

Governance for a “socialised economy”.
A case study in preventive health and work integration

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Governance for a “socialised economy”.

A case study in preventive health and work integration

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Abstract

This work is motivated by the question of how organisational governance can address the needs of vulnerable groups. This paper offers a conceptual reflection on how the production of complex health-related services, such as aspects of preventive psychiatric illnesses, can be governed to the benefit of users and communities society more broadly. The analysis is applied to a consortium of twenty-two social enterprises (SEs), with worker membership, located in Italy. The governance model adopted by the consortium is of particular interest since it pioneered solutions based on the combination of preventive health and work integration services. The case, specifically, allows to illustrate and analyse interdependencies amongst multiple publics, and how these are reflected by the governance model. Specifically, the findings suggest that central to the success of the model in meeting such challenges are: a) the integration of different but complementary organisations and competencies, including health, social, and production competences; b) a mix of interdependent governance solutions, each activating different types of publics and social capital; c) membership, through which workers partake in decision-making; d) formal fiduciary duties between vulnerable publics and members complemented by bonding and bridging social relations; e) the integration of community assets as inputs into the process, and the creation of societal outputs in terms of employment, social integration and cohesion.

Keywords

Welfare services; Social enterprise; Governance; Social capital

JEL codes

I14; J14; L23; L31; O35

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1. Introduction

Interventions that address social inequalities and enhance social cohesion have been recognised as relevant ways for promoting people wellbeing and, in particular, it has been acknowledged that initiatives that reduce the marginalisation of vulnerable groups can help the prevention of mental illness (Royal College of Psychiatrists, 2010). However, the modalities through which firm governance addresses marginalisation and excluded groups have not been fully researched to date. For this reason, this paper offers a conceptual reflection on how the production of complex health-related services, such as aspects preventive psychiatric illnesses, can be governed to the benefit of users and communities more broadly.

The analysis is applied to the consortium In Concerto. This is a consortium of twenty-two social cooperatives located in the Veneto Region, Italy. The case is of particular interest in that it highlights how specific types of enterprises can meet the challenges of marginalisation, such as social exclusion related to mental illness. The governance model adopted by the consortium pioneered solutions based on the combination of preventive health and work integration services, and has subsequently informed regional social policy in the area. The case, specifically, illustrates interdependencies amongst multiple publics, and how these can be reflected in the governance model. Specifically, the findings suggest that central to the success of the model in meeting such challenges is a mix of interdependent governance solutions, each activating different types of publics and social capital.

But why talking of multiple publics? In 1927, one of the main thinkers of American pragmatism, John Dewey, wrote *The public and its problems*, a very influential book on the issues of political democracy. His analysis insists on the interconnectedness of multiple communities of interest, which he calls “publics”, who have little awareness of the influences that decisions taken elsewhere have on their own interests. Social problems, therefore, would originate from a participatory deficit or marginalisation, which prevents the excluded publics from contributing to decisions and use their “creative intelligence”. As a solution, Dewey specifically talks of creating institutions for the inclusion of publics in deliberative processes, thus improving the legitimacy of answers and the life experience of those included.

A number of articles published in psychiatry evidence that there is a connection between mental health problems and socially marginalised groups (such as black and ethnic minorities, lesbian, gay, bisexual and transgender groups, people with intellectual disabilities, immigrants) (Emerson and Hatton, 2007; King et al., 2008; Kirkbride et al., 2008). Stigmatisation and discrimination amongst these groups can induce a higher prevalence of mental problems than in the general population. This can start a vicious cycle, increasing social discrimination and marginalisation further, and resulting in

inappropriate access to healthcare, lack of understanding and unsuitable medical treatment (Bhui and Dinos, 2011).

One way of furthering inclusion of otherwise marginalised publics is, on a practical level, to engage them with an active role and beyond medical treatment. For example, for some psychiatric pathologies, the prevention of recurring illness requires the realisation of specific material conditions for the patient, such as having a social life, engaging with a motivating environment, reaching a good degree of autonomy and self-determination. This contrasts with a traditional public healthcare, which focuses mainly on the medical supply side (Bandura, 2004). It also contrasts with the charitable approach, which is not aimed at the autonomy of beneficiaries.

Following from Dewey's analysis, management and organisation theory has developed stakeholder-based approaches to the inclusion of marginalised categories, as in Freeman's early work (Freeman, 1984). Within this literature, various methods, approaches and applications have been developed. Stakeholder theory identifies the normative, instrumental and descriptive elements in support of stakeholder involvement in firms' decisions and operations (Donaldson and Preston, 1995). In parallel, stakeholder analysis aims at identifying and prioritising individual, groups and organisations that can be part of an issue or phenomenon (Reed et al., 2009). The vast literature developed on stakeholder theory and analysis over the last 30 years has contributed to bring to the forefront of firm studies the issue of how organisations can fulfil their obligations towards a plurality of groups, organisations, and individuals. Institutional scholars, especially, have inquired on how inclusion would impact and modify firm governance, or how concern for a wide set of interests can be reflected in the working rules and decision making processes of the firm (Sacconi, 2012; Sacchetti, 2015).

This contribution widens the theoretical perspective by considering organizations that do not pursue commercial objectives in a dominant way. A particular form of organisation, called the social enterprise (SE), does not maximise profits as a norm, and adds the social dimension as new fundamental element in the operation and aims of the organization. The presence and of the desired societal effects (i.e. the reduction of marginalisation) can therefore be studied starting from its implications for control rights and governance. This study develops a descriptive approach to governance, analysing the organisations that provide health-related services with respect to who is included, according to what criteria, and to partake in what (Bobbio, 1977; Ostrom, 1990).

Social enterprises (SEs) have spread over the last two decades, receiving attention from scholars and policy makers alike for their capacity to respond to the challenges of marginalisation innovatively. In the case of psychiatric illness or other forms of disadvantage that may eventually lead to illness, the approach tends to be centred on creating the conditions for health and well-being through work integration and socialisation. These entrepreneurial solutions aim at enabling the beneficiary to achieve emotional autonomy and employability through learning and socialisation. Rehabilitation

activities lead then to work integration in production activities. This “trail” is complementary but also very different from what preventive medicine can offer, and it necessitates different competencies and governance structures.

Conceptually, the paper refers to the common elements that have emerged within the inclusive and cooperative governance debate developed by scholars of the “strategic governance” approach (Cowling and Sugden, 1998; Sacchetti and Sugden, 2003; Cowling and Thomlinson, 2011 to name some), as well as by a number of social enterprise and cooperative firm scholars (Ben-Ner and Van Hoomissen, 1991; Hansmann, 1996; Borzaga and Defourny, 2001; Borzaga and Tortia, 2010; Sacconi, 2013 amongst others). These authors take the view that firm governance is an important consideration for marginalised groups since its key unit of analysis is the capability of these actors to participate in strategic decision-making processes (such as investment, employment, surplus distribution) that affect their own direction and life experience (Cowling and Sugden, 1999; Sacchetti, Sacchetti and Sudgen, 2009). What follows is that governance—or the structures and processes that define who decides what and how—can serve community welfare objectives if its processes and structures recognise interdependencies amongst multiple publics (Ben-Ner and Van Hoomissen, 1991; Leviten-Reid and Fairbairn, 2011; Borzaga and Sacchetti, 2015; Fulton, Pohler and Fairbairn, 2015). In our case publics are vulnerable groups and their families, ordinary workers, clients, public administrations, who have interdependent needs and interests and are interconnected through the production and use of health-related and work-integration services.

The justification for recognising such interdependencies is in the individual and collective advantages that derive from inclusion, such as the potential to integrate tacit knowledge from various publics, foster creativity, increase effectiveness, trust and lower internal costs (Leviten-Reid and Fairbairn, 2011; Sacchetti and Tortia, 2013; Borzaga and Sacchetti, 2015). Formally, interdependencies can be reflected in the nature and composition of membership, for example in the identification of who should be included in partaking results, decisions and in electing directors (Hansmann, 1996; Borzaga and Sacchetti, 2015). Likewise interdependencies can be taken into account with the institution of a multiple fiduciary relation by which users’ welfare is pursued by trustees (members and directors) through a fiduciary relation with other publics who are not formal members in the organisation (Sacconi, 2013). The approach has developed in opposition to governance models where strategic decision-making power is concentrated in the hands of restricted and exclusive groups thus leading to a failure in addressing the needs of the excluded publics and society more broadly (Dewey, 1927; Cowling and Sugden, 1998; Sacchetti, 2015).

A close and complementary view to the idea of interdependences and inclusive governance is social capital, which was developed by other scholars, to name some Granovetter (1983), Portes (2000), Putnam (2000), Woolcock (2001). Woolcock (2001: 13) suggests that “social capital refers to the norms and networks that facilitate collective action”. Such norms have been associated with cooperation, trust, and reciprocity of

behaviours. In this sense, a social capital approach contributes to understand how inclusive governance can be instrumental to enhancing the potential for collective action, i.e. action that includes a multiplicity of publics and ultimately benefits society overall.

Taking the consortium as the context for analysis, this work asks to what extent production governance solutions are conceived to address the needs of the most vulnerable categories, focusing mostly on psychiatric users. But we also ask to what extent these solutions have the capacity to activate broader processes of resource socialisation, which benefit not only the marginalised publics, but society more broadly.

Through the consortium case study, this work researches:

- (i) The interdependencies amongst publics in health and social care,
- (ii) How publics are engaged at governance levels,
- (iii) How governance solutions create social capital and benefit publics and society more broadly.

2. The social enterprise model

Integrated approaches to pathologies that carry a social stigma (such as psychiatric illness) or to marginalisation more broadly incorporate both social and health elements. Prevention, specifically, addresses at the same time the life experience of each individual and the need for cure and care. The direct implication is that solutions (whether public or private) need to provide a stable structure and path, whilst being capable of flexibility to address the specific needs of each and every person. The objective of offering personalised responses, therefore, justifies complex coordination systems between the suppliers and users of the services which ensure flexibility and, contemporarily, economic sustainability (Ben-Ner and Van Homissen, 1991; Pestoff, 2012). As mentioned, specific solutions have been developed by SEs. These are organisations which have an explicit social aim and, to achieve it, include in their statutory requirements a commitment to reinvest surplus (Borzaga and Tortia, 2010 amongst others). In particular, when addressing preventive health through social integration, SEs show a variety of distinguishing factors, such as the ability to provide innovative services, specific governance models, relational goods, social capital, and other tangible and intangible assets that would otherwise lose efficacy in the absence of SE organisations.

2.1 Innovative services

Sector studies have shown that SEs can provide innovative services with respect to public health. SEs have revealed a new paradigm with respect to what the public sector is equipped to offer to marginalised categories (Borzaga and Fazzi, 2014). In particular, in the European context SEs have introduced housing, training, psychological support and

work integration services for people with chronic pathologies, and for those with other difficulties that put them at a high risk of social exclusion, thus increasing the likelihood that they develop a medical condition (Almediom, 2005). Work integration social enterprises (WISEs), in particular, have approached prevention with a view to create the conditions for people with difficulties to have a salaried occupation paired, in some cooperative business forms, by membership and decision-making power. This has effects on the life experience of the person in terms, for example, of self-esteem and autonomy; and on society more broadly, by creating new jobs for ordinary workers, reducing social exclusion, income inequality, and welfare costs (for estimates, cf. Chiaf, 2013).

2.2 Governance models for engaging the publics

The inclusion of multiple interests has proved to require new governance and new service solutions, the two types of innovation being strictly connected. We could say that—as in other sectors of the economy—in health-related and social services the most important innovation is not technological, but organisational (Chandler, 1962; Marglin, 1974). The participatory requirement of preventive health, in particular, create the conditions for questioning the pyramidal hierarchy of the modern organisation (whether ownership is public or private) and substitute it with a heterarchy of multiple and active actors, more consistently, also in terms of production organisation, with craft production where master, apprentice and client can interact at different levels along the process.

SEs have over time developed a variety governance solutions, which can be more or less participatory (Cornforth and Spear, 2010). Because of the social remit of these organisations, governance solutions can be assessed with respect to their capacity to enhance the interests of vulnerable beneficiaries, other relevant publics (such as ordinary workers, volunteers, families of beneficiaries), and the collective interest more broadly.

When multiple publics and needs are at stake, however, a situation of “stakeholder ambiguity” can arise (Billis and Glennester, 1998: 86). The problem of furthering the needs of multiple publics occurs especially when the groups holding control rights, e.g. workers and volunteers or a mix of multiple stakeholders including donors and other social organisations, do not include the most vulnerable public (e.g. psychiatric patients or people with other disadvantages, such as the elderly, young people, and so on). In this case, the problem—as Sacconi (2013) puts it—is one of settling a “multiple fiduciary governance”, which requires a “social contract” amongst the publics affected (cf. also Donaldson, 1982; Brummer, 1991). In the case of SE, the social contract is embedded in the wide societal responsibility and social remit of the organisation. This remit is applied in practice through a non-distribution and reinvestment requirement, which in many European countries is normally identified by law. It follows that, because of the social remit, control rights can be given to the publics who can govern most efficiently, even in the presence of information asymmetries between the provider and the beneficiary (as in Hansmann, 1987). In other words, albeit not all the effected publics have membership,

those who do retain legitimisation only if they abide to the social pact of furthering the good of the most vulnerable ones, besides their own welfare and that of others (Sacconi, 2013). From this perspective, theory suggests that the “social pact” countervails agency problems that may arise between the members and the publics who do not have control rights.

2.3 Relational goods and social capital

Governance delineates the rights and obligations of one or more publics who hold membership in the enterprise producing the service. However, as Held (1977) and Baier (1988) have suggested, formal governance does not address fully how people interact with each other, what motivates them and how the relation of interdependence and cooperation unfolds between actors. It does not explain aspects of engagement amongst the publics, nor their commitment in the “mutual pursuit of mutual feelings and values” (Held, 1977: 742). Rather than occupying a marginal role, therefore, bonds of affective nature can reveal how persons from each public may experience interactions and, overall, their rehabilitation and work experience. Gui (2000) calls goods of affective nature “relational goods”. “Relational goods” are intangible elements characterised by communicative and affective nature, produced through encounters and interactions. In work-integration social enterprises, for example, the production of relational goods occurs in the day-to-day relation between beneficiaries, ordinary workers, and volunteers.

In this context, relations based on mutual concern and respect “may lead to the creation of a social bond which itself has a value” (Held, 1977: 743). Such value has been recognised by social capital theory, for which social capital is understood as the norms and networks that allow actors to act collectively and generate value for communities (Woolcock, 2001). The relevance of social capital with respect to preventive health, for example, has been confirmed by Szreter and Woolcock (2004). Specifically, social capital has been argued to play an enabling role, thus benefiting life satisfaction, health and overall social cohesion (Folland, 2007). It does so in three ways, by bonding, bridging and linking. Bonding and bridging social capital are the first and most immediate forms of social capital. Bonding identifies strong bonds between people who are alike “in important respects”, such as family and close friends (Putnam, 2002: 11). Bridging social capital is characterised by weaker, less dense but more cross-cutting ties, such as links with colleagues, acquaintances, or with other groups (ibid.). A third form is “linking social capital” and is characterised by “relationships between people who are interacting across explicit, formal, or institutionalised power or authority gradients in society” (Szreter and Woolcock, 2004: 655), such as connections between those with differing levels of power or status, e.g. between public administrators and other community groups.

2.4 Additional resources

Through mobilisation of social capital, social enterprises can raise immaterial resources such as the motivation, knowledge and ideas of people of people from the community. Research has evidenced that idealism, the will to help vulnerable publics or to help the collectivity more broadly is what motivates social workers (Rose-Ackerman, 1996; Light, 2004; Minkoff and Powell, 2006; Smith and Shields, 2013). The mobilisation of pro-social motivations and specific knowledge is especially key for health-related services that are non-standardised and require a personal relation with the user (Borzaga and Depedri, 2005; Griffiths and Woods, 2009; O’ Donovan, Doody and Lyons, 2013).

SSE organisations also leverage endogenous resources by reinvesting the surplus produced in the community whilst attracting assets from the public sector (for example dismissed spaces that require regeneration), or from the banking system at times when the public sector is not in a position to start new investments due to debt constraints.

3. Background and methodology

The consortium In Concerto was founded in 2002 by a former trade unionist, in the Veneto region of Italy. The first social enterprise was created in 1991, at the time the first national law on social cooperation was approved. For the law:

“Social cooperatives are intended to pursue the general interest of the community to human promotion and social integration of citizens through:

- (a) the management of social, health and educational services;
- (b) carrying out various activities—agricultural, industrial, commercial or services—aimed at providing employment for disadvantaged persons”.

(Parlamento Italiano, L. 381/1991; Art. 1, translated by the author).

The law provided the framework for the development of new social entrepreneurial initiatives with cooperative membership, and are therefore called “social cooperatives”. A process of constant growth, driven by reinvestment, followed. In 2002 the consortium brought together into an integrated production system all the enterprise spin offs created since 1991. At present, 22 social enterprises are members of the consortium, which spread between two municipalities of 35,000 and 17,000 inhabitants. The social enterprises address a variety of societal goals, from elderly care, to housing, to rehabilitation of psychiatric patients (in the Italian law, these are identified as “A-type” social cooperatives), as well as work integration in manufacturing, agricultural or service activities (called “B-type” social cooperatives).

The first social cooperative was a care home for the elderly. Since then, this activity has always produced economic value, and the surplus was reinvested to create new social enterprises that could address the needs or other marginalised publics, such as psychiatric

patients and individuals at risk of marginalisation more generally, through A-type and B-type cooperatives.

Today, whilst elderly care continues to be a profitable activity, the targeted groups are mainly individuals with psychiatric conditions, and more recently it has extended to so-called “new poverties,” i.e. people with very low household income including former prisoners, unemployed over 50 years old, single parents, and immigrants (interview 1). The consortium and its social enterprises employ over 1,300 workers, of which 30 per cent belong to certified disadvantaged groups.

Through the strict coordination between A-type and B-type enterprises, preventive health services and work integration occur in two modes.

The first is rehabilitation and professional training, partly subsidised by public administrations (A-type cooperative). People with a disadvantage go through a first integration phase reinforcing their emotional autonomy, their confidence, and work skills, combined with the possibility to move into a work-integration environment, which is at all effects a production business in manufacturing, agriculture, or other maintenance services (B-type cooperative). Protected accommodation is provided, if needed, by an A-type housing cooperative within the consortium.

The second modality is reliance on permanent, membership-based, salaried job, which is all self-sustained (B-type). Because of the cooperative form, all the enterprises in the consortium allow for worker membership. Once beneficiaries complete a rehabilitation route in a A-type cooperative, they can be hired in a B-type, where they become also members with the same statutory rights of other ordinary members. The aim, through membership and wage, is economic autonomy for the vulnerable groups.

Given this background, the intention, with this work, was to study the governance model of the consortium, its innovative elements, and understand how this addresses the needs of the disadvantaged. The consortium was chosen because of the variety of publics involved and the richness of its governance and relational model. Another distinct feature is that the approach to rehabilitation privileges users’ active role in production, and aims at being independent of public subsidies.

The case study has been developed using qualitative methods, and using primary and secondary sources. A series of 12 on-site semi-structured interviews was conducted by the author mainly in July 2016, albeit the founder was interviewed a year earlier, before he retired. Interviews involved the founder, the current president of the consortium, the presidents of the two main cooperatives (these two coordinate health services and industrial production), and the president of one industrial cooperative. Visits have been conducted to B-type cooperatives, including an industrial laundry and a mechanical sector subcontractor. Visits took place in A-type cooperatives, including a protected community, one agricultural cooperative with attached farm, restaurant, touristic accommodation facilities, craft and industrial rehabilitation laboratory (where the author stayed for five days whilst doing the interviews). Data have been collected also through interviews with

stakeholders, including one beneficiary, two volunteers, one worker member, one supplier, and a key public sector administrator who has been a historical partner of the consortium. Extensive, informal conversations (which were not recorded) were held also with Human Resources and Communication managers, who were also key players in selecting and scheduling the visits and interviews.

The goal of the interviews was to map the characteristics of the consortium, and specifically of its governance solutions. The intention was to understand how the broad fiduciary duty towards the most vulnerable publics was implemented through the governance and activities of the organisations and, overall, in the consortium. Complementary, interviews have addressed the relation of various actors with the organisation and their developmental experience in the context of the services provided by the organisation. Interviews were fully transcribed and then analysed alongside qualitative research practices (Yin, 1994; Bryman, 2008). Quotes reported in this work have been translated from Italian by the author. Secondary data included the documentation provided by the cooperatives, cooperative publications, budget reports, as well as extant quantitative research on the consortium. Further data were collected during a public event in 2015, during which a new industrial laundry plant was inaugurated (B-type cooperative).

4. Results

4.1 Production governance innovation

At the heart of the Consortium's production activities is a B-type cooperative which coordinates all production activities. This cooperative holds capital shares in most of A-type cooperatives and operates in strict cooperation with the main A-type cooperative, which also has a coordinating role but in the rehabilitative and preventive sector. Through these two main organisations, rehabilitation and work integration are harmonised, with the aim of providing continuity in the experience of beneficiaries (from user rehabilitation and emotional autonomy to work integration and economic autonomy).

It is in this sense that "*loosing the client*" was the motto of the founder, meaning that "*a A-type cooperative needs to show to the local health administration that the user ... is not retained to ensure a stable entry from the public health system... rather the cooperative does all it can to integrate the user in the labour market... [in this way] the cooperative becomes stronger since it shows that the rehabilitation model works. The more the 'clients' lost, the more the model becomes a reference point, and more 'clients' will come with new and more complex needs, which pushes the cooperative to improve rehabilitation solutions*" (interview 4).

Figure 1 illustrates the system. The main B-type cooperative, (which in Figure 1 is called “industrial coordinator”) would gather all the manufacturing demand from prime contractors outside the consortium, whilst the main A-type cooperative (which in Figure 1 is called “service coordinator”) would gather all the health-related and social service demand from public administrations. The industrial coordinator would then divide labour on the basis of the level of skills required for the contracted production. Very simple tasks are distributed to A-type cooperatives across the consortium, and used to undertake on-the-job training within day laboratories. These simple, and often repetitive, activities are used as part of the rehabilitation and training. Because the work at the laboratory is embedded in a broader production system, it gives (in the words of the founder) “*a sense of purpose*” to beneficiaries (interview 4). Differently, public day centres run by public authorities would use what we could call a “Penelope cloth approach.” Those who attended public day centres produced mostly small craftwork. But at night these crafts would be unravelled only to be rebuilt again the following day. A practice that to the eyes of the founder caused a deficit of meaning for the patients (which Johnsen, 2016 analyses in terms of “boredom”).

Within the day laboratory, beneficiaries do not receive a salary but a bursary. This has the function of rewarding commitment to rehabilitation. Half of the bursary is covered by the public sector, whilst the other half of the bursary is self-funded by the beneficiary through the value added produced at the laboratory. The outputs of day laboratories, rather than being dismantled every day, feed into B-type industrial cooperatives (interview 5). When introduced, this novel system allowed users to feel part of a broader production process. Users’ presence and commitment increased with respect to publicly-run day centres. Whether users went to the laboratory, every day mattered, since by not going they would hamper the activities of other workers. The idea was to encourage active participation and, ultimately, autonomy through work and responsibility, rather than stigmatising users as the passive recipients of assistance (interview 5).

Moreover, for the public sector the innovation reduced costs consistently, since the cost of day centres, per patient, was halved (interview 4).

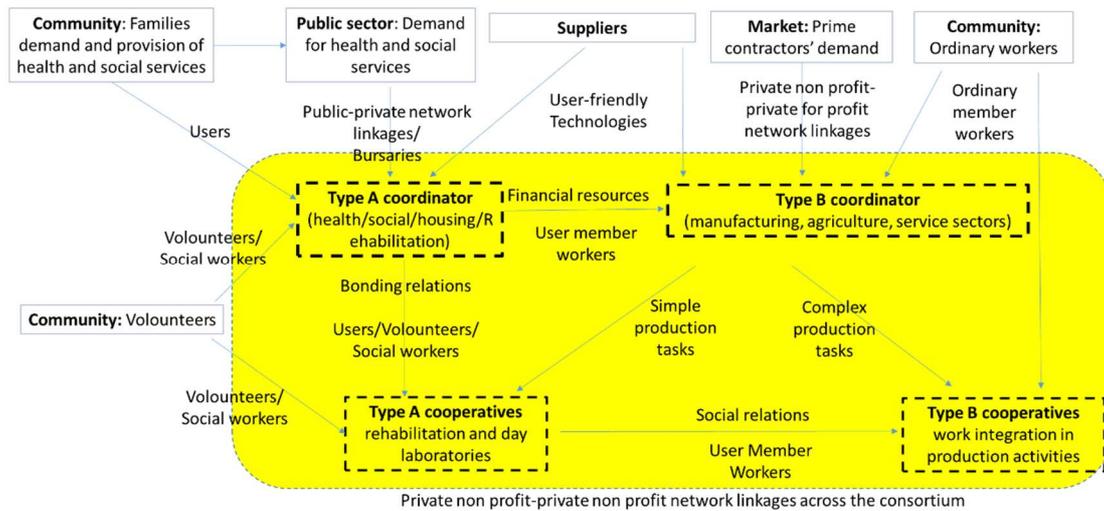
Complementary, the industrial coordinator distributes more complex production tasks to B-type cooperatives, where only users that have achieved good results are hired as workers and become members at all effects. Division of labour, in this interconnected system, is decided around the needs and abilities of the users and necessitates a high degree of integration and cooperation at system level.

Not all users’ needs, however, are met by engaging with the shop-floor; some would prefer other activities, such as those related to the cooperatives operating in agriculture and service provision. This include working open air in the orchards and fields on the hills surrounding the two municipalities, where the main A-type cooperative has dedicated “*a great commitment and a great partnership with the municipality, which has provided the land for twenty years, and where we [the main A-type cooperative] have re-*

qualified thirty hectares of land, revitalising local agriculture and planting traditional crops which had been abandoned... on these hills we are operating a re-valorisation of the territory”.

Other users would not find any benefit or interest in getting to an employability stage, and would be happy with being occupied in craft laboratories that are not directly connected with the production of B-type cooperatives. Crafting can motivate users also with important projects and the interaction with highly skilled volunteers, such as the construction of a 1930s airplane which was done over three years in collaboration with volunteers from the local aeronautic military division. Ambitious projects prompts users “to aspire at creating something really important, something that would seem impossible to realise...” (interview 1). Laboratories have been taken also to local school children “against the stigma and therefore prejudice” since “in reality, children do not have the prejudice that adults have, and therefore see the person as a little strange but do not judge her/him, they live the relation with ‘the diverse’ calmly and with serenity, ... adults are scared of psychiatric patients, but for children these people are the ‘maestri’ who taught them how to build and fly a kite at school or at the local festival...” (interview 1).

Figure 1 - The consortium integrated system



Note: The central box contains movements of resources within the consortium and its organisations. Other boxes identify the inputs coming from publics located in the wider community. Arrows identify flows of resources.

4.2 The consortium's "publics"

From rehabilitation and training in A-type cooperatives, through work integration in B-type cooperatives, the system was conceived for reaching the highest level of autonomy and self-determination of users, depending on each individual situation. It also strives towards economic independence from public subsidies, both by reducing the cost of the bursary granted to users in A-type cooperatives, and by being completely market oriented in the case of B-type cooperatives. The intention was to ensure a high degree of cooperation and coordination amongst all activities across A-type and B-type industrial cooperatives. This complex system aims at the welfare of users, but at the same time connects and spreads its effects to a number of other "publics," within and outside the consortium, as Figure 1 illustrates. Specifically, the consortium publics are:

- *Beneficiaries or users*

Depending on the nature of the business of the social enterprise, users can be people in working age with psychiatric conditions, as well as single parents, immigrants, and elderly people. Users start in A-type cooperatives and then can become employed by a B-type enterprise are at the same time users and workers, since they receive a work-integration service, whilst contributing to the production of value added for a salary, which coincides also with living in independent accommodations. The whole process is described by a user who says *"Now I'm coming to the end of my journey because in terms of work, when, say, you come to be hired as a worker you have reached the end, and you are also out. I still live in a protected flat, but I am moving out of the flat to get full autonomy in fact. Here, let's say I'm living the phase that is, say, almost the last. After I will be independent. I will always be in contact with the cooperative, but I will no longer talk to the social workers, I will make a living on my own, with a companion eventually"* (interview 11).

- *Ordinary workers*

Ordinary workers include social workers, health workers (nurses), blue and white collar workers. Here ordinary workers learn to share their tasks with users. They may be driven by contingent needs when they start, with no specific sensitivity towards users. As pointed out by one B-type cooperative worker, *"At first, as I think most of us, we needed a salary to live and so I found this job. I was fine because there were shifts, and I could combine family and work"* (interview 10). Motivation however can change as ordinary workers interact with users: *"However, after it gets to your bones. Because it is not a normal job, in quotation marks. In the sense that either you fall in love with it or you leave... I had better job opportunities than this; however, I was in love with this. Because it is not finished when you go home, it gives you so much"* (interview 10). Pro-social motivation played a critical role especially in the first years. For example, when the first cooperative of the consortium was born, capacity was created by recruiting highly motivated professionals (nurses who just graduated from the local nursing school) who shared the socially-oriented vision of the founder. Motivation was high and all employees self-

funded the social venture by renouncing to their own salary during the first three months of activity (they were then paid back later on) (interview 5).

- *Volunteers*

They come from the community, from associations in the volunteering sector or because they become aware of volunteering opportunities at the social events and festivals organised periodically by the main A-type cooperative. Volunteers operate mainly in A-type cooperatives. They bring their pro-social motivations and tend to share convivial moments, building affective bonds with users (interviews 6 and 7). Amongst volunteers, there are also skilled artisans. These have a different role and played an important role at start-up stage. They were called *maestri d'arte* (art masters). Art masters were early retired, highly skilled workers, who volunteered to teach and transfer their tacit production knowledge to new as well as to disadvantaged workers.

- *Families*

Families of people with difficulties, or elderlies. Families are have a double role: they provide direct care to their relatives, but they also demand for services from the social enterprises or from the public sector. For the social business and their consortium, it is therefore important to work in collaboration with families, with the aim of achieving service continuity over time (interview 1).

- *Supplier firms*

These are traditional for-profit businesses or other social enterprises that supply services, technologies, or intermediate products to the cooperatives forming the consortium. In work-integration cooperatives (B-type), the collaboration with for-profit suppliers (beyond the geographical region) includes the introduction of new technologies, which best fit with the different abilities of disadvantaged workers (interview 8). Some of the long-term collaborations have developed with other commercial suppliers, and have led to the patenting of technologies for work safety and occupational health (interview 9). This required a different way to conceive solutions. As a technology supplier points out: *“If the mission is inclusion, all that creates an obstacle to this is seen as a harmful element. Sometimes it was difficult even for me to understand that I was in a world where you had to, say, mediate on some things but also because the danger [in terms of work safety] was actually pretty low. However, I remember, pass me the term, one ‘discussion’ between me and [the founder] on these things, on an issue, which is the problem of the repeated movements of the upper limbs, that is, all those jobs requiring a high dexterity at a fast pace. I imagined technological solutions for this, and his answer [the founder’s] was disarming, if told in dialect it would sound better: ‘if I do this, of course I take away work from these people [users]. If they [users] need to do repetitive manual labour, then all that you are telling me is wrong’. ... We were in a world where I say ‘this is a dangerous job and therefore throw it away’, whilst he [the founder] says, ‘but this is my job, and if I cannot find repetitive work that they [users] can do, nobody else will do’. So*

I realized it was a way of thinking that was very different from what I had in mind but his answer was right, not mine” (interview 9).

- *Client organisations*

On the demand side, the consortium has contributed to establish partnerships with public health sector and with local government units, based on long-term contracts, quality of results, and trust relations. Differently, demand coming from commercial clients follow market trends and is therefore less stable.

Overall, in Italy, municipalities are the administrative units that are mostly involved in the local management of social services to communities. They are responsible for health and social policies, and for providing health and social services. Public administrative bodies¹ include three district health administrations and the social service department of the two main municipalities, besides the regional administration. To support their role, public administrations would buy social integration and rehabilitation activities from the main A-type cooperative. This requires a “*change in the mentality of public administrators*” and requires a commitment “*to change what has always been a subsidy mentality, and stop doing charity which provides an immediate answer but generates nothing. Even worse, perhaps, it creates a sort of dependence, of assistentialism rather than transforming resources into opportunities, investments to create professional development pathways to try to revitalise people with involvement, engagement, respect for work and ultimately employment opportunities*” (interview 1). As in the past, public bodies design their policies together with the consortium, and it is from the consortium that they seem to derive new ideas. Several of the innovations introduced by the consortium were subsumed and funded through health administrations at regional level. When this happened, the consortium’s solutions are extended well beyond the municipalities borders. Moreover, the co-determination of services with public administrations allows the cooperatives of the consortium to make investment decisions consistently with future demand and with the emergent needs of the community.

Complementary, demand for B-type cooperatives comes from seventy private organisations. “Clients” can be other social businesses, (e.g. a care home requiring services from the consortium industrial laundry) or traditional businesses in manufacturing who externalise semi-finished products, assembly work or services “*from electrical wiring and paper technology, lighting technology, assembly of coffee machines, gas burners, air conditioners.*” The main industrial innovation was “*to ensure flexibility of plants and make them interchangeable depending on the type of assembly work to be undertaken*” (interview 2). Workshop have very similar characteristics so that people can move according across plants depending on variations in demand and cyclicity. Client

¹ In 2010, each Italian municipality spent, on average, 118 EUR per person. Twenty-three per cent of these social welfare expenditures go to disabilities and include educational support, day centres, care homes, homecare. In the North of Italy, each person with disabilities benefits of an annual expenditure of 5,370 EUR (against 777 EUR in the South of Italy). Whilst public welfare funds for disabilities is increasing, those for the elderlies tend to decrease (Istat, 2014).

firms are mostly worried about the price and quality of the service. One client illustrated how when selecting a supplier “*no-one is excluded*” and that only those “*who work well would be retained, whether this is a social enterprise, a not-for-profit, or a limited company*” (interview 3). This requires to B-type cooperatives to perform at even higher levels than traditional organisations, given the additional complexity of work-integration that they face with respect to traditional enterprises.

4.3 The governance of individual social cooperatives

Organisational governance mirrors this highly interconnected production system by stressing collective and shared management of assets and decisions, both at the level of the single organisation and at the level of the consortium.

The 22 enterprises that form the consortium are member-based organisations where membership represents mainly workers. Members form the members’ assembly, which works following the simple democratic rule one-head-one vote. In A-type cooperatives, its composition comprises a majority of ordinary workers and volunteers. In B-type cooperatives, controlling members are workers (including users). In rare cases, the membership includes other social cooperatives, public administrations, non-member beneficiaries or donors. Each social cooperative has a *consiglio di amministrazione* (board of directors), which is elected by the assembly (Table 1). This is where strategic decisions are taken within each of the social cooperative, consistently with the consortium’s overall social aim. In no cases the board of directors includes representatives of external organisations. Public administrations are not included in boards, albeit in the case of A-type social cooperatives they are the main source of service demand. Each social cooperative is represented in the consortium by its president who is ultimately a representative of the assembly: “*The president of the board of directors is a vital organ, is the one that carries the board and is voted together with the board of directors. After three years, the president loses her/his role. The assembly vote the nine directors from an open list, so members who want sign up for election can. When the board is elected, then the nine directors vote for the president, who must be voted amongst the nine directors. That is, it is not that if I do not get votes ... if I am not amongst the nine, I cannot be voted as president. The president must be one of the elected, however one of those voted by the assembly. This process has a totally democratic openness*” (interview 8). One of the issues therefore is to enable members of the assembly to be potential candidates to the board. The president of one of the industrial cooperatives says: “*Anyone can sign up. We, currently, we are working to raise the competences of the membership. We are doing an awareness course (37 have registered) to accompany us to the next year, when the board of directors concludes its mandate. If one signs up must also understand duties and rights.... there must be a team ready to manage 10 million euros in revenue per year*” (interview 8). Still the fiduciary duty works between the directors and the president. For example, in strategic decisions, such as research and investment in new technologies: “*Now I have to make a purchase of a plant that is worth two million euros. I did ask for*

a mandate from the board of directors to start research, explaining that these new systems are vital for us at a time of growth. Now, we went in to see four plants in Spain, France and Germany and we worked hard for some time, until late at night, to understand the offers and the specifications of the most important technological equipment. Now, being able to get to explain to all nine directors why it's better this machine or another is hypocrisy. There must be an argument about trust..., after two months of work, I have to explain everything in details? But it would be difficult even for those directors who are most of the day in front of a machine to be able to ... I could embarrass them if I put the three quotes in front of them and ask: 'In your opinion, what is best?', I think it puts distress on people. So, the process should be run democratically, but with some intelligence. And this is a very thin line in Italy, this reasoning here, because, in fact, you can also approve an offer not for the sake of your cooperative. And this is all about being a serious administrator." Engagement however is not substituted by the presence of trust or of a fiduciary duty. Trust must be cultivated: "Trust is basic, fundamental, and I have to understand this element in order to receive it. But I also do not forget that I should not loose them [the other directors] along the way... because then ... you know, things do not always go well and you need to have them with you in good times and bad times" (interview 8).

Table 1 – Governance bodies composition

Aggregate membership composition across cooperatives	
Members	979 (100%)
Ordinary workers	72%
Disadvantaged workers	15.5%
Volunteers	5%
Other member organisations	36
Aggregate board of directors composition across cooperatives	
Workers	58
Volunteers	11

Source: Depedri (2016)

4.4 The governance of the consortium

The consortium is governed by its members, which are the 22 social cooperatives associated to it. Each enterprise is autonomous and it is free to exit if the members wish, albeit this option seems sunk, given the high degree of integration of the system. The consortium is governed through a board of directors (composed by the directors of each cooperative) and coordination is enhanced by the presence of thematic committees, each one representing one of the strategic areas of activity, namely agriculture, manufacturing, services. The founding president, now retired, has been recognised in many occasions as

a strong and creative leader and has been, since its incipit, the main reference point for the board. When recently a new president went into place, the cooperative members had recognised the need of reviving the democratic and participatory routes of the model (interviews 1, 2, 4, 8).

Collectively, the consortium manages a number of assets, with the aim of ensuring stability over time and financing new start-ups. Collective assets managed through the consortium are physical assets and a solidarity fund. First, physical assets are managed collectively through one “scope” organisation. This is a real estate cooperative that owns all the estates of the other social cooperatives in the consortium, so that none of the cooperatives owns the physical assets used (the industrial buildings). These are collectively managed. Secondly, the consortium has instituted a *Fondo di Solidarietà Consortile* (Consortium Solidarity Fund). This is an internal financial asset created in 2006 and managed collectively. Funds are raised by contributing 0.10 euro cents per hour worked across the consortium. *“Every year we collect 150 thousand euro ca. and the fund is for B-type cooperatives to use, essentially to finance new projects in existing enterprises or new enterprise development. It is devolved each year to one or more cooperatives to sustain development”* and job creation (interview 4). The fund has been used also to support B-type cooperatives in crisis and to “protect work”. The solidarity fund *“is another innovative tool, meaning that it goes through the fiduciary relation between each cooperative director and the president of the consortium, otherwise if one thinks ‘I always give but never receive anything back’... the story is over. Therefore, I pay money in because I know that it will be used to increase the capacity of the consortium through its cooperatives. Therefore the consortium is functional: it is strong because its cooperatives are strong”* (interview 4). Through reinvestment, funds are also leveraged from public administrations and a local cooperative bank on specific projects. The consortium has, in these respects, innovated its role and aims with respect to other consortiated experiences that focus on the provision of transversal services to their members (e.g. accounting and HR services, advocacy).

5. Analysis

5.1 The key elements of the system

The consortium addresses the challenges posed by the social integration of disadvantaged workers with a highly integrated system, which conjugates production organisation and organisational governance at various levels. The system has proved, so far, to ensure sustainability and continuity in the experience of users. Results suggest that the model is centred on the integration of interdependencies amongst the publics and on the sharing of societal “goods” at collective level, such as work, salary, relations, and the possibility to partake in decision-making. These “goods” are complementary to the medical treatment

that the public sector can provide and contribute to offer a life perspective through work and social integration. The key elements of the model, specifically, pertain:

- (a) *Cooperative structures*. This implies the use of a cooperative business model for each social enterprise, mainly with a worker membership. Boards of directors include representatives of workers and volunteers mainly. Through multiple cooperatives, the consortium addresses a variety of social needs and publics at the same time.
- (b) *“Socialisation” of surplus*. Each cooperative’s surplus is destined to the consortium common reserves and, over time, it was re-invested for the creation of new social cooperatives, which accrued the consortium up to 22 organisations. Long-term investments required an ability to create new start-up firms. It also compelled joint planning with public administrations on a long-term basis. Surplus reinvestment can be interpreted therefore as the dynamic element of the system. Through surplus reinvestment, new needs (and new publics) have been addressed over time. The main outcome has been the creation of occupational work for the disadvantaged and, through this, for ordinary workers in the community.
- (c) *Production and work as a “goods” to be shared*. Within the consortium, work is instrumental to rehabilitation and social integration. Work is the *trait d’union* amongst different typologies of workers. In this sense, work and salaries are “shared” between workers with diverse difficulties and ordinary workers. This involves sharing production amongst the members of the consortium, dividing the work between training and rehabilitation laboratories (A-type) and production (B-type).
- (d) *Sharing of “relational goods” and “relational wealth”*. Volunteers are the main tie between the beneficiaries and the wider community. Through volunteers, the consortium builds bonding social capital, based on affective relations or, more simply, bridging social capital for mutual learning purposes. Likewise, when beneficiaries are reintegrated in production with a salaried occupation, socialisation occurs through the relation between beneficiaries and other ordinary workers, building bridging social capital. Conviviality, the richness of relationships and opportunities to join are shared not only amongst the disadvantaged and ordinary workers within the organisation. They are extended to the whole community through engagement in collective events, festivals and celebrations that are organised regularly (interview 1). Together with the enhancement of participatory processes at governance level, the possibility to build relational goods facilitates the emergence of multiple perspectives and experiences, which represents a first step towards challenging habitual ways of thinking and doing things at broader societal level.
- (e) *Common Assets*. Cooperation across cooperatives is favoured by common norms and solidarity values, which are reflected in the creation of common consortium assets. These are managed collectively through a board formed by representatives of the 22 social enterprises. This furthers the interests of the weakest groups, workers, and

communities more broadly since common assets that cannot be disposed of individually by each cooperative.

- (f) *Systemic integration*. This is described by cooperation between the consortium, its federations, client and supplier organisations. It builds on complementarities and is generally aimed at increasing coordination along the social value chain of service provision. At this level, social capital defines how organisations link and work together to coordinate on the health and social services (linking social capital). Through the creation of linking social capital, the consortium promotes cooperative behaviours also outside the organisational borders, without the constraints imposed by profit maximisation, but with the aim of accruing collectively beneficial outcomes.

5.2 *The key governance levels*

The elements of the system can be observed, with varying intensities, at different and nested governance levels, which include the single cooperative, the consortium, and the health and social service system.

5.2.1 *Governance of the individual cooperative*

Individual cooperatives can be principally defined by their worker membership, albeit other publics are also involved (namely volunteers and other third sector organisations). The prevalence of worker membership ties in the idea of the valuing and “protecting work” as a way to improve health and prosperity through employment and membership rights.

In A-type cooperatives, beneficiaries are not worker members yet, but they are part of a project where work is the central “good” to be shared. This means that each beneficiary is not the passive recipient of assistance, but the active participant of a learning and rehabilitation project run mainly by worker members, with volunteers and other representatives from other third sector organisations. The governance of A-type cooperatives engages multiple publics to the extent that the fiduciary relation involves ordinary workers, volunteers and other social organisations. In A-type cooperatives, these publics retain control through the assembly, and have the right to elect directors and, indirectly, the president. Because of the social nature of the cooperative project, members understand that their authority is legitimised only if it is also instrumental to the benefit of vulnerable categories. This is the social contract with non-controlling publics (Flanningan, 1989; Sacconi, 2013). The fulfilment of the social contract towards the most vulnerable publics however goes also through the quality of relations nested into governance and production solutions that reinforce bonding social capital between beneficiaries and volunteers, or bridging social capital between beneficiaries and ordinary workers on the other.

In B-type cooperatives, then, beneficiaries become worker members, which means that they become part of the controlling publics. The governance of B-type cooperatives engages multiple publics to the extent that the fiduciary relation involve different publics within the same category (ordinary workers and workers with difficulties). B-type coordinator's statutory document, for example, states that "the cooperative pursues community welfare in partnership with public and private organisations, and that it does so by developing work opportunities to the best possible conditions for worker members" (translated by the author). The welfare of workers and that of beneficiaries have several points in common, since they are both worker members, albeit with different needs. The aim of furthering work conditions has been implemented also during the recent contraction of industrial demand. Directors exerted their fiduciary duty towards members by reallocating workers from cooperatives that had lost market contracts to those with higher levels of demand. These decisions are informed by positive reciprocity amongst ordinary workers and user-workers, who share the idea of searching their own welfare in conjunction with the welfare of others that, statutorily, hold equal positions.

5.2.2 Consortium governance

The multi-publics governance model occurs evidently at consortium level, featuring interactions based on reciprocity between multiple and non-homogeneous actors, which use a unitary organisational structure (the consortium). The continuity between rehabilitation and occupational work activates elements of bridging social capital between users and multiple types of publics within the same category, such as between ordinary workers in A-type cooperatives (these are typically social and health workers) and ordinary workers in B-type cooperatives (these are typically white and blue collar workers). Albeit sharing the same social obligation towards the benefit of the most vulnerable public, directors in A-type and B-type cooperatives have different conditions to meet. For one, A-type cooperatives must be competitive with other social cooperatives to meet public sector demand. On the other hand, B-type cooperatives compete with traditional enterprises, and are entirely subject to market dynamics. Deliberative processes that harmonise the respective needs and integrate strategies are therefore required. This is evidenced by institutionalised solutions applied to inter-sectorial coordination and for the accumulation and management of collective funds.

The social obligation towards the weakest groups and work more generally is maintained through the re-allocation of surplus from profitable cooperatives to the others. This is done through the rule of reciprocity. Reciprocity means that the cooperative who receives does not necessarily reciprocate the organisation who has given in the first place. For example, A-type cooperatives generate a surplus that is reinvested mostly in B-type cooperatives. A-type cooperatives, in fact, have an interest in the growth of work-integration activities, since that is where their beneficiaries aspire to be employed. The B-type cooperative who receives support reciprocates the A-type cooperative by ensuring the persistence of the work integration system, which, ultimately, benefits A-type cooperatives which can "loose the client". The overarching social aim of the consortium

allows A-type cooperatives (with ordinary worker membership) to support B-type cooperatives (with ordinary and disadvantaged worker membership) in growing overall occupational levels in the community, with a proportion, set by law, of one disadvantaged worker every three ordinary workers. Albeit the main B-type industrial cooperative drives production organisation, it is the main A-type service cooperative which drives and underpins the economic sustainability of the system and the fulfilment of the social contract towards the most vulnerable publics and work more broadly (Figure 1).

5.2.3 Systemic governance

Systemic governance is a form of inter-organisational governance where many centres of decision-making that are formally independent come to constitute, to different extents, an interdependent system of relations. Actors (not only organisations but also individuals and other community constituencies) who recognise reciprocal interdependencies enter in various contractual arrangements, as well as formal and informal cooperative undertakings (cf. also Ostrom, 2010 on polycentric governance). In the consortium, systemic governance is evidenced by the densely knitted relationships that connect A- and B-type cooperatives, as well as by the long-term interactions with client and supplier organisations outside the consortium, including public administrations, for-profit enterprises, other cooperatives and their federations. Federations, in particular, cover coordination along the social value chain, building on the common cultural roots of cooperation in the region. Such cooperative relations support long-term investments and planning. At this level, the governance of inter-organisational relations mobilises linking social capital amongst diverse territorial and extraterritorial actors. Together, the time horizon and the social capital favour innovation, improved processes and beneficial outcomes for the publics (cf. Sacchetti, Sacchetti and Sugden, 2009).

6. Concluding remarks

The consortium experience illustrates how the interests of vulnerable groups, such as psychiatric patients, and ultimately those of society more broadly can be enhanced through work integration. Applying rules of solidarity and reciprocity, the consortium coordinates production interdependencies so that vulnerable publics can become and be active participants who strive to reach autonomy and a decision-making role, whilst improving employment levels for communities overall.

Specifically, the findings suggest that central to the success of the model in meeting such challenges are a number of connected elements. First is the integration of different but complementary organisations and competencies, including health, social, and production competences. Secondly, the needs of marginalised groups are served with a mix of interdependent governance solutions, each activating different types of publics and social capital. Third, the model is based on membership, through which workers partake in

decision-making. Fourth, the model relies on formal fiduciary duties between vulnerable publics and members complemented by bonding and bridging social relations. Fifth, the model produces benefits for society overall through integration of community assets as inputs into the process, and the creation of societal outputs in terms of employment, social integration and cohesion.

Conceptually, the analysis points at a novel way to interpret governance, in terms of its capacity to activate collective and shared benefits, to mobilise economic resources, and social capital for the publics. As Edward Bellamy had argued at the end of the 19th century, the question is whether production solutions contribute to the socialisation of the economic system. In other words, we need to assess enterprise governance on the basis of its ability to mobilise publics, reinvest in the community, and promote a culture for which work, wage, and social relations are shared. This very last aspect raises a question on other consolidated concepts in economic theory, such as innovation, work and wage within a social economy context (and possibly beyond it). What is the meaning of production and innovation when the aim is not profit maximisation but rather one of enabling people; why wage is to be considered a cost when, instead, it represents a necessary outcome for the social integration and health of the people. These results support recent pleas from Borzaga, Ferri and Sabatini (2012) as well as Welter et al. (2016) who ask researchers to be more aware of organizational diversity and of the need to study how established explanations change when organisations give themselves structures and rules for the pursuit of societal aims.

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