Innovations in Governance: The Involvement of Social Enterprises in Health Service Delivery

Helen M Haugh

Judge Business School
Trumpington Street
Cambridge
CB2 1AG
Tel. (0)1223 766592
Email h.haugh@jbs.cam.ac.uk

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Introduction

This paper examines the Lombardy model of governance and identifies six critical tensions raised by the model. This is followed by an abbreviated account of the changes in the provision of health care services in the England since 1979 which led to the creation of opportunities for social enterprises to deliver health services. Each of the critical issues is then addressed in the context of social enterprise involvement in health care.

Governance Context

Governance arrangements have traditionally been interpreted in terms of hierarchies, markets and networks (Coase, 1937; Granovetter, 1985; Williamson, 1985; Thompson et al., 1991). In hierarchies, policy determination, decision-making and resource allocation are highly centralised; in the public sector this would be characterised by government that both determines resource allocation and organises and controls public service delivery. In contrast, markets involve the interplay of supply, demand and individual choices in which competition between players determines the allocation of resources. In network forms of governance, 'multiple and overlapping networks create dense patterns of action, interaction and reaction' (Exworthy et al., 1999 p.15) within and between individuals and organisations. These alternative forms of governance are generally considered as competing alternatives, however the reality is that each form is usually present to a greater or lesser degree in most contexts.

In many European countries, the late 20th century heralded an era of devolution of authority away from the centre to lower levels of government (OECD, 1997); with this came innovation in governance arrangements which introduced aspects of markets and networks into traditionally hierarchical structures. For example in the National Health Service in the UK, the separation of purchaser from provider in the early 1990's introduced an internal market for health services in which health authorities purchased services from a range of competing suppliers, and NHS trusts

competed for contracts in competition with alternative providers. The separation of the role of purchaser and provider has parallels with the administrative and governance reforms in Italy.

Administrative and Governance Reforms in Italy

The traditional political economic model of Italy has been characterised by hierarchical governance arrangements embodied in a highly centralist model of decision-making, policy determination and fiscal management. For example, in relation to health, priorities were set centrally and 90% of regional budgets came from Rome (Colombo & Mazzoleni, 2006). This high level of control from the centre established national standards and central control over public services delivery through formal hierarchical structures and tight budgetary control. However, the centralist model operated to constrain autonomy at regional level.

In the 1970's and early 1980's, regional activism and new political movements began to press for greater autonomy at regional level and the devolution of political power away from the centre to the regions. To this end regional governments were established in 1970 (Ongaro, 2006); each would have an elected President with significant amounts of power and influence (Giordano & Roller, 2003).

In 2001, constitutional amendments (see Ongaro, 2006) set out the new relationship between the State and its regions. The central government would retain power over some functions (e.g. economic development, foreign policy and immigration), share powers with regional government in some functional areas (e.g. education, health and commerce) and devolve other functions to the regions (e.g. health services) and provinces (e.g. cultural heritage) (for a full list see Giordano & Roller, 2003).

The structural reforms were inspired by principles of governance derived from subsidiarity. According to the principle of subsidiarity, decisions should be taken at the lowest possible level of government, namely that which is closest to citizens (Barber, 2005). In essence it is a theory of social responsibility that recognises that 'individuals ought to be included in decisions relating to the exercise of public power' (Barber, 2005 p308).

The philosophy is based on the belief that matters should be handled at the lowest or closest level to where they will have their effect (Colombo & Mazzoleni, 2006). Administrative structures, such as central and regional governments, should only intervene when necessary to protect the common good, and perform those tasks which cannot be effectively carried out at a more immediate, or local, level. Hence subsidiarity is associated with empowerment of democratic institutions (Barber, 2005) and emphasizes the importance of local structures - the family, the church, community groups and voluntary associations – as mediating structures which empower individuals, and represent and communicate their interests.

Subsidiarity is based on the principle of empowering individuals with the autonomy and resources necessary to accept the responsibility for developing and delivering the services they need. Thus it goes hand in hand with collective action and new models of governance which are more open, inclusive, accountable and participative. The role of formal administrative structures is to uphold freedom of action at local level, entrust and uphold local initiatives, confer primacy in their strategic choices, and harmonize efforts across localities with a view to the maintaining the common good.

In Lombardy, the regional president, Roberto Formigoni elected in 1995, has been strongly in favour of the principle of subsidiarity (Ongaro, 2006), and since 2000, governance in the region has been based on this principle. A wide range of functions and responsibilities has been devolved to local authorities (provinces and municipalities), and the role of the Lombardy government has moved away from being a deliverer of services to being a commissioning intermediary. In this way the regional government's strategic role is to ensure services are delivered in the best interests of tax-payers and users; and to uphold procedures to maintain local influence and accountability. In practice, the regional government is concerned with governance issues relating to: openness and participation; monitoring and controlling the functions and services; regulating the system of services; and information management. By 2001 the region had consolidated its image as the leading example of subsidiarity in Italy (Ongaro, 2006).

In theory, the new governance arrangements have brought the design and management of service provision closer to the citizens. However, as the management and delivery of services has been devolved to autonomous organizations, the reforms have required systemic changes at regional level. The financial implications of the structural and governance reforms are many, and include for example the costs associated with funding: training in the skills needed to effectively commission service delivery; the design and implementation of contracts for service delivery at local level; the design and implementation of new and transparent systems for stakeholder consultation and participation; monitoring, evaluation and control of performance; and the collection and dissemination of information about service needs and performance.

The devolution of power and fiscal authority to the regions, and the separation of the roles of commissioner and deliverer, has opened up opportunities for new providers to compete for contracts to deliver services. This has led to competition between alternative service providers and the emergence of quasi-markets (Le Grand & Bartlett, 1993) in which commissioners and customers have choices. For commissioners, competition between alternative service providers has the potential to raise the quality of services delivered as alternative providers innovate and compete to secure service delivery contracts. For customers, competition can also raise quality of services delivered as they exercise choice to select the provider which offers services that best fit their expectations and needs.

However, to derive benefits from the new competition, there need to be alternative providers that compete for service delivery contracts. Hence potential service deliverers need to be aware of the new contracting opportunities and are likely to need guidance and support when bidding for contracts; commissioners need the skills to effectively compare alternative providers and select those which most closely match their requirements; and service users need the skills to make choices between alternative providers. Hence the reforms incur costs, sometimes hidden, in the shift from hierarchical to market based governance structures.

Subsidiarity and Policy Implementation

Thus far, this paper has considered the structural reforms that have influenced governance reforms in Lombardy. The second aspect of the structural reforms is related to the devolution of power over policy implementation to the regions. The distinction between formal policy reforms (programmatic aspects of social policies and services) and operational policy (the organization, administration and delivery of policies and services) (Carmel and Papadopoulos, 2003) is integral to the Lombardy experience. Structural reforms widened the autonomy of the regions and led to operational policy reforms (Borghi & Berkel, 2007) in which aspects of the political hierarchy, the market and citizenship become complementary. In Lombardy, the structural reforms delegated new duties and responsibilities to the regions which, in time, gave the regions wide ranging power over their statutes, electoral systems, forms of government, supported by some ability to modulate taxes.

In health and social care, the State would set out universal general principles on which the regions could build their own service portfolio, matched to the needs of the communities they serve. This shift reflected broader changes in the 'core objectives of the welfare state arrangements from protection and indemnification to participation, activation and independence,' (Borghi & Van Berkel, 2007 p.84). The transformation led to the involvement of new deliverers of services from the private and non-profit sectors. For example, local hospitals acquired the status of independent state-owned firms and are refunded, at the same rate as private providers, for the services they offer.

Critical Issues in Governance Reform

Analysis of the process of structural reform in Italy and the Lombardy experience has identified six potential institutional tensions associated with the adaptation of regional governments to the separation of the roles of purchaser from provider of services.

The principle of subsidiarity has shifted decision-making and responsibility for the design and delivery of a specified range of services from the centre to the regions. In devolving responsibilities in this way, the first tension identified relates to a continuum between **devolution versus abandonment**. Devolving service delivery to the regions is marketed under the auspices of empowering the regions to make

decisions and choices about services which better reflect the needs of their locality. However, in devolving services, the question arises as to whether the centre has absolved itself of responsibility for the regions and in effect abandoned them to their own devices. This tension can be managed by setting and maintaining standards from the centre, whilst simultaneously devolving responsibility for service design, implementation and evaluation to the regions.

The traditional hierarchical governance structures in Italy were centralist and control was retained by the centre. One of the consequences of centralised governance was that the autonomy of the regions was severely constrained. In loosening the control away from the centre, the autonomy of the regions in terms of decision-making and local action has been increased. However, from a national perspective some regions are likely to perform better than others in terms of the management of their new authority, and in the interests of national equality, a balance needs to be found between the tensions of **central control versus regional autonomy**. This tension can be managed by a system of regular, carefully managed independent reviews, and inspection of the quantity and quality of locally delivered services against centrally upheld service standards.

The decentralisation of the commissioning and delivery of services to the regions means that regionally-based commissioners can contract with whichever service provider offers the most effective, efficient and appropriate services to users. The diversity and multiplicity of user needs however creates a tension between **decentralisation versus fragmentation** of service delivery. As the needs of users grow, and their confidence in expressing their needs to commissioners increases, the feasibility of satisfying all needs becomes remote; yet the pressure to do so increases. This tension can be managed by educating service users about the need to balance idealistic expectations about services and their delivery with the reality of physical, financial and human resource constraints.

The principle of subsidiarity pushes decision-making as close as possible to those affected by the decisions that are made. In devolving the design and delivery of services closer to citizen consumers, the pressure for service deliverers to be flexible and innovative to better meet citizen needs has to be managed with the pressure to

meet national standards of service and professional codes of conduct. Thus there is tension between the pressure to conform to national targets and standard procedures versus the desire to innovate to better meet user needs. The tension between **accommodation and innovation** can be managed by setting national minimum standards which are monitored and controlled by the centre, with devolved flexibility to the regions to innovate the design and delivery of services over and above the minimum standard.

The devolution of power and authority away from the centre was accompanied by limited fiscal autonomy at the regional level. However, the requirement to manage rising user expectations about the quantity and quality of service availability with the budgetary constraints of regional government leads to a tension between **efficiency and service**. This is perhaps the most intractable of the tensions as consumer expectations appear to rise inexorably as the purchasing power of budgets diminishes. The tension might be alleviated by public information campaigns to reduce the demand for services, such as in improved personal health care and illness prevention; compulsory competitive tendering between potential service providers to enable alternative providers to be evaluated systematically on a range of indicators; and the inclusion of both quantitative and qualitative targets and criteria in contracting decisions to ensure that evaluation goes beyond purely financial performance.

Finally, the range of services typically delivered by public sector organizations extends from those where the performance can be measured by outputs e.g. refuse collection, to those where the measurement of performance is ambiguous. For example, in health and social care, measurable outputs (e.g. the number of procedures, vaccinations, operations) are achieved simultaneously to short and long term outcomes (e.g. improved sense of health and well being). This tension between **outputs versus outcomes** can be managed by ensuring that both outputs and outcomes are included in service delivery contracts, and that appropriate metrics are designed to monitor and record outcomes as well as outputs.

The remainder of this paper shifts the focus of attention away from Italy to England. The purpose of this is to present an account of a change in governance which might offer some insights for the new administration of health services in Lombardy.

Fundamental changes in the governance of the health and social care sector in England since 1979 created a quasi-market in which the roles of purchaser and provider were separated; and in doing so created many opportunities for new deliverers of health services to enter the market. In opening up the market for health and social care, providers from the non-profit sector, including social enterprises, now compete with the private sector to win contracts to deliver services. The following sections present an account of the introduction of devolved health service delivery and innovation in governance; and this is followed by a review of the role of social enterprises in health care service delivery in England.

Devolved Service Delivery in the UK

The delivery of public services in the UK changed dramatically when the Conservative government introduced neo-liberal privatisation policies from 1979 onwards. The introduction of the market mechanism into public service delivery represented a shift in governance away from the hierarchical command and control of the 1948-1979 era (Exworthy et al., 1999). The creation of quasi-markets (Le Grand & Bartlett, 1993) brought in charging for services, compulsory competitive tendering for contracts, and increased partnership working to deliver services. Fundamental to the shift was the separation between the purchasers of services from providers. This resulted in the creation of quasi-markets with competition between alternative providers from the private, public and non-profit sectors (Cornforth, 2003).

These massive structural changes meant that public services were removed form the direct control of local authorities; in their place new organisations (quasi-autonomous non-governmental organisations (quango's)) were created to deliver public services under contract to local authorities and government departments. The quangos were managed by boards of appointed members (and not elected officials). Performance was controlled by the introduction of performance indicators and multiple audits. These changes meant that the relatively simple structure of multi-functional local authorities working with central government, was replaced by a new, more complex, system of local governance (Cornforth, 2003).

Governance and Health Care in England

In 1974, prior to the Conservative party reforms, health services were under the auspices of the NHS. The management of health services was undertaken by various authorities who performed the necessary governance functions (Ashburner, 2003). Health authorities were composed of a combination of people appointed by the Secretary of State, various groups of health professionals and local authorities, and lay people (usually personal contacts of local dignitaries).

The total transformation of NHS governance was laid out in the NHS and Community Care Act (1990), implemented in 1991. New boards were established which removed all local authority and most professional members, and replaced them with non-executive directors drawn from successful businesses, who it was hoped would introduce ideas from the private sector, and managers of the organisation. Whereas the authorities had been accountable to their local communities, the new boards were accountable to government.

Boards in the public sector can set individual organisational strategy but must remain within the limits of government policy (Ashburner, 2003). Hence, they are responsible for interpreting and implementing policies that are determined at a higher level in the hierarchy. In this way the Government constrains the extent of strategic choices, and imposes decisions that might not otherwise have been made (Ashburner, 1997) and which may not reflect the specificity of local needs.

In the continuing 1980 reforms, independent trusts were established to deliver health services (Cornforth, 2003), and new partnerships in Health Action Zones were created. These new structures had the power to commission services that provided the best value irrespective of whether the deliverer was from the private or non-profit sector.

Since the election of the Labour government in 1997, the structural reforms have continued, with a renewed emphasis on modernisation and partnership working. Few changes have been made to the governance structures, except that the appointment of non-executive directors has been made more transparent and passed to the newly

created NHS Appointments Commission, which reports generally to Parliament. Trusts are accountable to the Department of Health, and their performance is controlled by targets that are set centrally by government. The techniques of new public management (McLaughlin et al., 2003) that have spread throughout the whole of the public sector and which emphasise improved business efficiency are also found in the NHS. The new techniques include greater emphasis on user-orientation, the introduction of market mechanism into service purchase and supply, and competition between service providers. Taken together, the reforms of the health and social care services have promoted five ideals: greater efficiency and improved outcomes; innovation in service delivery; tackling inequality by improved access to services; personalisation and choice of services; and empowerment of service users.

In the NHS, the expansion of the Board model led to the establishment of Primary Care Trusts (PCTs). Primary care boards are responsible for purchasing of care across the health sector. PCTs do not have a clearly defined organisation to oversee, but manage a network of small disparate organisations – primarily general practices. PCTs are fund holders and are responsible for purchasing of all health care for their populations, health promotion, public health and preventative care. The contracting out of health services has created many opportunities for the non-profit sector. It is into this opportunity that social enterprises have stepped (Walsham et al., 2007).

Social Enterprises

Social enterprises have been identified as a cornerstone of UK Government policy. They are organisations that combine business efficiency with achievement of social outcomes. They are defined as 'businesses with primarily social objectives whose surpluses are principally reinvested for that purpose in the business or community, rather than being driven by the need to maximise profit' (DTI, 2002, p.13). They thus aim to be financially sustainable from trading, and when a profit is made, this is not distributed to those with a controlling interest in them. Hence any surplus is not distributed as profit sharing; it is used to further the aims of the enterprise. Social enterprises are firmly rooted in the localities they service by governance structures that are community-based.

Although reliable statistical data are difficult to locate, recent estimates suggest that there are 55,000 social enterprises in the UK, with a combined turnover of £27 billion per annum, accounting for 5% of all business and contributing 1% to GDP (DTI, 2006).

Social enterprises bring distinct advantages with them to the market place. First, their simultaneous pursuit of financial sustainability and social outcomes means that the business models they adopt focus on efficiency and effectiveness. Second, their close contact with the individuals and community they serve, manifest in stakeholder-led governance structures, means that they are knowledgeable about the needs of the communities they serve. They thus have the capacity to overcome asymmetries of information typically found between larger organisations and individual consumers. Third, by virtue of the greater trust they inspire between them and the communities they serve (Mancino & Thomas, 2005), they have the capacity to penetrate the gaps left by ineffective public and private sector service delivery. This closeness between them and their communities generates high trust which confers on them legitimacy to operate in their localities. Their legitimacy is further reinforced by their responsiveness to individual and community needs, enabling them to identify and deliver services matched to clients needs. Fourth, the majority of social enterprises are small, and this gives them the flexibility required to design and deliver services to meet the specific needs of smaller client groups. Finally, by working closely with their communities, social enterprises have the capacity to not only deliver services, but to contribute to building social capital through citizen participation (Evers, 2001).

Health Care and Social Enterprises

Recent NHS documents have encouraged a mixed economy of welfare health service providers and identified the potential of more diverse providers from the independent and private sectors with greater potential to innovate to deliver health care services (DH, 2005a; 2005b; 2006a; 2006b). These policy documents have specifically noted the potential of social enterprises to deliver health care services. In 2005, a task force was established to investigate the potential of third sector organisations to work in partnership with the NHS to design and deliver services to users. The task force report estimated that more than 26,000 third sector organisations were already

involved in delivering health and social care services in England, with an annual income greater than £13bn (DH, 2006b). The majority of these organizations are small, with an annual income less than £50 000. Their smallness means that most social enterprises work in partnership with the agencies of the NHS, and enter into a commercial relationship between public sector commissioners of health and social care services to provide services to users. The management of this relationship is key to the success of the reforms and separation of commissioning and delivery.

The advantages of social enterprises already noted make them appropriate organizations for delivering health and social care services at the local level. Their entrepreneurial focus means that their business model is fundamentally driven by the pursuit of financially sustainability; this promotes innovation driven by greater user and patient choice and leads to creativity in service design and deliveryIt also has the potential to increase efficiency and value for money. Their close engagement with stakeholders, patients, users and employees means that they are responsive to users' needs and can involve service users in the design and delivery of services. Deeper relationships with stakeholders means that they bring these capabilities much more into play in developing innovative services that respond to need (DH, 2006b). Their local embeddedness means that they possess deep knowledge about the needs of the communities they serve, and this feeds into service design and delivery. They can make a difference to their local community, as well contributing to public good, by revitalising deprived neighbourhoods in two ways: employing local people; and delivering services to the socially excluded. This can lead to improved access to services, and enhance the creation of social capital by building a bridge between local communities and large institutions that commission the delivery of health care services. Their smallness means that they are less bureaucratic than hierarchical structures and increases the potential of delivering value for money. In addition, social enterprises are committed to the values of non-profit organisations and public service for the common good, and this generates benefits for the organization in terms of staff morale and staff retention.

However, the relative newness of social enterprises disadvantages them in several ways: when bidding for service delivery contracts due to lack of commissioner knowledge about their skills and capabilities; the complexity of preparing contracts

for competitive tendering to health care commissioners; and in designing monitoring and controlling service delivery.

In 2006, the Department of Health established its own Social Enterprise Unit to promote the involvement of social enterprises in the health and social care sector. This unit established a Pathfinder programme in October 2006 which aim to identify social enterprises that are leading the way in delivering innovative services. The Pathfinder project provided financial and advisory support to 26 social enterprises. This scheme is currently in progress and is scheduled for evaluation between 2007-9 (DH, 2007). The purpose of the evaluation is to provide a robust evidence base of their performance, and actionable lessons for social enterprises in health and social care.

Critical Issues and Devolved Service Delivery in England

In England the process of separating the commissioning and delivery of health and social care services has been managed to ensure that national standards are monitored and controlled simultaneously with flexibility in local action (DH, 2004). Thus the prospect of abandonment has been restrained into one of managed devolution of authority to Trusts, and from then on to local deliverers of services. The modernisation of public service delivery has been pursued simultaneously with increased centralisation and uniformity (Greer et al., 2003) thus maintaining centralised control of standards with autonomy at the level of local delivery. However, the new relationships between the State and providers of health services has given way to a structure that is characterised by organisational fragmentation, plural modes of governance and a complex network of mediating partnerships (Skelcher, 2000). Theoretically the maintenance of national standards and equity in access to health care is managed through a myriad of objectives and targets, however in reality there are variations in the availability and quality of services between localities.

Innovation has been encouraged through greater diversity of service providers, and in service design and delivery. New legislation to encourage asset transfer and capital asset development, thereby enabling social enterprises to achieve financial independence through revenue generation increases the potential for them to achieve

financial sustainability and survive in the long term. The requirement to conform to national standards has created some flexibility that new providers have embraced in the design and delivery of health and social care services.

The pressure for efficiency has been pursued through compulsory competitive tendering for service delivery contracts. Thus potential service delivers strive to design competitive contracts within the financial and social constraints of health spending budgets. Further, the evaluation criteria of best value means that commissioners can accommodate the qualitative differences in service delivery offered by social enterprises. The distinct advantages of social enterprises builds outcomes as well as outputs into their performance criteria, and these can be used to strengthen their differential capabilities when competing for contracts. Thus the social enterprise model is an organisational format that combines business efficiency, social outcomes and community-based governance, and which has the potential to diffuse the tensions outlined previously in this paper.

Conclusion

This paper has reviewed the Lombardy model of governance and identified six critical tensions that arise when the commissioning and delivery of public services is guided by the principle of subsidiarity. To illustrate how innovation in governance can lead to innovation in service delivery, the case of health service reform and the role of social enterprises in health service delivery in England was presented. The illustration is pertinent to Lombardy in that the principle aim of subsidiarity, to shift decision-making and implementation nearer to citizens, is embodied in the community-based governance structures of social enterprises. This has led to high expectations about the potential and performance of social enterprises which may need to be tempered as they take time to acquire the necessary skills and expertise both to compete with the private sector for service delivery contracts, and to deliver the services for which they are commissioned. Thus far the costs associated with: organisational and institutional learning for both purchasers and providers; the design of contracts for transactions with new providers; the management of new contracting relationships; and the deep cultural changes that are occurring in governance and health care have not been explicitly recognised in the opening up of health service

markets. In addition, the dual burden of governance costs associated with the new structures as well as professional codes of conduct has also tended not to be explicitly recognised. This may be a reflection of the fact that the involvement of social enterprises in health service delivery is relatively new, however it creates many opportunities for further research in the future.

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