data availability on MASs, which were mostly organised in large groups of mutual societies[1].

In 2009, there were 1,428 Italian MASs geographically divided as following (Table 1): 53% in only three Regions (Piedmont, Liguria, and Sicily). Members and their relatives make up a total of about 600,000 (Fimiv, 2008) and their geographical distribution highlights a particular concentration in Central and Southern Italy (respectively 23% and 25%) and Islands (14%). That is because consistently with the development mode of Italian geographic areas, MASs set-up and rooted in primarily in the North, while the gap between economic development and welfare has led to an increased demand in welfare assistance in the Southern regions.

Table 1 – Geographic distribution of Italian MASs (2009)

Regions	*n.*
Piedmont	**409**
Liguria	**252**
Sicily	**96**
Veneto	84
Latium	74
Apulia	73
Lombardy	67
Emilia-Romagna	65
Friuli-Venezia Giulia	54
Marches	54

[1] INAM (for general diseases), INPS (for tuberculosis, disability, and old age) and INAIL (for work accidents and occupational diseases). There were also mutual professional organisations: INADEL (for local government employees), ENPAS (for government employees), ENPDEDP (for employees of public corporations) and ENPALS (for employees of the show business).

Tuscany	52
Campania	34
Umbria	27
Sardinia	21
Calabria	21
Basilicata	16
Abruzzi	15
Aosta Valley	5
Trentino-Alto Adige	5
Molise	4
TOTAL	**1.428**

Source: Our elaboration on FIMIV data

1.1.2. Normative notes

The Law no.3818/1886, "Law approving the legal constitution of Mutual Aid Societies", is the legislative reference to incorporated MASs, or which are legal entities (the so-called "regular")[2].

Instead, unincorporated MASs (the so-called "irregular") are real "associations without legal status", with a mutual aim, further called "mutual bodies different from societies". In addition there is the section on "associations without legal status" of the Civil Code (art. 36 and following). These MASs are different from incorporated ones because of the impossibility to establish *supplementary health funds.*

More in general, MASs are bound by certain restrictions to their work, which may include the following:

a. commercial activities involvement constraint: MASs cash money from their members (membership fees) that are then redistributed to the same members who are in disadvantaged situations (subsidies). For example, it is forbidden to provide direct insurance activity: that is the impossibility by MASs to make insurance contracts with their members as an insurance company do (as well as an insurance mutual societies). However, they are permitted to cover the role of the intermediary between the members and insurance companies;
b. non-profit distribution constrain, as a dividend or other forms (for instance, refunds);
c. participation prohibition in the Society as financing members or donors and related issues of financial instruments of any kind;
d. members do not have the right to be refunded for paid contributions in case of dissolution of the membership related to just one member as well as when the Society is dissolved.

Recently, the proposal of amendment of the Law on MASs[3] has been introduced after the issuing of a rule of simplification directed towards the removal of laws older than 1st January 1970 and not relevant at national level from the Italian code. Consequently that has sped up the renewal of the discussion on the future of Italian mutual aid movement.

[2] In the light of changes in Italian society and economy over the course of time, some Regions have enacted specific laws for the protection and the promotion of MASs, in order to supplement the national law. Up till now, these Regions are: Abruzzi, Calabria, Friuli-Venezia Giulia, Liguria, Lombardy, Piedmont, Apulia, Sardinia, and Veneto.

[3] The starting point of the reform is an *upload* of the *definition* of MASs, that have to be consistent to their *distinctive characteristics* (e.g., their mutual nature, non-profit aim, the chance to provide services and contributions only in respect of members and their cohabiting relatives, the adoption of a regulation acting to govern mutual relations with members).

1.2. MUTUAL BENEFIT SOCIETIES IN ITALY

In the last decade, Italian National Health System (NHS) has been deeply changed by the Legislative Decree no. 56/2000, establishing fiscal federalism, and the Constitutional Act no.3/2001, which included health among the subjects in the current legislation between State and Regions. In this context, the definition of Essential Assistance Levels ("Livelli essenziali di assistenza", or LEA) by the State plays a key role in defining the exact boundary of the intervention of public health and to implement article 32 of the Constitution[4].

The Prime Minister Decree (Decreto del Presidente del Consiglio dei Ministri, or DPCM) of November 29th, 2001 concerning healthcare integration defines the percentage of cost not covered by health service for all those services of the so-called "grey area" in this sector where not every time allows a simply division of duties and responsibilities between social area and health area. The DPCM provides for the possibility to use "supplementary health funds" that can be managed by MBSs.

The crucial element of this form of mutual aid is that the refund of services purchased by members is strictly subordinated to the availability of the same mutual aid fund and so it is not ever completely sure. For this reason, MBSs maintain with their members an associative and not insurance relationship with a charitable goal.

In Italy there are numerous MASs mainly oriented towards social volunteering and recreational and cultural activities, while less of them are acting in the field of health mutual aid, although in recent years this sector still appears to be expanding. MBSs make up 4,8% of Italian MASs. Their geographic distribution on the national territory highlights a concentration in Lombardy, Veneto, and Emilia-Romagna, where there are 47% of subjects working in health, healthcare and/or social care (Figure 1). There are 44 MBSs in Northern Italy, 14 in Central, 5 in Southern and 5 in the Islands. The focus on the health, healthcare and social care fields basically highlights a proportionality to the total number of Italian MASs.

Up to now, MBSs has heterogeneously developed according to the population of reference setting up many different types of experiences.

MBSs have played an important role in health protection and providing an integrated system of social services rooted in the Third sector and thus as a direct expression of civil society. It is particularly relevant to highlight the innovative role that has been acknowledge to the Third sector in the regulatory framework of NHS. The national planner points out as health and social policy can be better pursued involving all the types of bodies of the local community: social institutions, volunteering, associations, social enterprises, institutions of the productive sphere. That is the reason why the "negotiation" is designed not only as a strategy acting to bring out the different active institutions in health and social policies, but also – and particularly – as structural and strategic condition in facilitating the meeting between local responsibilities and available resources to invest in goals defined by the "planning"[5].

National social cohesion, in fact, is proportional to the level of its "social capital", that is: at the micro level, a network composed by long-term more or less institutionalised

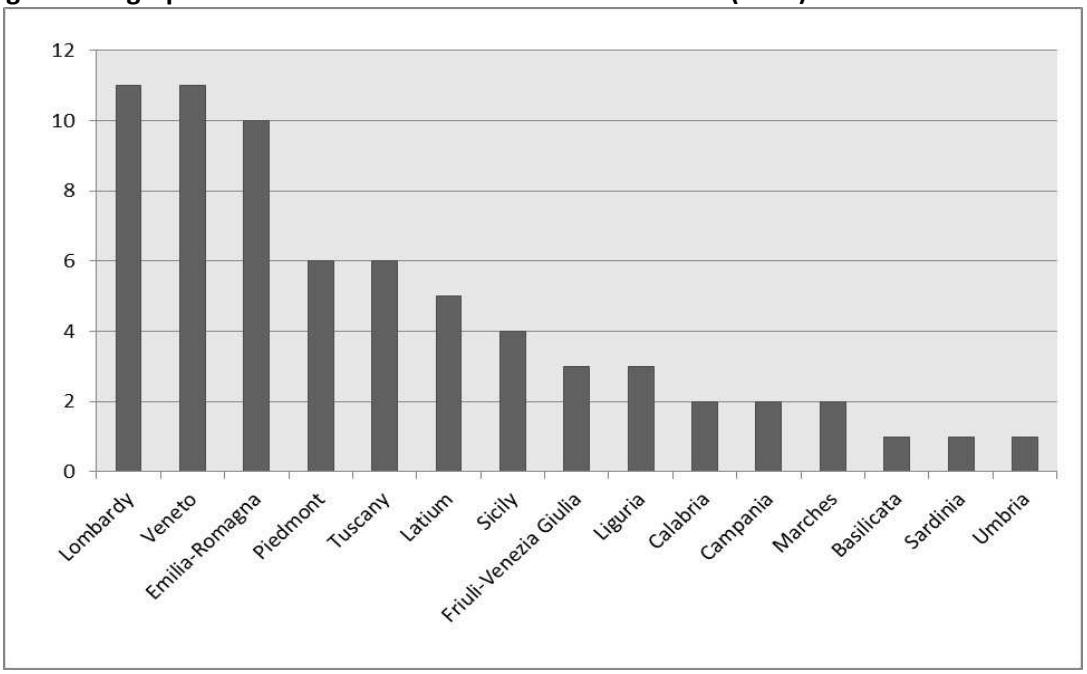
[4] "The Republic protects health both as fundamental right of the individual and collective interest and guarantees free medical care to the indigents. Nobody can be forced to a specific medical treatment unless required by law. The law may in no case violate the limits imposed by respect for the human person".

[5] See Italian National Health Plan 2006-2008.

relationships of social mutual recognition (Bourdieu, 1986); at the macro level, a network of civil rule ("civicness") able to trigger a virtuous cycle between institutions and citizens (Putnam, 1993). Social capital is fundamental in mediating the most effective ways of access to welfare services: the higher the levels of trust, social participation, and associative institutions are, the more people declare to be satisfied by the health policies and institutions (Galesi, 2006).

Concerning social cohesion and social capital issues, Third (or non-profit) sector organisations may act in healthcare education and prevention in order to spread a culture of well-being for the promotion of more responsible lifestyles that reduce or prevent health risks. Particularly, MASs work along these lines becoming carriers of trust and a reciprocal sense of solidarity, concepts reflected in MBSs.

Fig. 1 – Geographical distribution of Mutual Benefit Societies (2009)



Source: Our elaboration on FIMIV data

1.2.1. Subsidiarity principle and Mutual Benefit Societies

The building of a post-modern welfare system able to replace the current welfare state model must to be oriented by the so-called "principle of subsidiarity"[6]*:* according to Zamagni (2008), this concept is not just about limiting the intervention of a higher authority on a person or a community able to act by themselves – "vertical subsidiarity" –, but it is also connected to the obligation on that authority to provide the tools by which people and communities can achieve their goals – "horizontal subsidiarity". Italian local authorities and Regions are entrusted with the task of specifying the admitted forms for a wide and representative involvement of the non-profit sphere in different areas of responsibility in healthcare services. Also the current National Health Plan (2006-2008) provided the promotion of solutions that guarantee the chance to qualify the presence of Third sector

[6] Cf. art. 118, paragraph 4, of the Italian Republic Constitution: "State, Regions, Metropolitan Cities, Provinces, and Municipalities must act in order to favour the autonomous initiative of citizens, both individual and associated, to carry out activities of general interest based on the principle of subsidiarity". The concept of subsidiarity as well is the main principle of the European Union.

organisations promoting long-term qualitative investments, according to the demands of services characterised by the continuity of care and methods to take care provided by the Essential Assistance Levels (LEA). This is to enable these entities in performing actions in a synergistic and coordinated way with institutional activities.

Today, with the new launching of supplementary health care forms, MBSs have assumed an important subsidiary and solidarity role in the system of social care and health services. Today, in comparison with the world of for profit institutions, also MBSs may assign tangible numerical value to the social distinctive parameters: democracy and participation, relational moments, and social capital (Zamagni, 2009).

Furthermore, nowadays, one of the most plausible and actionable strategies to make sustainable the "health universalism" is to *empower* more and more citizens themselves, through subjects as the MBSs able to aggregate a demand aware and informed on health and healthcare issues.

1.2.2. Health as relational good

The solidarity conception of welfare models – including the Italian one – has so far allowed the identification of the individual positions of difficulty and hardship with the lack of an adequate level of resources to meet needs and requirements deemed worthy of social protection (Sacco, 2010). Today, however, new sources of hardship – and, consequently, the new welfare goals – are increasingly linked to the lack of acquisition of capacities, to the full inclusion in relational life, to the individual and social identity pathologies.

This is exemplary of the growing need for a paradigmatic change: a need for a "clever", advanced and non-standardised welfare system, able to integrate its solidarity dimension with the acquisition of people capacities focusing on relations. In this sense, civil society organisations, such as MBSs, need, from one hand, a "cultural change", starting from a rethinking of the notions of "innovation", "entrepreneurship", "social cohesion", and "sustainability" that can replace the role of "mutuality" in the changed social and health environment; while on the other hand, to be able to identify and enhance their "social value", both in the perspective of members and internal human resources.

The new welfare model have to be based – as already said – on a cultural change starting from a rethinking of health as "relational good". According to Bruni and Zamagni (2004), the latter is a good whose utility for the person consuming it depends not only on its intrinsic and objective characteristics, but also by ways of use with any other people, or the relationship that is developed between those who offer and those who demand. In the relational good, what is important in producing utility is the "manner" with which it is delivered and consumed. First of all, this good requires the "knowledge of the identity of the other person", or that people involved in the established relationship really know each other; then, this is also a "non-rival good", whose consumption nourishes the good; finally, it requires an investment of *time* rather than money. Relational goods put in the context of the "reciprocity principle", which along with two other regulatory principles (exchange of equivalent goods and redistribution) are the basis of the Civil Economy[7]. According to

[7] The principle of "exchange of equivalent goods" is the one where relationships are based on a price, which has equivalent value of a good or service exchanged. This is the principle that guarantees the efficiency of the system and the institution of reference is the market. To be effective, the economic system should redistribute – principle of "redistribution" – the wealth among all those who belong to for giving them the opportunity to participate in the scheme. This is the principle which guarantees the *fairness* of the system whose institutions of reference is the State. Those principles are the building

Zamagni (2007), reciprocity is the key element that would facilitate interpersonal relationships at the basis of the relational goods by which it is generated diffusion of knowledge, control and protection functions and processes of coordination and social support able to promote economic activities.

So, health is absolutely a relational good. This interpretation allows a better comprehension of MBSs role as institutions of Civil Economy working in health and healthcare.

2. METHODOLOGY

The present work is part of a wider research project[8] which was conducted both by the analysis of existing literature and documentation on MASs/MBSs more in general and through a structured survey questionnaire, developed and administered to the main MBSs providing coverage for supplementary health and healthcare services. The questionnaire allowed us to collect in a systematic way quantitative and qualitative data on the activities of MBSs, referring both to organisations active on a predominantly local dimension as well as those at regional and national levels.

The main goal of this survey was to provide an updated recognition of the overall size and the specific articulation of MBSs' activities in order to ensure to their members a supplementary coverage for health risks.

A second important goal of the empirical survey was to better understand the operational ways through which MBSs established relationships with their members, the main solutions adopted inside the organisational structure, as well as the forms of interaction with territorial stakeholders and with other Third Sector institutions.

Therefore the process of systematic acquisition of information from the players on the field provided an evaluation of the effectiveness of MBSs in pursuing social aims.

The survey questionnaire is divided in three sections as following:

a. general features of MBSs;
b. MBSs' identity and organisation;
c. services provided by MBSs.

In addition to general data on dimension and composition of the social base of MBSs, more specific information has been collected in order to reconstruct prevailing models of internal governance, as well as to understand the specific ways in which MBSs arrange for the participation of members in setting the organisational goals and methods of achieving them.

On suggestion of the Italian Federation of Mutual Benefit Societies ("Federazione Italiana della Mutualità Integrativa Volontaria", or FIMIV) Italian MBSs have been identified for their significant role in health and healthcare risk hedging activity.

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blocks of political economy. The challenge of Civil Economy is not to displace these two regulatory principles and replace them with the principle of reciprocity (characterized by the presence of three subjects – triadic structure –, where one – *homo reciprocans* – takes action against another not because is moved by "claim" to reward the action, but by "expectations", failing to break the relationship), but instead the integration within the same social system underlining, in particular, the importance of that principle.

[8] Developed by AICCON and the Italian Federation of Mutual Benefit Societies ("Federazione Italiana della Mutualità Integrativa Volontaria", or FIMIV), with the academic support of the teaching staff of the University of Bologna, Department of Economics.

Dataset used for the survey covers a total of 20 MBSs involved in the coverage of health risks that come to collect a total of over 360,000 people, including members and their party entitled relatives.

Concerning geographic distribution, the highest concentration of members is present in Central Italy (63%), while the other macro-areas are relatively homogeneous units ranging from 16% for the North-West, 11% for the South and the Islands, and up to 10% for the North-East.

Also interesting is the analysis of the *professional composition* of beneficiaries of supplementary covers. 37% are employees while the absolute majority is made up of members' relatives to which coverage has been extended (53%). Weight of retired people is much lower (7%) as well as the self-employed (3%).

The areas of prevailing activity in which MBSs are involved are not fully superimposable. According to criteria used to define the survey sample, the overwhelming majority of surveyed organisations (88.9%) is engaged in the coverage of health services, but a significant proportion (55.5%) reports being active even in the coverage of healthcare and social care services.

3. MAIN RESULTS: THE ADDED VALUE OF ITALIAN MUTUAL BENEFIT SOCIETIES

Part of the research conducted on the sample has been oriented to analyse the "added value" of MBSs as a key in reading and understanding the role that they have in the production of "social innovation" inside the Italian welfare system.

The concept of "value" emphasizes all positive characteristics and qualities of a specific product/service/institution through which it is possible to recognise and identify it as such. A value is then "added" when a good/service/institution produces a positive change in its own frame of reference distinguishing it from other similar goods/services/institutions.

According to Bassi (2011), "products/services provided by Third sector organisations generate added value on the condition that they have a different value – or rather it is differently perceived from beneficiaries – than the one provided by other types of institutions (e.g., public authorities or for profit institutions)".

The survey questionnaire allowed to analyse the sample of the research through the added value dimensions of MBSs distinguishing them from other institutions carrying out similar activities (e.g., for profit insurance companies).

Concerning the added value topic, the main difficulty pointed out is about the definition of its elements: in fact, unlike the case of for profit institutions, it necessary to observe a wider range of sides of the added value creation within the Third sector organisations (hereinafter TSOs), not only economic ones. That is because of TSOs primarily pursue the "social utility" rather than maximization of profit as in the for profit sphere of the entrepreneurial system (Ormiston & Seymour, 2011).

At the same time this does not mean that must not be take into account the meaningfulness of "economic value" of the Third sector and its contribution to the Italian GDP. On the contrary, it is generally admitted that it is extremely necessary its clear and univocal accountability in national statistical accounts.

In order to measure the economic side of the added value of TSOs, it is necessary to move from the concept of "efficiency". That is, in the case of TSOs, it could be referred to a proper and suitable use of means (funding, human, and organisational resources) (Colozzi, 2011). So

the economic added value could be measured as increase (or not consumption) of material, economic, and funding – investment and saving – wealth produced by the core business of an organisation (Venturi & Villani, 2010).

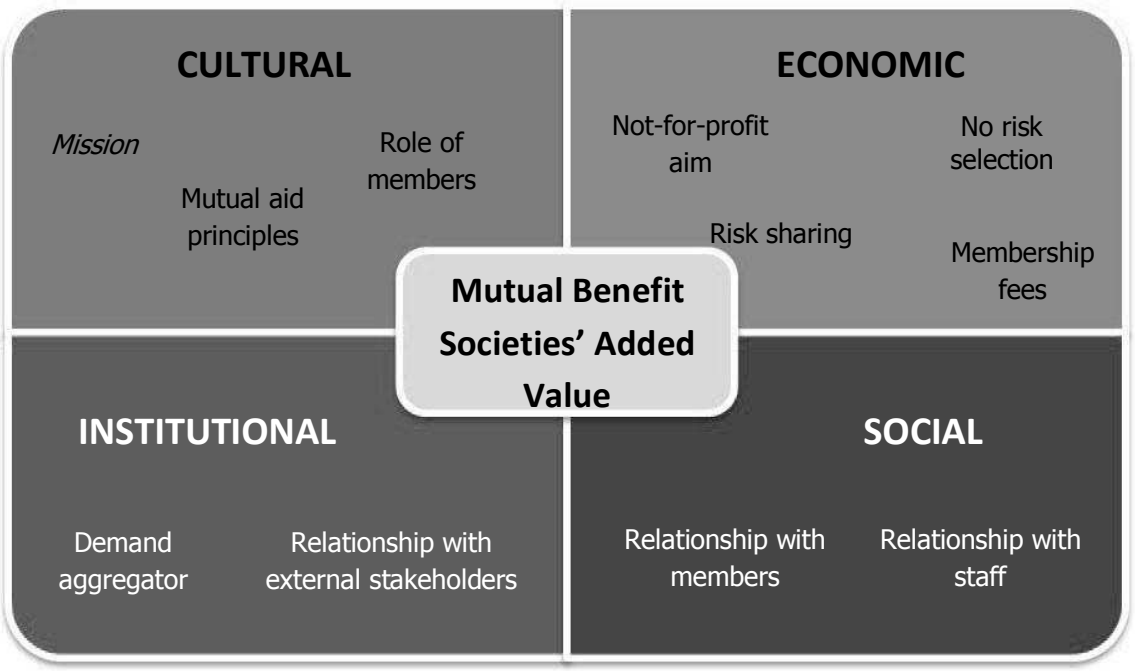
Other types of value concur to form the total added value of the Third sector: "social added value" moves from personal relationships and related expectation of reciprocity (Miczo, 2002), that is a specific contribution given by organisation in terms of production of relational goods (internal relational dimension) (Venturi & Villani, 2010); "cultural added value" as the specific contribution in terms of diffusion of organisation's principles and values connected with its mission (e.g., fairness, broadmindedness, mutuality, solidarity, inclusion, social cohesion) in the community (Bourdieu, 1993; Holden, 2004); "institutional added value" moves from their institutional activity in order to provide public utility services carried out together with other public institutions (according to the principle of "horizontal subsidiarity") aimed by the same goal. That kind of added value could be measured moving from the observation of the level of social capital created as evidence of the external relational dimension of the organisation (Venturi & Villani, 2010).

Concerning Mutual Benefit Societies, the specific goal is to evaluate their contribution in building networks carrying out protection services supplementary to the public sector's ones.

Assuming a wider perspective, extremely relevant is the evaluation of the ability of interaction of MBSs with other social and economic institutions in order to guarantee a significant improvement in supply quality as well as in citizens' protection from social and health risks through an integrated network of services.

Analysing the survey sample of the questionnaire, it will be following developed in details the four dimensions of the added value of MBSs (Figure 2).

Fig. 2 – The added value of Mutual Benefit Societies



Source: our elaboration

3.1. CULTURAL ADDED VALUE

It is possible to analyse the added value of MBSs moving from its *cultural* side that is the diffusion of mutual aid principles as goal strictly connected with their mission, origin, and identity. The survey questionnaire allowed to collect information on this topic giving a more definite view on how this dimension describes MBSs' action.

Concerning *their set-up*, two MBSs were born in the XVIII Century. On the opposite side, 11 MBSs recently set-up (between 1980 and 2000). The remaining MBSs mainly set-up in the first half of the previous Century.

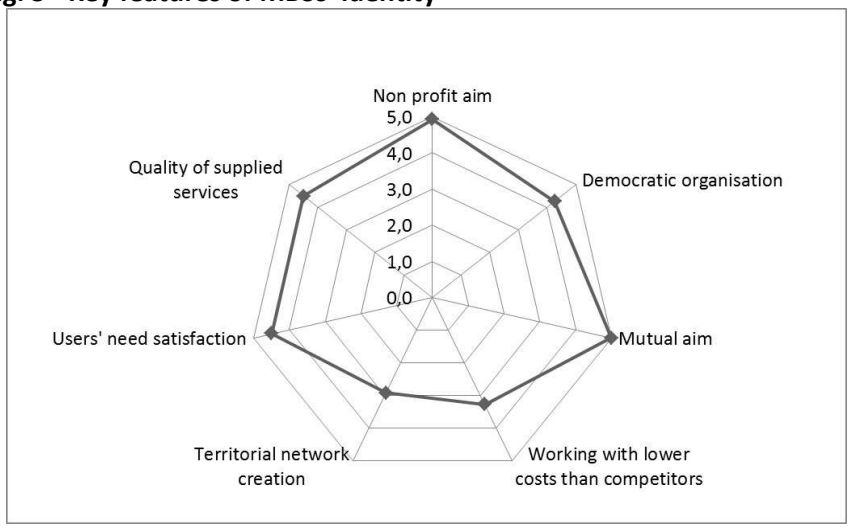
Concerning their *legal form*, the whole sample is composed by incorporated Mutual Aid Societies according to the Italian Law n. 3818/1886.

In addition, information collected allow to identify some characteristics of the identity and mission of MBSs. The questionnaire investigated the relevance of specific sides connected with the "identity" of the mutual aid movement and it requested to assign a score (from 1 up to 5) to a list of elements in order to highlight the main aspects connected to the cultural dimension.

As represented in Figure 3, middle values highlight as mutual aid nature is the main aspect connected with the identity of MBSs, even before the non-profit aim. Data confirm that internal solidarity goal is an additional side of the latter and that is the reason why is extremely important to separate these two aspects. This high attention to relationships among members is reflected also by the relevant importance attributed to qualitative sides connected to services supply.

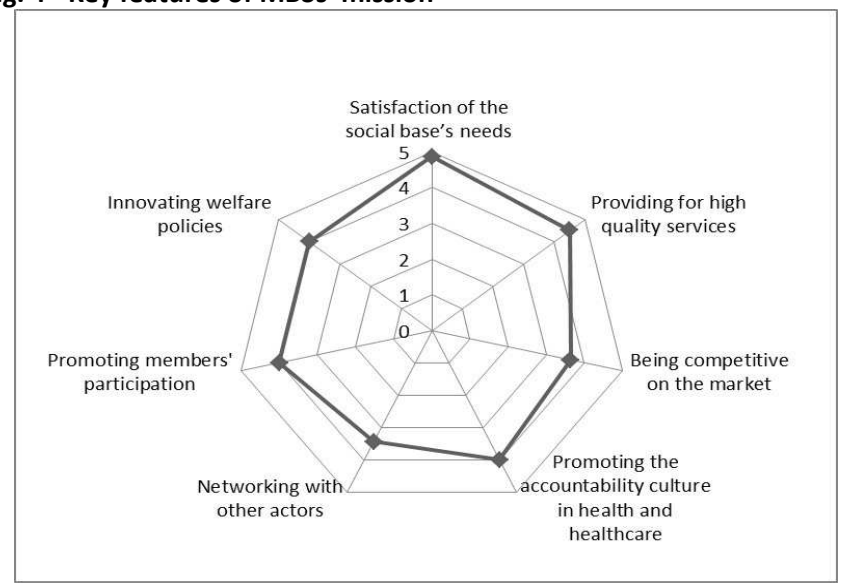
The inclination towards the value creation for the member generated by the satisfaction of the membership's needs is the key factor of the mission of MBSs (87% of the sample) (Figure 4). So the centrality of member is the key element for building cohesive relationships and, consequently, for an easier and wider diffusion of organisation's values.

Fig. 3 - Key features of MBSs' identity



Source: our elaboration on survey data

Fig. 4 - Key features of MBSs' mission



Source: our elaboration on survey data

3.2. SOCIAL ADDED VALUE

Both at domestic and worldwide level, social added value is a recent topic of research. If, on the one hand, much scholars and institutions already tried to measure it[9], on the other hand it is much more difficult to find valid systems of measurement to capture qualitative sides of non-profit institutions.

Difficulties are connected more with the identification of useful elements for measuring/evaluating social dimension rather than with the understanding of the relevance of this measurement by these organisations. As a matter of fact, according to Colozzi (2006) the gap that exists in measurements of non-profit organisations' quality is linked with the difficulty in highlighting "which is the distinguishing element of the Third sector compared to public bodies or for profit enterprises and which is the social added value produced by these organisations within a welfare system".

According to Bassi (2011), social added value could be analysed moving from participative dimensions, through which it could be possible to identify some indicators useful in finding this type of value, that is: a) internal democracy degree; b) external relationship degree.

[9] Many attempts to measure social value of non-profit organisations have been done, particularly in UK. The most frequent measurement methodology – also adopted by the Office for Civil Society of the Cabinet Office – is the so called SROI Analysis. In order to quantify in economic terms the non-financial social value of an organisation, the SROI Analysis is made up of five steps: a) identifying of outputs b) shifting of outputs in monetary value – where it is possible; c) developing of the Social Cash Flow, that is the elaboration of a sheet where there are calculated financial indexes related to social benefits and costs (i.e., Social Return on Investment, Social Net Present Value, Social Impact Return Ratio) using the most suitable discounting back rate; d) in case of a qualitative output, the evidence of relevance, extent, and criteria through which it will be possible to predict its fulfilment; e) identifying a detailed list of used sources. For a development of this issue, cf. Wood & Leighton (2010).

3.2.1. Democracy and participation

Democracy is historically one of the original feature of organisations as MBSs. They are set-up "by members" and "for members". This is the reason why it was considered important to verify the components of this principle within the survey sample.

The participation of members to the governance of the MBS contributes to produce social added value from different perspectives (Propersi, 2011)[10]. First, it allows to reduce informative asymmetries through a wider distribution of information among members. In that way, they assume "an active position within the context of reference of the organisation" (p. 329). Furthermore, a democratic organisation allows a better control through which it is possible to inhibit opportunistic behaviours stimulating at the same time the strengthening and the diffusion of trust among members.

To this end, it was investigated both on governing bodies, where typically is expressed the internal democracy of TSOs (which is manifested through the principle of "Democratic Member Control" or "one member, one vote" in the meeting and the election of the board of directors by members) and ways in joining to the MBS (principle of "Voluntary and Open Membership").

The composition of governing bodies is generally quite similar among MBSs of the sample and they are: the members' meeting, the board of directors, and the supervisory board (Tab. 2).

Concerning the members' meeting, all the organisations of the survey regularly call it. The members' meeting is composed by 2,136 people on average – even if it has been possible to collect only a third of answers. However, excluding from the count the biggest MBS – having 9,959 members – the members' meeting is composed by 181 people on average.

The whole analysed sample had replied in the affirmative concerning the presence of the board of directors too. The latter is composed by MBSs' internal people on 82% on average. Finally, the 67% of the MBSs of the survey has got a supervisory board – composed for the 50% by internal people on average.

Almost the 90% of the survey sample replies in the affirmative on the whole presence of traditional governing bodies that are renewed every 2 years on average concerning the members' meeting and 3 years on average for the other bodies (at least 45% of the sample).

Tab. 2 – Composition of governing bodies

	Internal	**External**	**With wage**	**With only attendance fee**
	Average	*Average*	*Average*	*Average*
Members' meeting	2,136	-	-	-
Board of directors	9	2	4	9
Supervisory board	4	3	3	3
Board of Arbitrators	7	1	-	1
Regional representatives' delegations/other consultants	57	4	-	-

Source: our elaboration on survey data

[10] For more developments of advantages of the participatory governance, cf. Borzaga & Mittone (1997) and Sacconi & Faillo (2005).

The average turnout of members to the annual meeting is 3.7%[11], a data lower than the one that hypothetically would be expected by institutions set-up in order to respond to the needs of their members.

MBSs who answered to this issue have got different percentages which oscillate between 0,5% and 10%. However, if we consider the dimensions and the set-up year of MBSs as two variables, it emerges that the participation to the members' meeting is wider in smallest and more recent MBSs rather than in biggest and oldest ones.

The limited participation to the members' meeting could be explained through the type of services delivered by MBSs. That is as the possibility that health risk will be result in relevant expenses during the entire life of a member is low, the latter may feel discouraged in taking part actively and regularly in the definition of development policies for the organisation. If we consider more generally data on participation in conjunction with the low number of recesses and the trend of long-lasting adhesion, it could be understand as an index of suitable satisfaction in organisations' leading.

MBSs of the sample respond to involve their members engaging them in Societies' activities, as well as through the annual meeting of members, and the possibility of use of reporting procedures by the members on issues, and problems faced in the activities of MBSs (40% of respondents).

Using these opportunities for comparison, 13 organisations declare to adapt supplied services to the specific demands expressed or the emerged needs of members generating benefits for the creation of added value of a long-term relationship between member and organisation. Rebounding on the improvement of the ability in answering members' needs and reinforcing existing relationships based on trust or creating new ones, it has positive consequences on each level of the organisation nourishing an internal virtuous circle.

To ensure the members' participation, MBSs can also provide for specific items in the articles of association or certain standards of protection of social participation: 87 per cent of MBSs' sample provides this kind of commitment to their members.

3.2.2.The production of relational goods

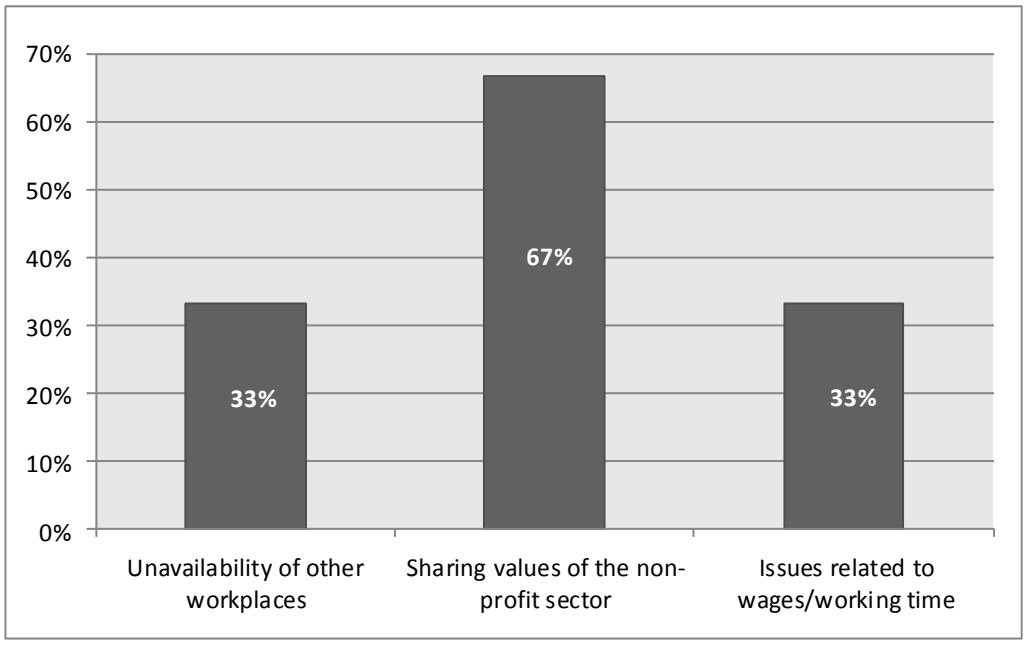
The degree of internal relationship is strictly connected with the intensity and the nature of relations among internal stakeholders referring to both qualitative and quantitative elements. It is particularly relevant to distinguish actions connected with working relations (social added value for the staff) from those which concern the memberships (social added value for members).

The carried out investigations focused on MBSs' staff (employees, external collaborators, and volunteers) counting 0.5 point for each working unit involved with a part-time contract. The total amount of employees is 531 people in the whole survey sample (450 belonging to a single MBS excluding which the average number of employees is around 5 units for each MBS). The 36-55 years old female element is relevant. Volunteers are much more significant as they are almost the 80% of the workforce in 6 MBSs and the entire work force in other two. According to these information, it seems like MBSs are not interested in dealing with employment goals differently from other types of TSOs. It confirms that the distinguishing element of these organisations is more connected with the member and their needs rather than with the staff element.

Concerning the latter, in feeding the sense of belonging to the organisation where they work and, consequently, strengthen the relationship between worker and MBS, it results that only 40% of the MBSs carries out a specific training on their own identity issues (i.e., non-profit aim, mutual nature, democracy, and so on). Furthermore, an even lower percentage (20% of the sample) has played a survey/research on the motivation of its staff. According to data on MBSs that have played it, the greatest part of employees in a MBS chooses to work in because they share non-profit values and principles distinguishing it from other sectors (Figure 5).

[11] However, data is calculated on a 73% of respondents of the survey sample.

Fig. 5 – Main motivations of MBSs' staff



Source: our elaboration on survey data

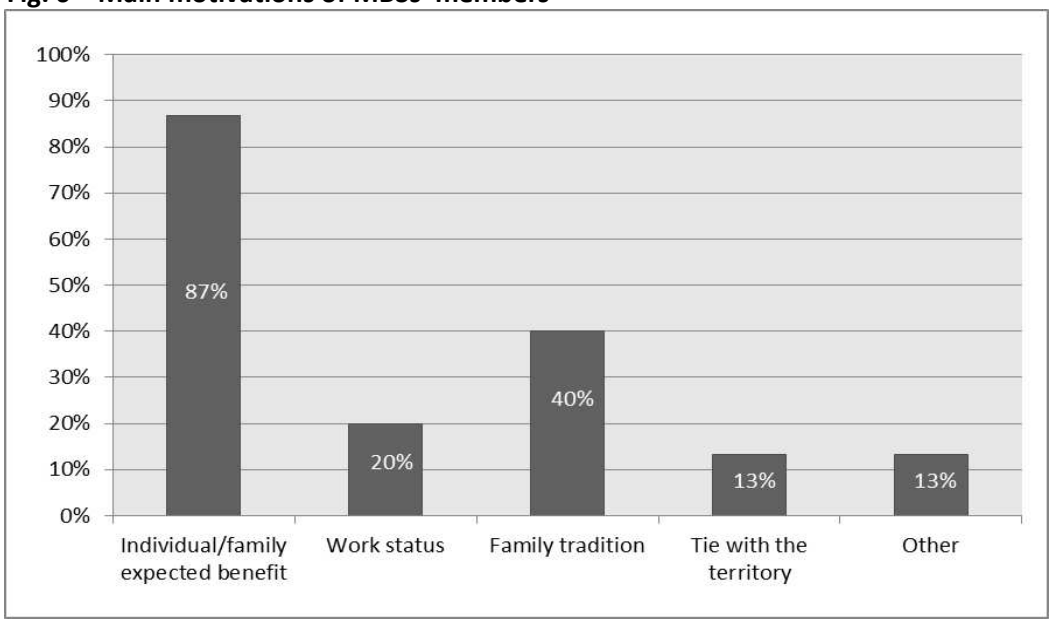
In general, such a low number of employee could determine, from the one hand, a self-selection of those people really motivate in working within the Third sector; on the other hand, the low taking into account of staff involvement and motivation aspects by MBSs unlike other types of TSOs.

However, from the members' perspective, the reasons that most support a person to join a MBS are "individual/family expected benefit" (87%) and "family tradition" (40%) (Figure 6). The former suggests that, from the demand side, aside from ideal motivations and solidarity aim, there is a need to insure itself and its family from health risk going over the public system supply. However, even if with lower results, other kinds of motivations maintain a significant weight as, for example, those referring to family-ideal ones and that are strictly connected with MBSs characteristics.

First of all it is necessary to focus on the importance of the "family tradition" (40% of members). This finding supports the following consideration: the relationship between members and MBS is intergenerational based on trust that is passed down over time and creates a positive and continued expectation in members towards the Society related to the ability to meet their health and healthcare needs.

However in order to regularly identify the members' level of satisfaction only 40% of MBSs states to achieve an activity of systematic evaluation of the satisfaction of services offered to members – and particularly to resigning ones – by questionnaires. Moreover only one time had been done a yearly evaluation of the efficiency of the social security cover using indicators on average percentage of reimbursement of services and on the increasing in number of new joinings. The evaluation of the members' satisfaction is mainly carried out by medium-big size MBSs. That could be justified by the relative greater difficulty in implementing evaluation tools found by small MBSs because of the lack of employees with specific skills on evaluation methodology and rendering of data collected. In addition, smallest organisations frequently evaluate the satisfaction of members through informal methods due to nearness among members and organisation.

Fig. 6 – Main motivations of MBSs' members

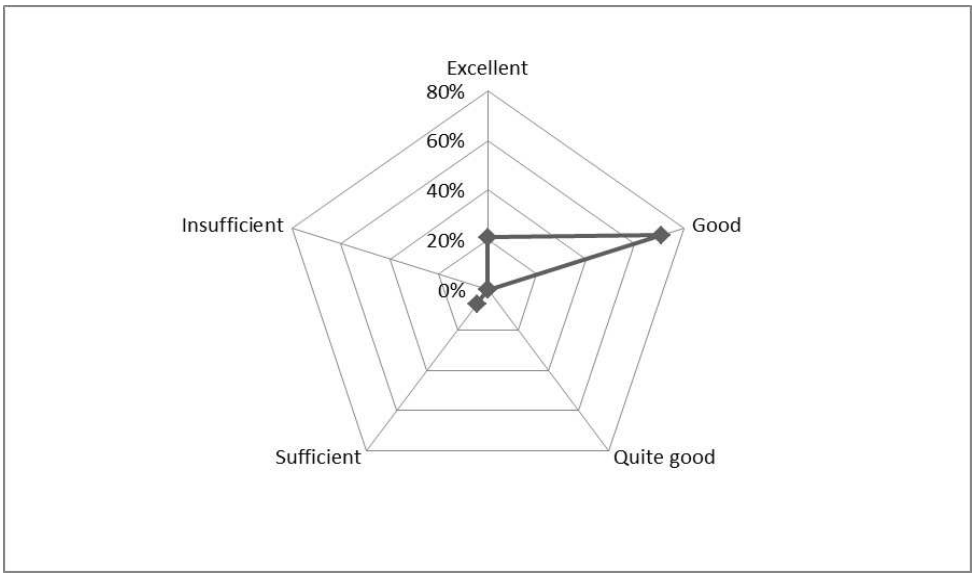


Source: our elaboration on survey data

The assessment activity also influences for 60% on the supply trend of MBS. Information collected on members' needs are necessary to MBSs both for improving the quality of offered services (by a percentage equal to 47%) and widening quantitatively their supply (53%).

A self-evaluation made by MBS on the perception of members' satisfaction on their activities shows as these institutions consider that the level of approval by their members tend to be "good" (Figure 7). In only one case the opinion is "sufficient".

Fig. 7 – Users' satisfaction perceived by MBSs



Source: our elaboration on survey data

Another element able to define the quality of the relationship between member and MBS is its average length. Information given by the survey sample about this topic highlight as the membership has a duration between a minimum of 5 years and a life-long relation. The average data of the whole sample is between 15 and 20 years, especially if members join to the MBS when they are around 60 years old and then it is suspended around the age of 80 years because of economic reasons or arisen institutionalisation. Also assuming this point of view, it is confirmed the existence of long-term relationships between member and organisation and then potentially less exposed to opportunistic behaviours than other types of cover. That is a confirm of the role of MBSs in determining a stable relation and a useful interaction with members in order to enhance the participatory dimension in the course of time.

In MBSs, the associative relationship is particularly nourish by subsidiary or secondary activities (in comparison with principal or institutional ones) regarding cultural and social aspects involving the social base even at times other than those strictly related to health and healthcare items. In most cases - as revealed by survey data - they are “cultural and social events” (40%), but also “economic subsidies to members” (27%), and supporting actions to education - provision of scholarships to members and their relatives (13%). Moreover, there is the emerging of activities relating to environmental issues and to organisation of leisure (e.g., social tourism), as well as the improving in training of members and their relatives (such as University and post-graduate training or lifelong learning courses).

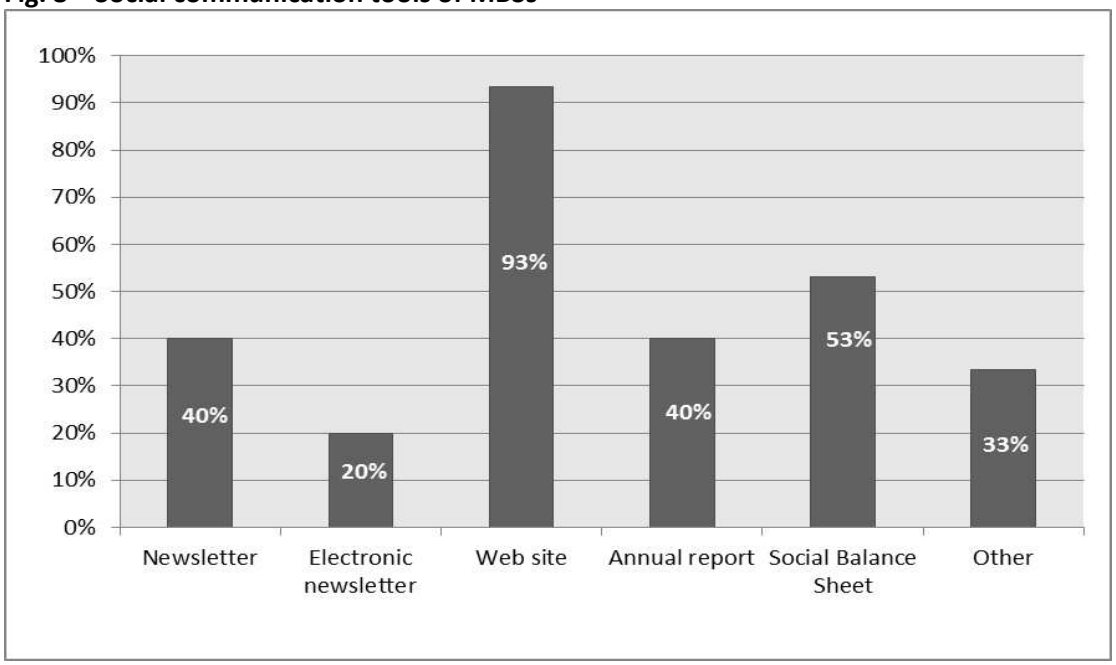
Building a long-term relationship between member and MBS based on trust, on the one hand, it implies a greater ability to a tacit and voluntary peer-to-peer control (i.e., among members) regarding to possible opportunistic behaviours or the emergence of unmet needs, allowing the decreasing of explicit cost of monitoring. On the other hand, it still need other ways of enabling a top-down control in order to encourage responsible behaviours of members. 40% of MBSs provides an internal mechanism, which results in 67% of cases in the tool of the “temporal lacks of required refunds”.

Finally, concerning again the evaluation of the involvement of MBS’s members, survey data underline the activities of social communication and accounting, or how members are informed of MBS’s activities and how they are involved in. These tools allow to maintain a continuous and regular contact with members and, at the same time, to communicate their activities to the outside (i.e., external stakeholders or potential new members). According to the survey sample, the main tool of social communication is the web site (Figure 8), through which MBS provides for news about its activities. However, if on the one hand this tool of virtual communication confirms itself as the most used also by MBSs, on the other hand less common is the use of another tool which is now spread, or the electronic newsletter, used by only 20 per cent of the sample.

There are 6 MBSs of the survey sample sending to the residence of member an annual report of activities – only in one case instead of the organisation’s web site. Other tools are communications via traditional mail, at the member’s work place, participation to exhibitions, local bases or counters, and regional members’ meetings.

Furthermore there is a growing number (by a percentage equal to the 53% of analysed sample) of MBSs that approaches the tool of the social balance sheet to account and communicate both of their economic and social sides.

Fig. 8 – Social communication tools of MBSs



Source: our elaboration on survey data

First of all, social balance sheet allows to report yearly to members activities and (economic, financial, and human) resources used to these purposes. It also provides for monitoring activities in the medium-long term checking the path started by MBS and comparing it to its social goals in a broader time horizon. Finally, social balance sheet is an effective and popular tool of social value produced by MBS, which drawing upon to develop activities of social communication not only oriented to members but also to external stakeholders and to the community.

So, social communication is managed on average by MBSs with less personalised and more "mass" oriented tools in order to reinforce the image of the MBS as active organisation within the community. In this area it remains an important space for a future development particularly pushing those communication tools oriented to increase the value of relationship between the organisation and the single member.

To this day research data, on the whole, highlight as the social added value of MBSs is mainly based on the MBSs' ability in building internal relationships – especially with its own members – based on trusts and the sharing of values and elements of the organisation identity that find a complete fulfilment in the solidarity nature of membership bond with the MBS. Consequently it improves the sense of belonging to the organisation – where the person works or to which he/she joins to – through the unavoidable intergenerational shifts too.

The presence of a democratic governance structure and the attempt to extend members' participation circumstances highlight the relevance of formal and not relational occasions within MBSs in order to collect critical opinions as well as outstanding need of members. Going beyond the pure supplementary health/healthcare activity, these occasions are able to comprise relational and reciprocity elements also in the decisional-making and organisational process, according to the Social Economy paradigm where MBSs are included.

3.3. ECONOMIC ADDED VALUE

According to the "Association International de la Mutualité" (AIM & AMICE, 2008), mutuality is described as an important tool in involving citizens also from an economic perspective, in order to combine at the same time economic performance with social integration criteria. Assuming this perspective, Italian MBSs are one of the demand side institutions of health cover able to protect their members from the risk of an out-of-pocket expenditure to finance that part of care demand not covered by the public system.

A possible alternative is represented by for profit insurances or supplementary founds, typically with business or categorical nature. The clearest distinction is obviously the one in the comparison with for profit insurances, where the contractual relation connect apart every single subscriber with the insurance, whose business is typically a for profit activity. This element is not present in business or categorical founds that are therefore more similar to MBSs.

A first distinguishing element of MBSs is the reference not to "insured" but to "member". As above highlighted, the whole business of the MBS is based on the centrality of the member, both for the choice of reimbursed services and about the governance through the members' meeting and other governing bodies assuring in that way an active participation to the life of the organisation. In this context, the solidarity relationship among members may have a relevant role both in defining the relation between member and organisation and as tool to hold potentially opportunistic behaviours among involved parts. That is particularly significant in contexts connected to health care services that are characterised by greatly incomplete and asymmetric relations from an informative perspective as well as by high monitoring costs.

A second relevant diversity compared to for profit insurances concerns the risk sharing: in fact, if in the case of insurance companies it is transferred from insured to insurer, MBSs do not transfer the risk but they share it equally among members.

Evermore in a logic of democracy and pure mutuality, MBSs do not calculate a mechanism for risk selection at the time of members' joining. For this reason, the membership fee does not calculate significant differences related to the health risk category of individuals. These are introduced only where there are some strictly identified cases in order to guarantee the organisation from the explosion of adverse selection phenomena that could have destabilizing effects for the MBSs' financial equilibrium. Taking into account the principle of the so called "Voluntary and Open Membership", it is indispensable consider the possibility of joining of high risk members. That is the reason why it is necessary to take into account forms of control for limiting *ex ante* opportunistic behaviours. MBSs seem like to be completely conscious in potentially being exposed to this kind of phenomenon as they are bodies with voluntary joining.

One of the characteristics of MBSs is the research of long-term memberships. According to the "Voluntary and Open Membership", it is usually forbidden to the MBS to withdraw the membership as that decision belongs only to the member. In a for profit insurance company, on the other hand, the withdrawal can be arranged by special contract clauses due to the emergence of disabling and unannounced pathologies. So a MBS is potentially able to take care of their members for their entire life – if they wish so – while a for profit insurance cover generally ends once reached age thresholds such that the risk of coverage is excessive.

Evidences emerged from the questionnaire confirm those awaited differences. Concerning the principle of "Voluntary and Open Membership", MBSs declare that the joining method is open, that is there are no limits connected with gender, geographical location or particular health conditions of the potential member. As already abovementioned, this approach could expose these organisations more than other forms of coverage to issues related to information asymmetries (adverse selection). That is because of information on the real state of health of member or potential ones are not used by MBSs in order to exclude people at greater risk, both *ex ante* and *ex post* their joining. Although in a context where it was highlighted the prevalence of long-term relationships among members and organisation, it is interesting to analyse the causes mentioned in the Memorandum of Association/Internal Rules that may lead to forfeiture of membership. All of the MBSs of the sample identifies the cause "waiver and withdrawal", while respectively 40 and 20 per cent indicates the "non-payment of member" and "other causes" (such as, for example, death or financial difficulties of the member) as factors in the withdrawal of social status. Only two MBSs indicates the "expulsion" as a reason to exclude a member from the organisation. That potentially indicates a relationship between these institutions and their members based on mutual trust.

The only restriction on membership to MBS derives from the age of the applicant. Indeed if once joined to the MBS age is not binding for the continuation of social relationship, this is an initial discriminant (barriers to entry) of the relationship between MBS and the future member. 73% of MBSs of the survey provides a limit of applying age that is on the average around 67 years. Two MBSs specify this limit: on the one hand, it is used as a variable linked with the selected care plan; on the other hand, the limit is the member age of 70 years, even if its family members whom are registered can be older than 70 years. In all other cases, the age limit is between 65 and 71 years old and a MBS indicates 18 years as initial bond for joining the organisation[12].

In addiction MBSs can calculate also further limits for the provision of subsidies in order to guarantee a total economic-financial equilibrium of the organisation. That is especially because of the MBS has to guarantee itself from possible opportunistic behaviours originated by the awareness of conditions of imminent weakness of the aspirant member. It could be calculated in fact mechanisms as generic initial temporal shortages – between one month and one year after the first membership – and quantitative limits of provided reimbursements. In that way it is possible at the same time both to guarantee a wide application of the principle of "Volunteer and Open Membership" and to avoid opportunistic behaviours (adverse selection and moral hazard) of members in case of a lack in applying informal methods of monitoring.

A fundamental element allowing the evaluation of the level of openness of MBSs is the membership fee as contribution paid by the member for joining the organisation and the payment of which is repeated every year for the renewal of membership. 44% of institutions considered indicates that there are no distinctions of membership fee or all members pay the same amount. However who applies different amount of fee (56% of MBSs) is doing so with respect to criteria such as age, employment status or if the member agrees individually or through a form of collective bargaining. The amount of the membership fee is 69 euros on average.

[12] The aim of those thresholds is to maintain an actuarial equilibrium between the entity of the membership fee and the one of awaited reimbursements. However, on the whole thresholds seem to be determined at so high levels that it is possible to exclude that they are justified by the will in applying relevant practices of risk skimming.

Also concerning the economic added value as for the social one, the main characteristics are connected with the benefit for the member arising from joining to the MBS. The different working mechanism of those bodies, that is based first on the membership of the individual (and eventually of its family) to the MBS and, only subsequently, on the dimension of integration of the health cover, allows to improve an economic added value connected also to loyalty (or to establish relationships based on trust) of who joins the organisation, first as members and then as beneficiaries of the economic subsidy given at the occurrence of diseases.

In this context, the ability in generating more responsible (and consequently more efficient and effective) behaviours is a discriminating element compared to other bodies involved in the same activities of MBSs. In that sense the fundamental guarantee is the establishment of a memberships based on trust having as the main goal to lessen and/or avoid opportunistic behaviours from both of parties. Joining to the MBS, the member has the awareness that the organisation will not apply discriminatory actions of risk skimming towards him/her, while the creation of a long-term solidarity-based relation reduces risks of extra-demand of reimbursement from the members, particularly regarding services with low level of priority or, even worse, of doubtful pertinence. The economic sustainability of the activities is the key topic that broaden the concept of MBS internal responsibility (in terms both of rights and duties) to the outside, or opening to the community of reference and the whole society, particularly in relation with the on-going changes within the welfare system. According to the evidences emerged from the survey, this side must be empowered and organised in a continuing and strategic way from now on.

3.4. INSTITUTIONAL ADDED VALUE

According to the survey results, one of the characteristics of MBSs is the ability in answering to members' needs by the provision of quality services. The feel of being a subject able to aggregate the demand and then to direct its members towards a suitable supply of welfare services is strongly felt and it is a really significant element in defining the identity shape of these organisations.

The questionnaire highlights as some MBSs – usually the biggest ones – define strategies to address the demand of services from members towards NHS or private structures operating within the MBS. On the contrary, members usually prefer turn to private rather public structures because of the shorter waiting list and more customised services – especially for specialist visits and screens. MBSs can allow a better resource allocation contributing to reduce the informative gap on the quality of provided services by different bodies as well as bargain over suitable fees for their members. However, by the orientation of the demand, it is possible to improve also incentives to consumption choices towards responsibly services from the inside. Doing so it is possible to nourish a mechanism able - through MBSs' action - to develop an orientation to a social responsibility towards the whole community. This is the reason why together with the resulting created bond with health and healthcare policies developed at the State and regional level, it is possible to contextualise MBSs' actions under the concept of social innovation.

Starting from the definition of social innovation[13] as the application of new ideas on a product/process/organisational arrangements that produce an outcome or a stable and positive change in the level of well-being of a community or part of it by the creation of social added value, it is possible to affirm that social innovation is inherent in the organisational element of MBS that enables it to link the collection of demand with the supply management of health services. This is supported by the convictions that some of the most effective methods of developing social innovation starting from the assumption that people are perfectly able to find solutions to their problems and so that the involvement of beneficiaries in the different moments that make up the social innovation process is a *sine qua non* condition for success.

Social innovation is not aimed only at increasing quality of life standards and social cohesion within communities. It can play an important role in terms of economic competitiveness – increasing the efficiency of resources – and sustainability[14].

According to an interpretation of the social innovation from a "civil society perspective", it can be understood as a solution to social needs by groups of citizens through a democratic action (Hulgård, 2011), just like the one implemented by MBSs. This perspective emphasizes the role of democratic decision-making mechanisms that it is reflected in the organisational model of MBSs.

In response to the crisis in the public system of social protection, MBSs now face new challenges and opportunities. The goal is to combine the universality of the Italian welfare system with its economic sustainability. Therefore, MBSs are candidates as the institutions that, because of their original features, better than others may deal with the problem of the redefinition of policy interventions. In fact, they potentially reflect needs and desires of its members and build networks with healthcare providers (e.g., cooperatives), especially in services with high social rather than health contents, as in the case of long-term care to elderly people.

Because of this need, another concept that MBSs face today is the one of *social enterprise* (Borzaga & Defourny, 2001; Defourny & Nyssens, 2008)[15]. The realisation of that kind of

[13] Both at international and national level, there many different attempts in defining "social innovation" concept. The *Social Innovation eXchange* network provides the following definition: "*Social innovation is the process of designing, developing and growing new ideas that work to meet pressing unmet needs*" (2010). Cf. also Noya (2010) and European Commission - Enterprise & Industry (2010).

[14] The increasing relevance of these topics for the entire economic system is confirmed by the "Global Redesign Initiative" of the *World Economic Forum,* a project that aims to criticize lack and failure of the worldwide economic cooperation as established at the present time and to identify a list of specific proposals for its future improvement. That project led to the writing of a report (2011) where there are many ameliorative actions, as for example the one concerning the topic *"Maximizing the Value of the Social Innovation and Enterprise*". This action recognises the value of social enterprises in the producing and selling/provision of goods/service deriving from the possession of a specific *know-how*, a better ability in working within social field compared to the public authorities, and a greater sustainability of their business model due also to their ability in developing and using workforce at local level. In the same report it is contained another proposal to highlight the importance of the topic "social innovation", or that one related to "*The Global Social Competitiveness Index*". The index wants to measure and assess countries according to the effectiveness of their law, tax, and cultural system from the social innovation perspective, aiming to highlight the ability of a country in deal with social and environmental issues to the policy makers and to identify actions in order to improve this ability through case studies.

[15] The more complete definition of "social enterprise" is the one develop by Emes – European Research Network at the end of the 90's. The definition is following two main dimensions: the economic and entrepreneurial one and the social one. Four criteria reflect the economic and entrepreneurial dimensions of social enterprises: (I) a continuous activity producing goods and/or selling services; (II) a high degree of autonomy; (III) a significant level of economic risk;; (IV) a minimum amount of paid work. Five other indicators encapsulate the social dimensions of such enterprises: (I) an explicit aim to benefit the community; (II) an initiative launched by a group of citizens; (III) a decision-making power not based on capital ownership; (IV) a participatory nature, which involves various parties affected by the activity; (V) a limited profit distribution (Borzaga, 2010).

business as well as the possibility of combining economic objectives (i.e. efficiency and effectiveness) with social purposes, can allow a wider change in the way they interpret the citizens' needs and as a result provide solutions. Indeed, MBSs who understand the potential of the social enterprise are becoming increasingly frequent but also, perhaps, of the whole non-profit sector and encourage and promote forms of *social entrepreneurship*, for example through the establishment of cooperatives and buying groups (*gruppi d'acquisto,* or GAS) in order to save costs and improve members' life quality. That is we are facing the construction of an action of strengthening and encouragement "from the non-profit sector to the non-profit sector", or the development of close cooperation between the various types of non-profit institutions in order to reach a stable and lasting growth within the national welfare system.

According to this perspective, also the analysis of the MBSs action confirms the existence of an effort for assuming a more prominent institutional role in the health care field. At the same time, the necessity in giving a suitable answer to much more growing and diverse needs defines new potential field of action for MBSs (i.e., healthcare, dentistry, etc.).

In the following part of the paper, it will be analysed the topic of outside relationships of MBSs, particularly those aspects that allow the creation of institutional added value.

3.4.1. The creation of social capital

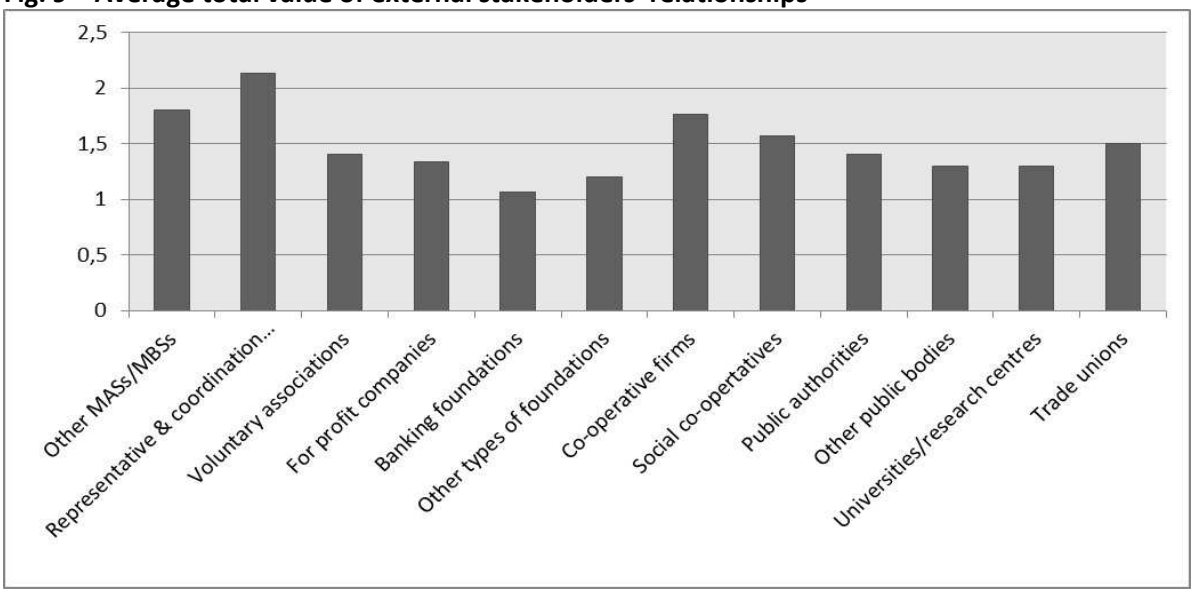
The degree of external relationships is an index of the relations between MBS and external stakeholders, or with the following institutional categories: other MASs/MBSs, representative and coordination agencies, voluntary associations, for-profit companies, banking foundations, other types of foundations, cooperative firms, social cooperatives, public authorities, other public agencies, Universities/research centres, and trade unions.

Relations with other institutions can also be distinguished according to the type of relationship (economic-financial, training, and planning) as well as to their frequency (no relationships, occasional or continuous ones). In order to evaluate the intensity of these relations, it has been asked to MBSs to assign a value equal to: 1 if the relationship is non-existent, 2 if the relationship is occasional, and 3 when it is continuous. Figure 9 highlights an average total value obtained adding together the three types of relationships (economic-financial, training, and planning).

According to the survey, relationship between MBSs and external stakeholders are often very limited and sporadic and, particularly concerning relations with economic-financial and training goals, most say they do not really establish contacts with external stakeholders (respectively 64% and 82%) (Table 3).

It is relevant to emphasise the evidence emerged from the analysis of data concerning relationships with Third sector external stakeholders (other MASs/MBSs, representative and coordination agencies, voluntary associations, banking foundations, other types of foundations, social co-operatives). Actually, if, from the one hand, the percentages of relationships established for economic-financial and training goals are not dissimilar to those totals abovementioned, on the other hand, data on the existing relations for planning purposes indicate a higher percentage of continuative relationships (36%) (Table 4).

Fig. 9 – Average total value of external stakeholders' relationships



Source: our elaboration on survey data

Tab. 3 – Relationships among MBSs and external stakeholders

Economic-financial relationships	***No***	***64%***
	Occasional	16%
	Continuous	19%
	Total	*100%*
Training relationships	***No***	***82%***
	Occasional	16%
	Continuous	2%
	Total	*100%*
Planning relationships	No	47%
	Occasional	***29%***
	Continuous	***24%***
	Total	*100%*

Source: our elaboration on survey data

Tab. 4 – Relationships among MBSs and Third sector organisations

Economic-financial relationships	***No***	***66%***
	Occasional	16%
	Continuous	18%
	Total	*100%*
Training relationships	***No***	***86%***
	Occasional	10%
	Continuous	4%
	Total	*100%*
Planning relationships	No	43%
	Occasional	***21%***
	Continuous	***36%***
	Total	*100%*

Source: our elaboration on survey data

Therefore, MBSs weave continuative relationships for *planning* purposes particularly with other MASs/MBSs (70%), with representative and coordination agencies (78%) and social co-operatives (33%)[16] (Table 5). Occasional relationships with voluntary associations are also largely established (44%), while in most cases are not established relationships with banking foundations or other types of foundations.

Over the relationships with the Third sector, only data on relationships with co-operative firms (for economic-financial and planning purposes) is relevant. MBSs build on average occasional relationships with these actors. An explanation could be that those actors are actually closer than others (for example, for profit firms) to values and characteristics of the identity of MBSs.

Tab. 5 – Planning relationships among MBSs and Third sector organisations

With other MASs/MBSs	No	20%
	Occasional	10%
	Continuous	***70%***
	Total	*100%*
With representative and coordination agencies	No	22%
	Occasional	0%
	Continuous	***78%***
	Total	*100%*
With voluntary associations	***No***	***44%***
	Occasional	***44%***
	Continuous	11%
	Total	*100%*
With banking foundations	***No***	***88%***
	Occasional	13%
	Continuous	0%
	Total	*100%*
With other types of foundations	***No***	***75%***
	Occasional	13%
	Continuous	13%
	Total	*100%*
With social co-operatives	No	22%
	Occasional	***44%***
	Continuous	***33%***
	Total	*100%*

Source: our elaboration on survey data

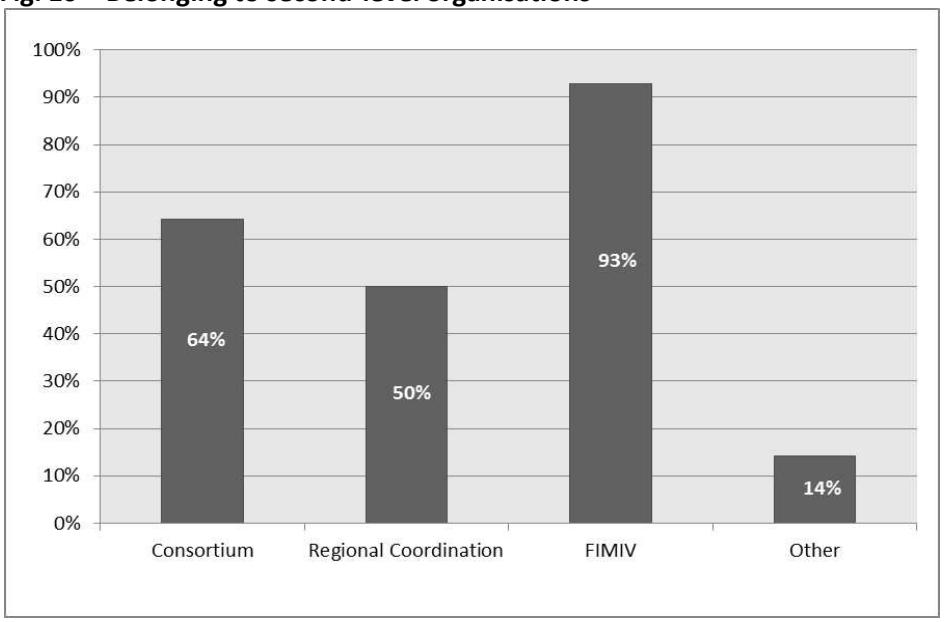
Furthermore survey data, in the last years as well as in most recent months, in Italy it has been started a series of projects and experiences that highlighting a great interest in strengthening and improving the relationships with other institutions of Third sector by MBSs as well as in developing new growth paths. These first interesting experiences are forceful examples of how it is possible to start a transformation process of welfare systems giving effective answers through citizens' self-organised solutions.

Belonging to second-level organisations indicates an even more precise ability and willingness of MBSs to be part of a network of actors, belonging to the same sphere or field

[16] In the case of social co-operatives is right to point out as largest percentage (44%) of MBSs reports to have occasional relationships with these actors rather than continuous.

of action or homogeneous geographical location. The actors of this network are able to talk to each other as well as with stakeholders outside the network, such as public authorities, thus going to raise their level of incidence regarding policies of interest to be implemented, and the ability to increase their weight within the landscape in supplementary health field by managing supplementary health funds. The 93% of MBSs are part of second-level organisations. Specifically, the highest percentage (93%) is member of the Italian Federation of MBSs (Federazione Italiana della Mutualità Integrativa, or FIMIV) and a 64% to a consortium (e.g., the Consortium of MBSs, or "Consorzio Mu.Sa.") (Figure 10). The lowest proportion of membership to a Regional Coordination is justified by the fact that not in all Regions there is this kind of organisation. As in general, the Regional Coordination is an association acting in promoting and protecting the historical, cultural and solidarity legacy of associated MBSs, it is possible to affirm that, while, on the one hand, through FIMIV and Consortium Mu.Sa. feeds the bargaining power and the role of the manifold of needs and, therefore, of health and healthcare demand, on the other side it seems to be relatively weak - due to less diffusion of Regional Coordination - the ability of MBSs to protect their original features concerning identity and mutual culture by second-level organisations.

Fig. 10 – Belonging to second-level organisations



Source: our elaboration on survey data

Overall, the added value of MBSs is today particularly based on their distinctive ability to build internal relationships – both with their members and with their staff. This is based on trust as well as on shared values and identity issues feeding the sense of belonging to the institution where they are members/staff, also over the inevitable generational shifts.

The sustainability of MBSs' activities is the theme that expands the concept of internal responsibility (in terms both of rights and duties) to the outside, or opening to the community of reference and to the whole society, particularly in relation to the current changes in the national welfare system (transition from "welfare state" to "welfare community"). According to survey data, this aspect must be continuously and strategically enhanced and structured.

In this context, the ability in generating more responsible (and, consequently, more effective and efficient) behaviours is the discriminating factor with regard to other institutions that have overlapping activities of MBSs. In this sense, the fundamental guarantee is to set up memberships founded on relationships based on trust in order to protect a substantial (relational) asset as the health.

CONCLUSIONS

Dealing with the dramatic financial and qualitative problems of the welfare state, Italy has chosen a multi-pillar restructuring in health as well as in social security, where private expenditure is invited to convey various forms of collective mutuality able to share more efficiently and fairly risk management. The direction taken is the one of a division of responsibilities between public and supplementary private system, where the latter is still highly regulated in order to create a complementary network to the public system that shares the features of solidarity. Assuming this new perspective, the State continues to pursue the constitutional protection of health as well as, at the same time, defining its financial and managerial commitment to a predefined threshold, beyond which organised initiative of workers and citizens is delegated to carry out a subsidiary integration. This is clearly a huge cultural change in which the society, used to a universal health system for over thirty years, must have time to adapt (Bonfanti, 2006). However it is clear that the development of a second pillar could also affect the relationship between public and private providers in health. In the light of these problems, the main requirement is to define new and effective welfare policies, aimed particularly at the overcoming of the crisis of the dual model State-market.

For a long time, it referred to a concept of happiness and well-being fully identified with the increased individual wealth and the “welfare society” embodied the idea that the increase of economic wealth and consumption levels would be translated in the growth of the degree of happiness (both of the individual and of the whole society) (Venturi and Villani, 2010).

One of main interesting dimensions to the new concept of welfare (or rather of well-being) in advanced societies is the quality of relationships.

The main trend of our society is to replace personal relationships with positional goods, that is connected to the status of their owners. The time taken to social relations isolate the person with extreme consequences (the so-called “relational poverty traps”).

This is the framework where MBSs could contextualise as part of the wider concept of Civil Economy, the development of which creates the conditions for a most common well-being. In fact, it focuses on the question of an equitable distribution of resources and outcomes of increased productivity, as well as the relational dimension of social and economic action.

Among the many issues that the on-going transformation of the welfare state should shed particular light on is what and how much space is attribute to the user of social services. The figure of the citizen-consumer means that the welfare system acknowledges to subjects – both individual and collective – the ability that allows them to become active partners in the process of planning interventions and in the adoption of subsequent strategic choices.

This, in turn, requires that civil society should organise itself properly if it wants to find a way to convert the practical needs of a supply of services respectful of personal autonomy.

In this context, the contribution of Civil Economy emerges in the production and enhancement of social capital. Civil Economy organisations act on both sides: on the supply side and on the demand side, allowing it to structure and organise itself to speak on their own with the supply-side subjects. The aim is to affirm that activities provided in the processes of social reproduction also affect the production of “meanings” and not just of outputs.

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