

**Active Citizenship and Organisation of Local Welfare:
the Italian Case of the “Microareas” Programme**

Lavinia Bifulco, Massimo Bricocoli, Raffaele Monteleone*

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* Lavinia Bifulco is Associate Professor at Milano-Bicocca University. Postal address: Dipartimento di Sociologia e Ricerca Sociale, Università di Milano-Bicocca, via Bicocca degli Arcimboldi 8, 20136 Milano Italia. E-mail: lavinia.bifulco@unimib.it

Massimo Bricocoli is Assistant Professor at Politecnico di Milano. Postal address: DiAP Dipartimento di Architettura e Pianificazione, Politecnico di Milano, Via Bonardi, 3 – 20133 Milano Italia. E mail: massimo.bricocoli@polimi.it

Raffaele Monteleone is Contract Researcher at Milano-Bicocca University. Postal address: Dipartimento di Sociologia e Ricerca Sociale, Università di Milano-Bicocca, via Bicocca degli Arcimboldi 8, 20136 Milano Italia. E-mail: raffaele.monteleone@unimib.it

Introduction

As Borghi and Van Berkel (2007) point out, the emergency of the so-called “active welfare” in Europe is set between the change of the “substance” of policies and the change of their “operational” aspects, i.e. of “the way in which policies and services are organised, administered and delivered” (*ibidem*, p. 83). Along different trajectories, which reflect the national institutional contexts, since the 90s many European countries have started with reforms involving both sides of the change, thus redrawing the contents of the policies and their organisational structure.

The core of this double transforming movement is an interlacement of multi-interdependence factors: the development of the “neo-liberal” politics and of the public philosophies related thereto; the modernisation of the State, which mostly develops according to the model of New Public Management (NPM); the rationalisation or the reduction of public spending; the pressure exerted by European Union on the member States, dealing both with the respect of budgetary constraints and the harmonisation of policies.

This picture is neither univocal nor linear. On the contrary, it presents some well known ambiguities. First of all, the perspective of activation embraces disparate meanings and actual dynamics which are not always consistent with each other (Van Berkel, Møller, eds., 2002). Secondly, we need to consider the ambiguity of governance, as a *passe-partout* concept (Rhodes 2000; Newman 2001; Lafaye, 2000). As for the NPM model, its spread across the European countries is in fact articulated by disparate strategies, visions and directions (Pollitt, Bouckaert, 2000).

Our paper reports over a research work which is based on an Italian case-study, investigating the organisational logics wherever policies seek to promote conditions of “active citizenship”. In Friuli-Venezia Giulia Region (in the north-east of Italy), the reorganisation of health services has been the lever in order to consolidate social rights. We analyse a specific pilot programme which was launched two years ago in order to develop innovative practices in dealing with health policies and services. After outlining the main features of the national and regional context, we examine the case of the so called “Habitat-Microareas” programme in order to focus on practices promoting conditions of active citizenship. Some conclusions on organisation of local welfare and active citizenship are then discussed.

1. The Italian policy context

The ways Italy chose to enter the active welfare perspective – and its connected transformations – reflect the well-known mechanisms through which various and isomorphic pushes are filtered and adapted to specific institutional contexts. In comparison to other European countries, this perspective is less associated to the introduction of programmes and measures inspired to welfare-to-work. The reasons why the latter hardly asserts (despite a politically propitious climate) are to be found in the traditional configuration of the Italian welfare system, characterized by a high degree of familism (Saraceno, 1994) and by a scarce stateness (Ferrera, 1996). In this situation, partly still present, factors like the lack of a national system of income support (Paci, 2005) and the fragmentation of unemployment protection policies have stopped – more for reasons of feasibility than for evaluation of opportunities – the creation of organic connections between the two institutional spheres of social assistance and labour at a national level. An exception was the experimentation of the Minimum Income of Insertion (RMI)- a national measure which linked income support to social and job insertion- but, after four years, it was abandoned.

With respect to activation, Italy has had the occasion to try and transform the policies based on services, in particular social and health services. In general terms, the idea guiding recent transformations is to promote the role of individuals and local communities in the development of

well-being conditions. Despite this idea is not without ambiguities, it appears to encourage civil society and recipients' participation in designing services and putting them into practice.

This perspective was officially introduced by the national reform of social services passed in 2000 (law 328). In general terms, integration is its guiding idea and this is the reason why the reform entails a vast field of change including the setting of a new, organic and participated system of social services (Bifulco, Centemeri, forthcoming; Paci, 2005). In fact, the law aims at promoting the well-being of citizens through some basic services to be guaranteed across the entire national territory: to do that, it establishes LIVEAS, i.e. essential levels of social services. A new governance asset is redesigned allocating political-administrative responsibilities to State, Regions and Municipalities on a principle of vertical subsidiarity. Within this structure, the so-called "local welfare" is the meeting point of the two main axes of integration: a) the connection between social services and other relevant well-being services, in particular the health ones; b) the coordination of the various (institutional and non institutional) actors involved in governance of social policies. In this framework the *Piano di Zona* (Area Plan) works as a device aiming at developing a negotiating model of local governance: on the one hand, obliging the Municipalities to associate in order to plan a territorial system of social services; on the other one, pressing for a shared design, management and implementation of policies which involve third sector organisations, local communities and citizens. In this sense, the reform strengthens the role of Municipalities, which should mobilize and coordinate the local resources and networks of action.

In the background, at the root of this idea of integration, lies a model of citizenship which tries to conciliate a principle of (selective) universalism –based on equality– with a principle of diversification that takes into account the specificities of people and places. That is why this model is based on interventions which should increase people's capabilities and, at the same time, on a decentralized and negotiated form of public action. Moreover, the model assigns a key role to the integration between social and health services. This integration is conceived as a device to enforce citizens rights for social protection as well as to mobilize and make institutional and social resources consistent with each other in territorial contexts.

Setting a model with these implications is problematic given that the fragmentation of institutional sectors and competences is a constant of the Italian policy context. In fact, the integration between social services and health services is one of the most important and uncertain aspects of the construction of local welfare. Possibilities and related problems don't come unexpectedly, but belong to a long path full of expectations and failures. In other circumstances, this kind of integration had been already prospected by the national Health Reform back in 1978 (law 833). This reform was a trail-blazing venture not only with reference to the Italian situation. In fact, it instituted a universalistic national health system and gave a central role to an approach focused on the social dimension of health needs and on territorial services alternatives to hospitals. Moreover, grasping the opportunities given at that time by the recent institution of Regions, the reform chose the way of decentralisation, thus empowering the role of municipalities and of Regions themselves. The *Unità Sanitarie Locali* (USL: Local Health Units), were introduced as municipality based territorial operative structures deputed to planning as well as to managing services.

The problems of integration between social and health services reflect the different stories and institutional characteristics of the two sectors. Social services and interventions have been facing the lack –since some years– of a national law and of an organic regulative framework: this led to territorial inequalities and to a high discretion in choices and interventions. It must be added that this is still an extremely crucial problem. In practice, the basic levels stated by the reform of 2000 do not display the true characters of "demandable" rights. Moreover, the levels have not yet been fixed.

On the contrary, the institution of a national health system coincided with the introduction of health rights in Italy. However, this system has been affected by winding processes of reorganisation depending on the changes of political phase. The following two are among the principal steps of these processes: a) the introduction, in the early 90s, of mechanisms of "managed competition"

inspired to UK model of *quasi*-markets, but with a stronger emphasis on regionalisation; b) the shift, at the end of the 90s, to a model of “managed cooperation” and, at the same time, the reinforcement of the role of the State and of the Municipalities, to the detriment of Regions (Maino, 2001).

The different institutional trajectories of the social and of the health sector are interwoven with variable configurations of the relationship between political-administrative subjects acting at central, regional and municipal level. In fact, for a long time the power of Municipalities concerning the intervention on social and health needs has been restricted.

Another important difference concerns marketisation dynamics, which in the health system are much more developed. These dynamics are connected with the so-called “corporatisation”, that involved Hospitals and Local Health Units, these latter being renamed *ASL-Aziende Sanitarie Locali* (Local Health Companies). Although they kept their public nature, these structures have been transformed thanks to the introduction of organisational models and principles taken from the private sector. Nowadays, this is one of the cases of application of NPM that, in Europe, mostly corresponds to the UK model. However, the ways this model has been implemented are heterogeneous and show significant differences in terms of regulative and organizing models.

On the regulative side, the separation between planning/financing/control and provision (which is the basis of managed competition) has taken place referring to three principal typologies: one dominated by public provision, one mixed and one dominated by private provision (Neri, 2006). We shall also consider the different modes of public functions of planning. In some cases the regional actor plays an important role in making choices (on priority of spending, on aims and standards of services and so on) which bind private providers, sometimes negotiating these choices with the territorial level of ASL. In other situations, instead, the model of negotiated planning involves both public and private actors. Only in the Lombardy case the regional actor has completely separated financing and provision and let competition mechanisms determine the supply (*ibid.*). In terms of organisational structures, we may find many different patterns of relationship with citizens. The ones are strongly oriented towards enforcing citizens as consumers; in other contexts more emphasis is given to the promotion of citizenship.

It is important to specify that, despite of these differences, in 2001, both sectors have been involved in a constitutional reform that was developed in the name of devolution and gave the Regions legislative powers on both social and health policies.¹ Today regionalisation is the political-administrative architecture which institutionalises in Italy the many aspects of local active welfare. As for the “operational” level, these aspects reflect the ways these following dimensions combine: the relationships between the regional and the local level; the relationships between State, market and civil society; the position of the citizens/recipients; the typology of effective citizens and local communities participation.

However, the possibility of inequality is high, first of all because of the high autonomy of Regions. Given that the basic levels of social services are not yet fixed makes the achievement of a territorial system of services very fragile, especially with respect to the variability of resources.

2. The Case study: the “Habitat-Microareas, health and community development” programme

The “Habitat-Microareas, health and community development” programme is being promoted in Friuli-Venezia Giulia, a Region which shows some peculiarities: a) the main role health policies have in the regional welfare system; b) the centrality of the public subject, even in the provision

¹ Except for the basic levels, which remains under State control both in social and health services. In 2000, moreover, a system of fiscal federalism was introduced in Health Service.

function²; c) a political and institutional culture oriented to recognition of social rights; d) a widespread and articulated social and health care service system; e) the strong presence of third sector organisations working in the fields of social rehabilitation and job insertion (Mauri, 2007).

These peculiarities are very much to be related to the experience of de-institutionalisation which was developed in the psychiatric sector in the 70s and that was particularly relevant in Friuli-Venezia Giulia. The strategy of closing mental hospitals along with the organisation of a system of territorial services alternative to internment has deeply transformed both the role of patients and psychiatric competences, in the technical/administrative area and in the whole health sector in general. The effects of this process converged in the national psychiatric reform of 1978 (law 180), and were then embedded in the National Health Service institutive law of 1980. This story, and the system of policies and services related thereto, represent a term of reference as well as a bench mark for the present dynamics. Further evolutions within the Region were the broad development of partnerships between public services and third sector organisations (especially those working in the field of job insertion interventions). These partnership as well reveal peculiar elements: we are referring to social cooperatives whose members are disadvantaged people themselves. Most of these organisations were founded with strong will and support of public institutions. Also, we shall must point out that the regional policy makers give special attention to health care costs, giving consideration both to the criterion of sustainability of expenditure and to the appropriateness of treatments to the real needs of the population.³ From this point of view the main question is to balance the relationship between the expenditure in health and that insocial services (at present the latter is 1/10 of the former). In a region with a high aging rate, this aim implies to reduce resources for clinical interventions and to increase resources for territorial and home based care on long term pathologies, degenerative diseases, disabilities.⁴

The guiding idea of the “Habitat-Microareas, health and community development” programme - expressed by the noun “micro” - is that a reference to a small scale would be strategic in facilitating processes of integration among issues at stake and in giving consistency to conditions for making citizenship and local communities active. The programme was conceived in Trieste – main city of the Region– and is rooted in the experience of a previous project launched in 1998 and called “Habitat”. At that time, ASL, Municipality and Public Housing Agency (ATER) had reached an agreement with the third sector in order to develop forms of intervention in some disadvantaged housing estates. These areas were representative of the main problems of social and spatial marginalisation in the city and being the city affected by a high aging rate, those inhabitants involved in experimentation were, above all, poor and disadvantaged elderly people.

The inter-institutional agreement, had selected five pilot areas where to set its seats and start working for the improvement of the social quality of the habitat. Activities aimed at joint actions on places and people, gathering social interventions, health care services, rehabilitation of housing buildings and public spaces. The core of the experimentation was the “social concierge” service: managed by social cooperatives, and working as a neighbourhood service, keeping inhabitants and different actors involved in touch.

Year by year, this first experience consolidated, so that the ASL decided to enhance it. Day-by-day actions of *Distretti socio-sanitari*⁵ (Social and Health Care Districts) clung to an arising regional policy debate on the development and innovation of local welfare. The “Habitat-Microareas, health and community development” programme was launched in year 2005, when ASL, Municipality and ATER decided to further develop and enforce the “Habitat” project. The new programme aims at improving life conditions of inhabitants through interventions on: health promotion, social disease

² In health service the presence of private actors is secondary and deals with outpatient services.

³ Friuli-Venezia Giulia is a so-called “Special Status Region”: its health spending is financed by a regional fund.

⁴ Health residences for elderly people usually absorb a great part of the health care resources.

⁵ Social and Health Care Districts, were created with law 833 in 1978; today they represent the local health authority and are deputed to assure social-health integration on the territory in a logic of associated planning between Health Services and Municipalities.

prevention, improvement of living conditions. Nine so called “microareas”, were selected in as pilot areas in the four Social and Health Care Districts of the city, . Altogether, the nine microareas are inhabited by 16.000 people (out of a city population of 245,000). Two criteria led to the choice of areas: the “micro” dimension –corresponding to a number of inhabitants ranging between 1,000 and 2,500 people– and a preference for public housing estates.

In 2006, the Regional Health Agency (ARS)⁶ of Friuli-Venezia Giulia promoted the Micro-WIN (Micro-Welfare Innovations) regional programme, which is actually attesting microareas as places where innovative actions and measures for local welfare are being explored; the regional programme also encourages the development of similar projects in the other ASL and establishes the widening of experimentation on the whole regional territory.

We must underline, however, that the original experimentation of Trieste –on which we are mainly focusing - is, by now, the most advanced in Region even thanks to the peculiar organisation of its health services. In fact, the ASL of Trieste has been developing the programme on an existing and consolidated complex territorial system in which, for example, a 7-days nursing service is active 12 hours a day with a 24h availability. The different Departments of the ASL⁷ (Department of Mental Health, of Addiction, of Prevention) and Specialist Structures (Oncologic Social Centre, Cardiovascular Centre, Diabetologic Centre) work on site throughout the territory. In this respect, the Habitat-Microareas experimentation is stressing the territorial vocation of health services in Trieste and the broad network of relationships between public and third sector (especially social cooperatives) which witnesses a deeply-rooted capacity of cooperation.

The aim of the Habitat-Microarea programme is to promote the health of people in their life contexts through the personalisation of interventions. In order to accomplish that, ASL singled out some specific goals for each microarea:

- to come to a high degree of knowledge on health problems of local inhabitants;
- to oppose institutionalisation (and to optimize interventions to foster people stay at home);
- to increase appropriateness of treatments and services;
- to promote self-help action within the civil society;
- to enhance cooperation among profit and non-profit subjects in order to elevate citizens well-being;
- to raise the coordination between different services working on the same individual or family;
- to give everyone the same possibility to benefit by health services, in particular referring to the most vulnerable people;
- to improve the daily life of disadvantaged people making them active and independent.

For each microarea, selected priorities are defined. Furthermore, each District appointed a microarea manager (mainly chosen among nurses highly experienced in home services and interventions) and, day by day, on-site centres have been opened as seats of the programme in accessible and recognizable locations in the estates. Existing social concierges, usually run by third sector organisations (more precisely to social cooperatives), are also directly involved in the activities. Together with these full-time workers, the programme involves District operators, social cooperatives and municipal agents operating in the same territorial area.

3. Organizing local welfare

As we will further illustrate, the implementation of the programme invests the institutional and organizational processes of services with reference to three connected domains which are specifically triggering logics and practices of activation.

⁶ Regional Health Agency support and coordinate the Councillor’s Office for Health and Social Protection and Local Health Companies in administrating the Regional Health System.

⁷ Departments are complex structures dealing with preventive and rehabilitative therapies for specific pathologies.

3.1 Corporatisation and autonomy

During the last five years the number of employees in the ASL of Trieste raised of a 30% (in particular nurses and rehabilitation operators). This growth is mainly due to the choice – according to regional policy orientations – of a model of integrated health system which is providing a major role for the public actor in financing and planning, as well as in provision and control functions. We shall indeed consider the existing involvement of social cooperatives, above all in the field of rehabilitation. In the same way as the regional context, Trieste as well has a significant tradition in cooperating which by now focuses on integrated partnerships between public administrations and third sector.

Despite the many employees and functions, the general structure of ASL is little centralized since its territorial services system has multiplied cooperation lines between workers and services. Experimentation in microareas is supported by this specific organisational feature and display its effects along three main aspects.

The first aspect concerns staff management. The key principle is to promote the autonomy of individual workers. This means, more precisely, “*to encourage people to be autonomous*” (ASL General Manager). This principle takes place within the management and incentivation of productivity. In 2007, for the first time, a part of additional wages is destined to reward individual projects that, in line with the aims of the service, contribute to organisational improvements. This same philosophy has been assumed for a long time in cultures and practices within the activities of Districts, and it is akin to the experience of de-institutionalisation in psychiatry. In this direction, the way the role of operators is defined is crucial. The importance of professional competences and institutional belongings is reduced. Far more important is the development of methodologies of intervention able to foster operative autonomy, diversification of tasks, relationships and connections between different roles.⁸ The Microareas experimentation enlarges this philosophy in two ways. First of all, face-to-face relationships with people in the context they live makes operators feel the need –when not the urgency- to plan specific interventions for each individual: they must regard where a person lives, the way he/she lives, his/her social relationships, his/her income etc. Then, putting this kind of intervention into effect means to create networks of cooperation not only among different services within the ASL, but even among different agencies. Microareas managers, from this point of view, are “*operators not belonging to any service*” (ASL General Manager). The networks being activated, in fact, cross hierarchies and institutional bonds of municipalities, ATER and ASL, and trace new and articulated geometries of relation. For example, it happens that a microarea manager (a nurse) is acting with a direct connection to ATER managers.

The second aspect regards control and monitoring devices. According to NPM model, for accountability reasons, ASL must put individual and collective performances under control. To do that, it uses specific procedures and devices (for example, monitoring schemes, indicators, a protocol of quality assessment). From a management point of view, these devices are subordinated to “the political” value of goals and priorities fixed the planning phase. According to the orientation of the regional policy makers, goals and priorities take into account issues both of sustainable expenditure and of appropriate supply. It is actually to be stressed that in a city affected by a very strong ageing process, the incidence of expenditure for pharmacological products and for hospitalisation is very much significant and represents the only critical element in an overall solid financial regime. However, procedures and processes are used to improve efficiency and effectiveness regarding health needs of the population and not as control devices. In this direction, while ASL has invested in monitoring the Microareas experimentation, at the same time, it is trying to let monitoring and evaluation devices enter the ordinary administration. Expenditure data are

⁸ Welfare service operators’ autonomy and discretionary power are well-known elements of the “street-level bureaucracy”: see Lipsky (1980). For a recent discussion see Hupe, Hill (2007).

kept under control, in particular with respect to the expenditure on pharmaceutical products and further more investigating the relationship between costs of hospitals and of territorial services. The autonomy of microarea managers is not formally controlled and verified while a broad network of relationships among different operators and services facilitates indeed a kind of collective and reciprocal monitoring. Moreover, the development and intensity of relationships between inhabitants and services seem to open up a perspective for a social, informal and daily accountability: this seems to be a relevant implication wherever services are learning to open themselves up and to be exposed to people's questions, while, at the same time, the people learn how to question the institution.

The third aspect regards the way changes are interpreted and pursued: this occurs along an interaction between top-down and bottom-up dynamics. The strategy of the General Manager is clearly not to impose change but, in a way, to facilitate it. *"Let things happen without forcing, keeping them from not happening but not insisting to make them happen"* (ASL General Manager). From his point of view, on the one hand it is necessary to accept and legitimate the will of (or - as we remarked before - the urgency for) change coming from below, and to direct it to an institutional way of change. On the other hand, it is necessary to use power to establish a system of rules constraining and providing incentives for change itself. This means to foresee a long term perspective for the production of significant innovation (which means it has to be rooted in social and institutional practices). In this sense, the perspective is to give time to people and services for *"growing fond of innovation"*.

3.2 Territorialisation

Selecting an area as a reference for planning and organizing services is an approach shared by many policy fields. Territorialisation of policies may take very different forms, such as decentralisation processes, actions based on positive discrimination, assumption of places as contexts in which policies come to a life and, consequently, assuming places as resources for the reconfiguration of public action (Offner, 2006). Several authors warn from ambiguities and controversial effects of area based approaches targeting urban disadvantaged areas (Castel, 2003; Amin, 2005; Meyer, 2006). Of course, there are very many open questions, many remarks on results (Robson *et al.* 1994; Barnes *et al.* 2005) and many critical positions on the ways national policies develop between place oriented and people oriented policies (Donzelot *et al.* 2003). As we noted above, the re-organisation of services which recently took place in Italian social and health policies, was significantly - although variously - marked by orientations to a territorial articulation and to processes of decentralisation.

The Microareas programme is being developed in this context and focuses on two main connected premises. The first is that referring to limited areas makes it possible to learn "how to do", starting from experimenting in the most critical places and extending them - by generalisation of the approach - to the whole territory. The Microareas programme does not aim at a unique model; on the contrary, it is a way to redefine the specificity of institutional action according to variability and differentiation of urban contexts. The second one refers to a general warning on the risk of a strong attitude of health policies and services in separating places for care and treatment and life places: this warning is considered as a drive to stimulate the Health Company's capacity for reflexivity. Thus, the programme was developed according to the lines of those "area based" policies which generally aim at promoting action on a specific territory, in order to re-combine what policies have been kept separated for a long time (Atkinson, 2005; de Leonardis, Emmenegger, 2005; Bifulco, de Leonardis, 2006; Bricocoli, 2007). Implementing this approach has meant "going in the streets": *"We go where people live, we don't wait till they to come to the ambulatory"* (Project Unit Chief of the 3rd District). The operators aim at more effective and efficient forms of action and try their way

outside territorial health centres, being on site, on the places people live. Moreover, they work in strict connection with the already operating local services: no new structure has been added.

As already mentioned, selected areas consist of public housing estates, with problems of physical decay, aging population and social vulnerability.

The Microareas experimentation assumes the territory as a “setting” for services: it is no more the place where to identify and take care of singular cases, but the field for the display of citizens’ demands and resources (de Leonardis, Monteleone 2007). While the overall goals are clearly defined, the definition of paths for action direction is left open, assuming that the differences of territorial contexts (both in physical and social organisation terms) imply and require very different forms of action. From this point of view, microareas are intended as devices for exploring what is not working in ordinary organisational practices and what is to be reorganized. The local visibility and presence of health services provided the microareas programme implies a far better accessibility to services, especially by those who would otherwise be most at risk of being recognized their rights to health. It also implies an intentional exposure of the institution to a redefinition of its tasks and, thus, to dynamics of institutional reflexivity (“*no chance of selecting: everything enters the microarea’s seat*”). In a way, the programme is tackling the perverse effects of policies themselves on the target areas. It is to be stressed indeed that the target areas – especially when they are public housing estates – are in a way themselves products of institutional treatment. In fact, processes which spotted public housing areas as “quartiers en crise”, “distressed neighbourhoods” are typically (not only in Italy) the result of institutional action. With the overall aim of providing a solution to a demand for affordable housing a whole set of devices has been put into operation for the selection of tenants, for the allocation of dwellings, for the regulation, management and maintenance of housing units which have significantly influenced the social transformation processes of the neighbourhoods (Bricocoli, 2007).

A beach umbrella. To waste and take time

To express the style and orientation of the programme since its beginning, some short stories may be usefully quoted.. First steps in the programme saw a crew of operators who decided to start focusing on a housing estate - mainly populated by elderly people - consisting of 5-floor buildings with no lift and in condition of heavy decay. The aim was to increase their knowledge of the inhabitants’ problems and needs through a direct contact. Unexpectedly enough, the easiest way of knocking at each door turned out not to be feasible because of the lack of confidence in these “newcomers”. Many didn’t know the health operators at all but - even more significantly - most people did not really know the Social and Health District. While for some people seeing a nurse knocking at the door, without being called for, was quite a positive surprise, many others opted for resistance and even for hostility. Along the summer, the group of operators decided to change their approach strategy in reaching out the inhabitants. The group realised that stepping out of the district offices is not enough to become visible and accessible and decided to more effectively express their new intentions through a symbolic action. A large and yellow beach umbrella was put in the central square of the estate to draw attention: operators sat under and waited for the people to notice them. They were apparently both “wasting” time and “taking” time. Little by little, inhabitants approached the umbrella: some bringing a chair, some others a drink. They started to question the operators and to tell their own stories: sitting in the square became strategic in order to focus on some action lines which eventually became crucial for the development of the programme itself.

Quoting one of the operators: “*We knew that inhabitants can bring resources, as well as we did not know what kind of resources they would bring; moreover we had no idea of which public resources could help in supporting the activation and expression of their resources. The only way we found was to approach them, to have a close look, to stay on site. While specialistic paradigms (such as the medical one) work on what is missing or not working and base their analysis on “objective” diagnosis and prognosis, the only way to work on what is present, to detect and verify subjective capabilities is to put them at work*”.

Today, 3 years later, in the same estate the seat of the microarea is located in a dwelling made available thanks to a partnership with ATER. When you enter the seat, you do not really understand where you are: it looks like a flat, not an ambulatory. A fully equipped and coloured kitchen, a refrigerator with ice-creams and sparkling wine, a living room with a sofa, and a pressure gauge lying on the table. The responsible operator interacts with inhabitants and wears no uniform.

3.3 Personalisation

In the microareas programme, territorialisation is associated with personalisation of interventions. Facing health conditions and the life context of inhabitants implies the development of personalized projects.

One of the first preliminary activities was related to the goal of raising the awareness of the territorial context health conditions through a *street level* work. The action was supported by the ASL Fund and Control Department, which draw microareas health condition profiles by analysing the health expenditure data for each area and for point (pharmacological, diagnostic, hospitalisation). Also, microarea managers and operators could have access to data and information concerning heavy users. Thanks to these information they could start planning home visits to these people in order to verify the accuracy of the intervention and to define, if necessary, a personalized project. Home visits have been useful to update and revise databases of the Fund and Control Department and, moreover, they helped in fostering a trust-based relationship between people and operators which eventually led people provide further information on the most disadvantaged inhabitants.

A personalised project implies strengthening the connection between different resources, both institutional and personal. It is the case, among the others of an intervention concerning an elderly (a 68 years old woman) hit by an ictus and managing to walk but with the support of a tripod. Living alone at the 5th floor of a building with no lifts, she was actually not able to leave home by herself. Thanks to the intervention of the microarea manager, ATER proceeded in relocating her down to the ground floor which meant to re-establish her autonomy. In the meanwhile services activated the procedure to obtain a care benefit⁹ which can be used to pay an unemployed next-door neighbour of the woman working as her caregiver. In this case, while the intervention is on living conditions, at the same time, the care benefit works as a job insertion intervention and becomes, more in general, a tool to develop social resources in the neighbourhood.

A second example brings forward the risk that logics of sanitary intervention estrange individuals from their life context. During a regular home visit to a patient of the territorial psychiatric service, some operators notice his old mum being in a state of mental confusion. The woman, who is 80 years old and suffers from senile dementia, seems undernourished and neglected. She has two sons: the first one, schizophrenic and under treatment since 10 years, the second one, working and keeping the family. They live in a decayed social housing dwelling: wiring is in short circuit and they can't use the washing machine as well as the boiler, sanitary fixtures are in bad conditions and there is no hot water at all. Everywhere you can find dirty clothes, beds are without sheets, mattresses are smeared. At first, the operators decide for hospitalizing the woman, then they contact her doctor to proceed with an application for a care benefit. In the meanwhile, they agree with the sons for an extraordinary upkeep of the flat to be financed by funds reserved to patients in charge to social services. The flat is sanitized and emptied for restoration works coordinated by ATER technicians. A social cooperative provides some decent used furniture and coordinates moving operations and cleaning; the microarea manager organizes a network at the neighbourhood level to support the family. In three months, the family is back to its "new" home. The operators involve two neighbours, both disadvantaged: a woman who lately became the caregiver (thanks to the

⁹ An economical support to disabled people's caregivers.

money provided by the care benefit), while a man – who was working as a painter in the renewal of the flat lately became a member of the social cooperative. The intervention (which gathered economic and professional resources from ASL, Municipality and ATER itself) has been altogether cheaper than an institutionalisation process on the woman and her disadvantaged son would have been. Moreover, two neighbours have become employed, and are now autonomous: they no more need resources that can be reinvested. The whole intervention has been supported by many different resources, not all belonging to health service: those from social services, those from ATER, those from the citizens and from the social cooperatives. It reveals how crucial it can be to overcome divisions of tasks with integrated work among operators. In such cases, individual-oriented projects may usefully stimulate and pioneer the birth and the enforcement of articulated forms of cooperation.

Lately, the Habitat-Microareas programme has begun tackling the problem of institutionalisation of old people in elderly residences. Even in this case, personalisation represents a turning point. A psychiatrist and some nurses are actually working on a project which involves up 219 elderly people and 9 residences. In many cases, some pharmaceutical therapies (mainly psychiatric) have been suspended or revised, and an effort is being done together with the staff to reduce claims to contention in the residences. At the same time new solutions are searched for those elderly people who cannot live at home alone any more. In a microarea, a social housing flat was made available by ATER to lodge 4 elderly people (providing common living spaces and private single rooms): for each one there will be a treatment project and an individual assistance, while ASL services (home nursing, rehabilitation etc.) will intervene as usual.

3.4 Activation

The idea of activation lying at the hearth of the programme presupposes a full accomplishment of social citizenship, in particular with respect to well-being and health rights. This is only one of the possible interpretations of activation being given in Italy and in the other European countries, and it usually is the less applied (Hvinden, Halvorsen, 2001). It stresses the aim of increasing citizens participation, along two connected axes. The first one focuses on the necessity to transform situations of deprivation by developing individual capabilities for action and for voice. The second one stresses the need to involve local communities in choices concerning them. In the Trieste case, both the axes are connected to experiences which have been developed in local social policies. Socio-health rehabilitating services have been following for a long time methods aiming at making people autonomous in order to realize both their social protection and freedom rights. Involving civil society organisations in services planning paved the way to practices of discussion and collaboration between public institutions and local communities, in a context of formalised negotiation that is now extended to some 160 non-profit associations.

The Microareas programme triggers various processes related to this idea of activation. In general, all of them aim at creating – rather than presuppose - activation conditions by strengthening the organisational fabric both on the demand and supply side.

A relevant process is the one that is putting “tenants” of public housing in condition to be “inhabitants” able to play an active role in organizing and managing their own living context (while generally they are passive and subordinated). Thanks to the door-to-door activity in favour of *heavy users*, as we noted, the inhabitants have been involved in personalized health projects. This leads to better equity and balances situations of hyper use of medicines and services on the one hand, and of isolation on the other. Microarea operators try to foster solidarity relationships, socialisation and self help among neighbours. The increasing possibility for people to access a service, the circulation of information, or the creation of places where to meet each other are now visible results: this does not happen because a host of operators has gone in, but because people themselves produce

information, notice situations, help, participate, talk about their own story. In this sense, the programme gives people a voice, the possibility to speak, to protest, to plan (Massiotta, 2006).

Within the single microareas, local actions are naturally open to change, and quite often it is up to citizens themselves to redefine them. An experimentation called “social kitchen”, born as a distribution of meals to disadvantaged people and run by a social cooperative, turned into a cookery course held by a retired chef living in the microarea. At the beginning, the traditional intervention was considering the socialising role of collective lunch : later on, the people organised themselves and completely changed the setting so that now they feel much more actors in a creative action than passive recipients.

A course of “soft gymnastics” followed a similar development. At the beginning, the course was offered in different locations of the neighbourhood (gyms, microarea-centres, clubs) and was held by physiotherapists in charge of old people in need. The response and demand of inhabitants was very positive. The evolution of the project is that nowadays self-organized groups of people do meet to exercise, or organize walks and excursions. Gymnastics has been recently involving many more younger people who feel in need of physical activity. Even in this case the intervention was transformed by inhabitants. Microareas often play a role of a sort of incubating device for different kinds of self-organized initiatives, such as groups of citizens organizing open parties, little markets or sporting events. All these practices seem to positively implement the overall goal of overcoming the need of specialised interventions transferring competences to the citizens.

Collective aggregation is still a problem in face of diffused situations of sorrow, frailty and loneliness. Nonetheless, more and more social protection interventions are combined with social promotion ones. In these direction some projects are being developed with respect to the valorisation of public open spaces. In a microarea , a new born association is rescuing open spaces which have been for a long time used as rubbish tips, proceeding in their regeneration and maintainance. Many inhabitants are participating in planting trees and flowers. In another area people advanced own proposals for the upgrading of a square which is now mainly a traffic-congested junction.

5. Conclusions

The Regional context of Friuli Venezia Giulia and the “Habitat Microareas” programme itself, cannot be considered representative of the national state of the art in health policies. Many are the peculiar and extraordinary factors at work and, as we mentioned above, a major drive may be tracked back to the psychiatric de-institutionalisation experience developed in Friuli-Venezia Giulia at the end of the 70s. which paved the way, also worldwide, to alternative solutions to mental hospitals. Moreover, the 2001 devolution reform gave to regional actors stronger powers and amplified territorial differentiation. While this reform, on the one hand, has pointed out some inequalities in Italian welfare system; on the other, it opened perspectives of experimentation on institutional and organisational structures at a regional scale.

In this picture, it is interesting to remark the way some pressures coming from transnational and supranational vectors are “translated” and implemented in the local context. From this point of view, we may consider two main reasons of interest of this local policy context: a first one, is the major focus of the policy on social citizenship; a second one, strictly connected, is the central position of the public subject.

These two aspects fix indeed the framework in which organizing processes of local welfare are at work. Instead of a reduction in social protection and in the role of the public actor, this programme aims at enforcing institutional responsibilities towards well-being. In comparison to other restrictive versions –some welfare to work programmes of other European countries- the perspective is here reversed. In fact, here no citizen is obliged to follow fixed rules, thus subduing the right to get a benefit to a compliance with these rules. On the contrary, it’s due to public institutions to give

citizens the opportunities to develop capabilities for action and for choice (Sen, 1992; Dean *et al.*, 2005). Thanks to the path dependency from the history of de-institutionalisation in psychiatry, institutional ways of treatment are conceived as the central issue of the programme. While that previous experience was demonstrating the necessity to invert the objectification dynamics of mental hospitals – in the name of the rights, over all to freedom, of the people - so the actual on site work in the microareas is used to discover people who have remained “unseen”, “forgotten” by services, the patches of shade, and those questions unanswered by prearranged actions or territorial work itself. And this generally happens in those “fringe areas” where “wasted lives” (Bauman, 2004) and “superfluous” social groups and individuals have been concentrating (Castel, 2003; Sennett, 2006).

Another significant aspect is related to expenses. A good employment of funds is a crucial matter for the programme. This does not mean to save money, but, on the contrary, to invest it on effective and efficient actions, being aware that effects of choices are visible in the long run. Thanks to the microareas programme, many situations and questions - which previously were invisible - emerged, and therefore the overall expenditure has been rising in the last years. Yet this does not keep experimentation from going on.¹⁰

With respect to the relationship with the third sector, we may put in evidence the interest of a model that is not delegating institutional responsibilities while it is based on distinction and integration of functions, in a perspective which gives to social cooperatives an essential role in project design and implementation processes.

Maybe it is too early to say if these aspects on the whole will make people fully participate in choices on policy issues of their concern: active local welfare perspectives can be ambiguous, and fluctuate between empowerment dynamics and bottom-up localism dynamics (Mayer, 2006).

Although we have illustrated up to now above all its positive sides, this kind of experimentation has in fact some critical points.

The first one deals with a feature shared by many policies which assume an orientation to a “positive discrimination” approach: they concentrate resources and efforts for innovation in a few areas. This leads to switch off some territories rather than others. In fact, although the Microarea experimentation will be widespread in a perspective of generalisation, at the moment it is active in few areas. Secondly, the aim of setting services in specific contexts may clash with a perspective focused on social rights and on the criterion of homogeneity that is the basis of the rights as such. Comparing different microareas, we can verify not only differences related to the district’s orientation and to operational approaches, but also some disparities in the provision and development of services. The rising of people’s voice may indeed feed localistic claims. The more attention given to some particular areas may imply critical situations and tensions for institutions which are responsible on others territories too. ATER admits how difficult it is to improve the quality of its services in some microareas while it stands up against more urgent interventions claimed by city quarters which are not yet involved. Besides, the widening of experimentation on the whole territory has to face problems concerning the organisation of actual proximity services in areas which, differently from urban contexts, are not densely populated. Another problematic field is the partnerships between institutions. While ASL and ATER are overcoming some difficulties, the relationship with the municipality is more problematic. Despite its formal engagement, the department for social services of the Municipality invests very little, thus obliging ASL to perform duties which are not within its field of responsibility. This weakens the philosophy and the impact of experimentation itself. Moreover, as we said, in Italy social services are not based on rights. As a consequence, there are different institutional logics: while ASL is engaged in putting the right to health into practice, Municipalities have much a higher degree of discretion. On the whole, these problems reveal the difficulty to integrate different institutional responsibilities and levels in a specific territorial area.

¹⁰ This rise implies both the increase of territorial service expenses and the reduction of expenses for hospitals.

Some critical elements emerge in the role of third sector organisations as well. With regard to the microareas, their involvement implies a strong and continuous cooperation with institutional actors. Yet in other fields of collaboration with ASL and Municipality, the social cooperatives suffer increasing competition with non profit organisations which don't aim at job insertion of disadvantaged people and therefore can assure higher productivity. Furthermore, social cooperatives themselves will be in need to redefine their own action because of the ongoing change of relationship between citizenship and services. In fact, an accomplished active citizenship should lead to a reduction in the provision of service by third sector organisations because of increasing capacities of self-organisations on the part of citizens and local communities. However, the way this repositioning could happen is not clear yet.

Finally, a background problem concerns the frailty of the overall national policy context. As already mentioned, fragmentation of regional health systems and lack of social services rights are two aspects of this frailty. Uncertainty over the availability of resources at a national scale for social and health policies has to be taken into account as well. Lacking a control on resources, citizens participation can hardly be conveyed towards a long-term strategy of well-being promotion. But, as the ASL Manager says, this is not at all a reason to give up: "(...) *we help people to become citizens in their own neighbourhood: at least there is one single institution saying: 'We are here, and we want to do something together'*". This definitely seems a further good reason to keep trying.

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