New Challenges for Public Services Social Dialogue: Integrating Service User and Workforce Involvement in Italy

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1. Introduction

The topic of service user involvement first entered the Italian political debate as a policy issue in the 1970s, in connection with the mass social movements of that period, often allied to the large trade union confederations, aimed at a deeper 'democratization' of society and public institutions. In the education sector, this process led to a 1973-74 legislation that created the so-called "collegial bodies" within a new system of school governance inspired to a model of "joint-management democratic participation". Such bodies – established at province, district (sub-province) and individual school level – had partly different tasks and composition depending on the level involved. They included, in varying proportion, elected staff and user (students, parents) representatives, as well as other stakeholder representatives, such as representatives of municipalities and representatives of interest associations. They had consultative and deliberative powers on a number of issues, mainly on school organisation within the province area at Province School Council level, on extracurricular activities at District School Council level, on school management organisation at School Council level. This latter body included teachers and other staff, parents and, in the secondary school, student elected representatives.

Similarly, in the health sector the issue of user/citizen involvement, within a wider demand for democratisation of healthcare organisations, goes back to a 1978 national legislation which created the universal National Health Service (NHS) in substitution of the previous Social Health Insurance system. The participation of citizens, local government institutions, universities and interest organizations was included among the fundamental principles of the NHS, linked to the duties of Regions and municipalities.

The channels and mechanism for user/citizen involvement were different in the two sectors and encountered, to different degrees, several obstacles in their implementation. In both cases, their effectiveness in promoting participation to the planning and management of public services declined in the 1980s, leading to a significant re-design in the following decade, inspired by foreign experiences like that of the British *Citizen's Charters* and, more generally, by the principles of the new public management approach. If 'democratization' and democratic participation were the key-words of the experience of the 1970s, 'consumerism' and 'consumer's choice', along with transparency and performance management and evaluation, were the guiding principles within which the role of service user involvement was mostly framed in the public service reforms of the 1990s and especially the 2000s. A clear example of this shift is visible in the reform approved in 2008-09 (the so-called Brunetta reform), with its emphasis on transparency measures as well as on mechanisms to survey the immediate 'customer satisfaction' of service users (sort of "I like/I

dislike" procedure). With regard to the principle of transparency applied to social dialogue institutions and practices, for instance, the 2008-09 reform introduced for each public employer the obligation to publish on the official website of the organisation the text of the 'integrative' collective agreements concerning the organisation, with data regarding also the cost of personnel, the incentives for managers, etc.; this would allow a closer scrutiny by users and citizens of the implications for the communities of decentralized collective agreements, with potentially indirect effects on employment relations.

Despite this shifting emphasis in the public discourse between the two periods, it cannot be ruled out the possibility of a *de facto* co-existence of both sets of principles – 'democratization' and 'consumerism' – in the actual experience of public services, as it is clearly shown by the case study on the health sector in this report.

However, such differences and qualifications aside, neither in the case of the 'democratization' wave of the 1970s nor under the 'consumerist', NPM-inspired approach of the 1990s and 2000s, there appears to be a systematic, direct link between the mechanisms and channels of service user involvement and the institutional and procedural architecture of public service social dialogue. Despite the undoubtedly increasing emphasis on service users 'rights' in the public service reform waves of the last two decades, the integration between the two arenas of user invlovement, on the one side, and of social dialogue on the other side, seems still uncertain and problematic. To put it in the simplest, and rough, way: no service user representatives are directly integrated within the bargaining agents in collective negotiations, neither at national nor at local, single employer level.

Nonetheless, this does not mean that there is not any impact at all of the various forms of service user involvement on the practice of employment relations and on some features of working conditions. Rather, as the two case-studies illustrate in detail, these links and influences can be significant, within a variegated multiplicity of forms of service user involvement; but such links apparently do not develop within a clear, and predictable, institutional design. In the Italian industrial relations tradition the attention paid to the involvement of service users as a 'new' actor in social dialogue institutions seems to be on the whole limited – probably more than in other national contexts (Kessler and Bach 2011). Perhaps, the only area with clear rules and institutions regarding this issue is that of the regulation of the exercise of the right to strike in essential public services. In this area, a 1990 legislation, partly amended in the year 2000, gives 'representative' service user/consumer associations, under certain circumstances, significant prerogatives in connection with the duties of the Authority supervising the implementation of the law, with potential effects on industrial relations (Bordogna 2008). In particular, according to this legislation, the 'representative' user/consumer associations, among other prerogatives, may ask the Authority (the "Guarantee

Commission for the implementation of the law") to formally open a procedure to evaluate whether, in certain circumstances, trade unions have violated the rules regulating the exercise of the right to strike; in case, the Commission can adopt the sanctions envisaged by the law. These organisations are also to be compulsorily consulted by the Commission during the procedure for the definition of the 'minimum services' that must be provided even in case of strike. These prerogatives, however, have very seldom be utilized by user/consumer associations.

The report is organized as follows. Section 2 briefly introduces social dialogue institutions and actors in the health and education sector. Sections 3 to 7, the bulk of the report, analyse the Italian experience of user involvement institutions and practices in the health and education sector, and present in detail the two case studies, a (territorial) local health enterprise with its hospitals, and a first-level secondary school (or *scuola media*, 11-14 year old pupils), both located in an Italian region (Emilia Romagna) traditionally characterized not only by a high trade union density but also by a rich participation of citizens and civil society organisations to the social and political life (Putnam 1993). Brief concluding remarks close the report.

2. Social dialogue in the Education and Health sectors: institutions and actors

Total employment in the education sector amounted at the end of 2013 to 1,038 million employees in all public schools of any grade, excluded universities, including personnel with one year fixed-term contract; teachers were about 800 thousand, head-teachers about 10 thousand. In the Health sector there were about 670 thousand employees, including about 115 thousand medical doctors, plus about 38 thousand employees with flexible contract (fixed-term contract, temporary agency employees, autonomous collaborations).

The main features of social dialogue institutions in the education and health sectors replicate, with some specificities, those existing in the Italian public sector as a whole. Since the major NPM-inspired reform that in 1993 privatized and 'contractualised' the employment relationship of the large majority of public employees, terms and conditions of employment, managerial staff included, are mostly determined - and exclusively with regard to wage issues - by collective negotiations between 'representative' trade unions and public employers. The bargaining structure comprises two levels, on the model existing in the private sector. At the higher level, nation-wide sectoral collective agreements[1] are negotiated between representative trade unions and a public agency

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[1] The nation wide bargaining units (or sectors) were initially (after the 1993 reform) 8: ministries; non economic public bodies (mostly compulsory social security); public schools; autonomous state firms (mostly fire-workers); national health system; regions and territorial authorities, among which municipalities; public universities; public research bodies. Between 1998 and 2007 the bargaining units were increased to 12, and finally cut down to a maximum of 4 by the 2009 Brunetta reform.

(ARAN) to determine in a uniform way all over the country the normative working conditions and inflation-linked wage and salary increases. ARAN is a public agency, created by the 1993 reform and partly amended in 1997 and 2009, which has the compulsory and monopolistic representation of all Italian public administrations in national level collective negotiations, ensuring in this way a 100% coverage of national collective agreements. At the lower, decentralized level collective agreements are negotiated between the local employer and the workplace employee representation body (Rsu), assisted by local level trade unions, regarding, among others, salary increases (intendedly) linked to productivity and work organization/HRM issues, within limits established by higher level agreements. In the education sector, decentralized negotiations take place both at regional level (Direzione/Ufficio scolastico regionale) and at individual school level. Rsu (*rappresentanze unitarie del personale*) are legally based bodies, introduced by a 1997 legislation, elected by universal suffrage every 3 years in each public administration unit with at least 15 employees; the last election was held in March 2012.

This institutional framework means that, since 1993, all Italian public employees are covered by a nation-wide sectoral collective agreement, renewed about every two years for wage issues and every four years for normative issues and by a decentralized collective agreement (called "integrative" agreement). In 2009 these two duration periods have been unified in a single 3 year period of validity of agreements, without distinction between normative and economic issues. Also decentralized collective bargaining is almost universally practiced, in sharp contrast with the private sector, where it covers only 25-30% of firms with more than 20 employees, and much less of smaller firms. However, as effect of the government austerity policies, since 2010 the entire bargaining machinery at national level has been suspended all over the public sector, first until the end of 2012, and later, by subsequent decisions, until the end of 2015. Also the room and resources for lower level, decentralized negotiations have been cut, consequently reducing the frequency and coverage of decentralized agreements. The wages and salaries of all public employees, also those remained under a public law regime, have been (and still are) frozen to the level of 2010.

As anticipated in the Introduction, in neither sector forms of involvement of service user representatives within the bargaining agents in collective negotiations are envisaged.

As usual in most advanced democracies (Visser 2006; Bordogna and Pedersini 2013), trade union density is in both sectors rather high compared with that of the private sector (just below or above 50%, higher in the education than in the health sector), with a highly fragmented union presence, especially in the Health sector. Also the participation to the election for the legally-based workplace representation bodies is traditionally quite high, especially in the education sector (about

80% in the last election of March 2012), while somewhat lower in the health sector (about 55%). The strongest unions, at least for non-managerial staff, are those affiliated to the three largest confederations (Cgil, Cisl, Uil), but at least two/three other 'independent' unions are also important in each sector.

3. User involvement in the Italian healthcare system

3.1. Historical background

User or citizen involvement in the Italian healthcare system traces back to 1978, at the age of the creation of the National Health Service, which replaced the Social Health Insurance system. Beyond the need for equality and universalism in guaranteeing the right to health, the NHS institution corresponded to the widespread demands for democratisation and citizen involvement in the healthcare organisations. These demands formed part of a wider request for participation and for opening up public institutions to society, raised from social movements emerged in the late 1960s and in the 1970s (Ginsborg, 1990). These movements were often allied, and also connected, with trade unions. Beyond the NHS creation, demands for democratisation and citizen involvement found clear expression in other reforms, such as the introduction of collegial bodies in schools, in 1974, and the administrative decentralisation within the municipalities, approved in 1976.

National legislation (Law no. 833/1978) placed participation among the fundamental principles of the NHS. The issue of participation is developed mainly in reference to the duties of Regions and municipalities:

1) the Regions, which from 1978 to 1992 were responsible for healthcare planning, drew up regional healthcare plans "after consulting the local government institutions, the universities within the territory of the Region, the organisations most representative of social forces and the healthcare workers" (article 11). In this article, democratic participation is conceived as consultation within the healthcare planning process. This consultation involves various parties, among them the "organisations most representative of social forces" and the "healthcare workers": in the social climate of the 1970s legislation seems to hint to trade unions, although these can represent professionals and workers in the healthcare sector as well as citizens or particular kinds of users. However, users or rather citizens seem to be represented mainly by local government institutions in the consultation process;

2) at local level, where public providers (hospitals, outpatient, prevention and rehabilitation services) were gathered within Local Health Units (LHUs), the municipalities had the statutory duty to ensure "the fullest participation of the healthcare workers, the existing social formations in the

territory…and the citizens, in all stages of the activity planning of the LHUs and in the social management of the healthcare services". Participation, defined and regulated by the municipalities, was not limited to planning, but had to be extended to the management of healthcare services. Moreover, according to Law 833/78, municipalities "shall also…regulate the participation of users who are directly concerned in the implementation of specific services", for the health education tasks attributed to the LHUs. This last statement is the only reference in the legislation to service user direct involvement, which can hardly be considered as participation, being more similar, in the Arnstein's Ladder of Participation, to the "Therapy" rung included in "non-participation".

Despite these challenging declarations of principle, the participation mechanisms activated at regional and local level were practically non-existent. In the absence of such mechanisms, user and citizen participation was in fact able to express itself only through the municipal councils and mayors, who had the responsibility to appoint the governing bodies of the Local Healthcare Units: this was therefore a very indirect form of participation. The capacity to effectively assert citizens' demands was assigned by a sort of *carte blanche* to the municipalities and their elected representatives. No channels, however, were created for direct participation of users and citizens, which remained completely undefined in the 1978 legislation.

Given the prevalence of political and partisan logics in the choice of the members of the LHU governing bodies, and in a social climate of the 1980s, marked by the decline of participation, the democratic participation promised by the municipalities was bound to be a complete failure. With the exception of individual cases, the municipalities turned out to be unable of assuring the point of view of users and citizens within the services. The inability of local communities to play an effective role in planning and managing healthcare services through municipal representatives expressed itself principally in terms of veto, i.e. in the opposition, often insurmountable, which citizens of small municipalities and local policy makers mounted against any proposals for closing small local hospitals.

The failure of municipalities and local political forces both in converting user/citizen demands into the organisational choices and in planning service provision in a rational way explains why a new NHS reform in 1992 deprived them of any power in service management and organization, transferring these competences and responsibilities to Regions (Maino and Neri, 2011). Some competences in local planning and, especially, in service quality evaluation were given again to municipalities in 1999 (Legislative Decree no. 229/99).

3.2. The 1992 reform and current national framework

Legislative decree 502/1992, which introduced managerialisation and managed competition in the NHS, profoundly changed the picture outlined by 1978 legislation. Title IV of the Legislative Decree 502, "Participation and protection of the citizen rights", consisting of a single article, no. 14, depicts in some ways the operating mechanisms of participation, devolving to Regional legislation their precise definition.

Article 14 lays down three levels of participation, national, regional and local:

1) at national level, the Minister of Health is charged with setting "a quality indicators' system for healthcare services and performance, relating to care personalisation and humanisation, to the right to information, to hotel services, and to the state of progress of the activity". To this purpose the Minister "shall make use of the collaboration of the universities…, of organisations representing users and NHS workers and of voluntary and rights protection organisations". The quality indicators must be used by the Regions to assess, "even in sociological terms", the state of implementation of citizen rights;

2) at a second level, the Regions, which now have the main powers in the NHS management and organisation, "shall promote consultation with citizens and their organisations, including trade unions, and in particular with the voluntary and rights protection organisations, in order to provide and collect information on the service organisation". These organisations must however be "heard" in the Regional planning and auditing process.

3) finally, at local level, the Regions must "favour" and regulate "the presence, within the healthcare organisations, of voluntary and rights protection organisations". This may include the creation of consultation bodies within the Local Health Enterprises (LHEs) and the public Hospital Enterprises (HEs), which are the public healthcare organisations created in 1992, accountable to Regions and comprising all the NHS public provision[2]. The voluntary and rights protection organisations (but also unspecified "organisations representing citizens") within the LHEs and HEs (inside or outside the consultation bodies) have to cooperate with public officials in monitoring and improving the quality of care, as well as in removing service failures, for example identifying "methods of collecting and analysing signals of service failure".

According to 1992 legislation, voluntary and rights protection organisations, as well as individual citizens can present "observations, objections, complaints and claims through administrative channels", within fifteen days of becoming aware of the behaviour or act in question, without prejudicing the right of recourse to legal action. Moreover, they can sign agreements and "joint

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[2] The Local Health Enterprises (LHEs) took the place of the Local Health Units which had been created in 1978. The LHEs are at the same time providers as well as purchaser (or commissioner) bodies within the quasi-market system introduced in 1992. Bigger hospitals were separated from the LHEs and gathered into autonomous (and public) Health Enterprises. Therefore, unlike England, the purchaser-provider split is not complete in the Italian NHS, depending on Regional choices.

programmes" with the LHEs and the HEs aimed at defining forms of cooperation and promoting "the adaptation of health organisations and services to the citizen needs".

As should become clear by the previous notes, the national level is the one at which participation undoubtedly remains much more limited and not continuous. In the regional level, there is more room for participation and user involvement, which can be classified mainly as information and consultation, concerning Regional planning as well as service organisation and monitoring.

At the local (and operational) level, references made to the creation of consultative bodies as well as to joint programmes to promote health service adaptation to citizen needs seem to open up space for institutional forms of collective participation, able to have a larger impact on the organisational decision-making, although the influence played by users still looks limited in general terms. User involvement is mainly intended as consultation and placation, in the Arnstein's language, but partnerships can be developed between user organisations and public healthcare organisations. However, unlike Arnstein's ladder, participation may not be simply classified as "tokenism" even in the consultation bodies, as we will see analysing the case study.

The priority given to the local/operational level is consistent with the 1992 reform design, aimed at introducing managerialisation and managed competition into the Italian NHS (Serapioni 2011). For this purposes the reform focused on individual patient choice, as an "exit" mechanism, instead of emphasizing collective forms of user involvement and voice mechanisms (Hirschman, 1970). Collective user involvement is considered mainly as an instrument to help managers to monitor access and service quality delivered by the healthcare organisations, but it has a subordinate (maybe complementary) role compared to that attributed to choice in addressing managerial priorities.

As a result, within the regulatory framework collective user involvement is focused almost exclusively on policy implementation and not on policy making where user influence looks very limited. However, user representative within the consultative bodies created after 1992 have always tended to extend their influence to policy making, though with incertain results, as shown in the healthcare case study.

The activity performed by the voluntary and rights protection organisations in monitoring service quality is connected with that performed by the Patient's Charter (or Service Charter) and the Office of Relations with the Public (ORP), both of them instituted in the course of the 1990s.

Inspired by the British experience of the *Citizen's Charters*, the Service Charters were introduced in 1994-1995 in all government departments and then in all public services. The Service Charter is the "document with which every service-providing agency assumes a series of obligations to its users with regard to its services and the means of delivery of these services and quality standards, and informs the user on the methods of protection provided" (www.urp.it). In the Service Charter, the

agency declares what services it intends to deliver, as well as the methods and standards of quality and quantity which it undertakes to guarantee for these services. The Office of Relations with the Public (ORP), which exists in most public service organisations (but not in schools), was introduced in 1990-1993 and its role was strengthened in 2000. The ORP has the statutory duty to enable users to get access to a public organisation and it is the principal instrument through which a public organisation performs the tasks of communications and relations with the public. In the healthcare sector, ORPs must guarantee the citizen the possibility of participating and accessing the LHE or HE activity, by providing all the necessary information for access and by listening to citizens, giving them the possibility of putting forward suggestions and complaints, as well as by monitoring user satisfaction. Therefore it is expected that the ORPs work in connection with user representatives and user associations within healthcare organisation such as LHEs and HEs. By and large, ORPs and especially Patient's Charters had a limited impact on healthcare organisations as well as in the public services as a whole. The government did not put much emphasis on these instruments, which did not have an importance comparable to UK. However, the case study in the healthcare sector shows how they can be pretty relevant connected with user involvement mechanisms at operational level.

From the 1992 reform the voluntary and rights protection organisations clearly emerge as having a prominent role in user involvement. At regional level, mention must be made also of the trade union organisations, considered not as representatives of the worker interests, but as organisation aimed at protecting user/citizen rights: in this regard, the trade union organisations for pensioners, maybe the main NHS service users, are of special importance. The trade unions are not explicitly excluded from the mechanisms of participation, but nor are they explicitly included as it was in 1978 legislation.

The 1992 national framework for user involvement says nothing about the way of selecting user representatives in the participation mechanisms at each level. In particular, the procedures were left completely undetermined for selecting the voluntary and rights protection organisations whose presence must be favoured in healthcare structures, and with whom common programmes are to be agreed, as well as the composition of the consultative bodies to be set up in the LHEs and HEs. The 1992 reform leaves the question completely unresolved, opening up a problem of establishing the legitimacy of those who are to represent the users/citizens and whether they are indeed representative.

National regulation about user involvement in healthcare has remained substantially unaltered since 1992, with the partial exception of some clauses introduced in 1999 by Legislative Decree Law no.

229, aimed at strengthening user involvement at regional level in monitoring access and service quality (Legislative Decree no. 229/1999).

User involvement through the voluntary and rights protection organisations seems, however, still to remain part of the process of planning and monitoring managerial and operational decisions, rather than entering into the decision of *policy*. If anyone can intervene in this sphere in some way it is the municipalities, as mentioned above.

Finally, after 1992 reform there is no connections about user involvement mechanisms or bodies and social dialogue institutions, which are considered as separate entities. The references to consultation processes at Regional and local level involving both workers organisations and citizens, which were mentioned in the 1978 reform though never implemented, do not exist anymore. However, trade unions may be consulted in the Regional planning and, above all, enter into LHE and HE consultative bodies not as workers' organisations, but rather as user rights protection organisations.

4. Healthcare system: Regional experiences and the case of Emilia-Romagna

As mentioned, national framework for user involvement in the NHS needed Regional legislation to be implemented. There is no comprehensive study of Regional legislation and policy on this issue.

From a first provisional "survey" which we have carried out[3], there do exist, scattered through the territory user participation bodies in many LHEs and HEs. These bodies are generally made up of a majority of representatives of voluntary and rights protection associations and a minority of representatives of the LHEs and HEs. As far as we know, they are always chaired by a representative of the voluntary and rights protection associations. Although there are significant differences, by and large these bodies are in charge of cooperating in assessing service access and quality.

Looking at Regional legislation, only ten Regions have chosen to explicitly include into their regulations the creation of consultative bodies (under various names) within LHEs and HEs, with the statutory duty of assessing service access and quality. In these Regions, furthermore, there is no certainty that the bodies are present in all the LHEs and HEs. Many of these Regions have later also set up such bodies at regional level.

In the following pages, we will describe one of the most highly developed and well-established experiments, that of Emilia-Romagna Region, in the Centre-North of Italy.

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[3] These information are drawn from the websites of Regions, LHEs, HEs and Agenas (the National Agency supporting Regional Health Services), from official documents on the subject, as well as from the interviews carried out in the research.

Emilia-Romagna made an early investment in user involvement, implementing the national framework in 1994 (Articles no. 15 and no. 16, Regional Law no. 19/1994). Successive regulatory interventions better defined the forms of participation and also widened its scope.

In 1994 Regional framework for user involvement, the national framework seems to represent a minimum base to be developed by the Regional government, for example promoting the consultation of citizens and their associations, with particular regard to the voluntary and rights protection organisations, on regulation concerning "service re-organisation and planning, as well as the methods of assessing the achieved results" (Article 15).

Collective forms of user involvement assumes a structural (and institutional) character, by the creation of the "Joint Consultative Committees (JCCs) for monitoring quality on behalf of users" within any LHEs and HEs (Article 16). The JCCs must provide for majority participation by the voluntary organisations and user rights associations, which entered in the regional Registry of the voluntary sector, and for minority participation by members designated by the LHE or HE chief executive, who are chosen among the medical and nursing staff.

The JCCs were set up for quality control, considered and assessed from the users' viewpoint. The Regional legislation is much more clear and explicit than the national legislation in addressing the consultative body's activity in this direction. Article 16, reviewed in 1999 (Regional Law no. 3/1999), specifies what is expected by quality control performed by the Committees:

"a) making quality control from the point of view of demand, especially with regard to service access;

b) promoting the use of service quality indicators on behalf of users at regional level (…);

c) experimenting with service quality indicators on behalf of users, defined at LHE or HE level, which take account of specific circumstances of local concern;

d) experimenting with methods of collecting and analysing 'service failures' ".

After 1994-1995 Joint Consultative Committees were created in every LHE and HE. In the course of the last decade the Regional government intervened several times on JCCs regulation by administrative acts to better define or to broaden its competences which remain, however, for the most part within the sphere of quality control. In this work of progressive adjustment the Regional managers took account, on the one hand, of the instructions which emerged in the dedicated seminars and meetings over the course of the years on this issue (such as the 2005 Regional seminar) and, on the other hand, of the proposals formulated by the Regional user associations.

Between 2000 and 2002 the Regional Consultative Committee for Quality (RCCQ) in the healthcare services was set up, as an institutional collective form of user involvement at regional

level. The RCCQ is composed, in the majority, of JCCs representatives, chosen from among the members of the voluntary and rights protection organisations, with a minority of representatives of the Regional Health Service, as we will explain shortly later.

The RCCQ has a consultative function and can provide recommendations for the Regional Health Department in matters related to healthcare quality and its assessment, particularly in the spheres of "information and communication for health; protection; participation; accessibility; continuity of care; service quality indicators on behalf of users" (Regional Administrative Act no. 508/2001). The RCCQ furthermore can get across the JCCs requests to the Regional management (and vice versa), in some ways "leapfrogging" the LHE and HE management, and above all it performs an activity of coordination and in part of homogenisation of the JCC activities.

4.1. The Regional Consultative Committee for Quality

The Regional Consultative Committee for Quality of services on behalf of citizens is made up of between 24 and 27 members, varying from year to year (at the moment there are 25 members). Among these, 17 are JCCs chairs, vice chairs or coordinators, all representatives of the voluntary and rights protection organisations. The Chair and Vice Chair of the RCCQ are chosen from among these 17 members, although this condition is compulsory only for the Chair. The RCCQ remaining members are "representatives of the Regional Health Service", chosen on the basis of their experience in the sphere of organisation and service quality, with particular regard to communication with the citizens. Among these are managers, representatives of

- LHEs and HEs;

- the Regional Department of Health (such as the Regional manager responsible for the Patient Charters) and Regional Health Agencies support the Department;

- a representative of the Assessorate of Regional Social Policies;

- a representative of the private providers associations (which count for about 20% of hospital provision in the Region, close to the national average);

RCCQ members are appointed for a three-year term and can be renewed. From June 2001 to December 2010 the Committee had the same Chair, the President of a JCC, while between the end of 2010 and 2014 the post was taken by two other user representatives. Apart from the senior management posts, scrolling through the annual reports on activities we find fairly frequent replacements of RCCQ members. The average attendance at meetings, which occur monthly (10-11 meetings per year) is 14-15 members. As in the JCCs, the participation of the RHS representatives is not always constant and represents a problematic aspect for the RCCQ life, although less so than

in the past, when for several years there was even the case of a Hospital Enterprise which had not even appointed its own representative to the RCCQ.

The Chair and the representatives of the voluntary and rights protection organisations have always striven to have high level managers as members of the RCCQ, as also for the CCMs, so as to involve the regional managers in the RCCQ and to have stronger legitimisation of its activity and decisions.

The main RCCQ activities consist substantially in: meetings with managers of the Regional Department of Health, who illustrate the Regional service organisation and the Regional health policy, and also with the Regional Minister of Health and the Chief Executive of the Department of Health; presentations of the activities of the JCCs; activities of the workgroups set up within the Committee; and discussion of problems and topics of the moment, suggested by RCCQ members.

The meetings with the Regional managers have a purpose that is at once educative and informative: to assert the user point of view, RCCQ members need to know the Regional Health System: data and detailed information relating to the population health and the healthcare services, as well as the Regional direction and orientation in health policy. The RCCQ annual reports state in detail the contents of the meetings, providing wide information on the healthcare organisation and the policies adopted in recent years.

From what can be understood, the communication has a predominantly unidirectional character, with limited, if any, interlocution by the RCCQ members, who have a role that is for the most part passive. A partial exception are the meetings with the Regional managers in charge of monitoring quality and user satisfaction or dealing with complaints. In these cases the role of the RCCQ members appears more active and the meetings are occasions for establishing or consolidating forms of collaboration in activities.

In 2007 JCC representatives started presenting their activity to the Committee. As declared in the annual report of the RCCQ for 2007, the presentations have the object of "socialising the various experiences of the Joint Consultative Committee and to try out a means of comparing them at regional level"; they also make it possible to "welcome all suggestions that are useful for improving or integrating the paths of the respective JCCs at local level". The presentations are at the root of the process of coordinating and homogenising the activities of the JCCs, which represent one of the principal objects of the RCCQ.

The workgroups are the essential working method within the Regional Committee. Usually two or three groups are set up every year and their activity often runs for several years, whether because of the complexity of the subjects they deal with or because of the difficulty to collect the information and data required, and draft a common document.

The groups range over a wide spread of issues: many concern the RCCQ or JCCs internal rules, as in the case of the groups charged with preparing a proposal document for amendments to the RCCQ regulations, or preparing a questionnaire to be sent to all the members of the JCCs; others concern research activities aimed at understanding the user satisfaction of specific Regional policies, as in the case of the research on the Integrated Home Care in the early 2000s, after that the Region reorganised the service; others concern the drafting of documents and proposals aimed at protecting and strengthening citizen rights within healthcare service (e.g. the Patient's Charter review or the "informed consent" regulation review).

The workgroups provide full expression for the role of the RCCQ, which assumes not only a merely consultative function but more sharply recommendatory. The capacity of the Committee workgroup proposals to have a substantial effect on the regional decisions is variable and remains undoubtedly a critical point: even in fields which are central to the RCCQ competences, such as user satisfaction and service evaluation by citizens, the role of the Committee often appears to support activities and initiatives unilaterally defined and arranged by the Regional Department of Health.

However, RCCQ relevance appears to be growing over the course of time, and there are important cases in which the Committee has had a fundamental or indeed predominant role in the definition of the final content of Regional decisions. We can mention the JCCs regulation review and, even more so, in the first part of 2000s, the definition of a uniform procedure for complaints and citizen reporting for all the (public) healthcare organisations in the Region. In this last case, the "Proposal for collecting, analysing and evaluating complaints and proposals for improvement" presented by the RCCQ in February 2001 had very significant weight in the final decisions by the Regional Minister of Health.

Using the Arnstein's ladder of participation, the case of RCCQ show how user involvement, formally designed to be bounded to tokenism (mere information, consultation and placation) is partially shifted to more substantial participation, with an effective acquisition of power by citizens. As far as we know, there is no relationship between RCCQ and trade unions. Linkages do not exist even in terms of shared membership: as we will see below, in the consultative bodies created at local level there are trade union members, which represent pensioners as a particular kind of users. On the contrary, no RCCQ member has never belonged to a trade union. At Regional level, collective forms of user involvement and social dialogue institutions are completely separate.

4.2. The Joint Consultative Committees

Joint Consultative Committees are the most important form of institutional participation for users/citizens in Emilia-Romagna's healthcare system. They involve a total of about 700 people

belonging to about fifty Committees set up not only at Local Health Enterprise and Health Enterprise level, but also in many of the territorial districts in which the LHEs are internally organised. JCCs are not required in private healthcare providers, whose associations have a representative in the RCCQ.

The JCCs are composed for the most part of representatives of the voluntary and rights protection organisations and representatives of the LHE/HE. The number of members can vary, from less than ten, in the case of some district JCCs, up to several tens of members for some of the larger LHEs and HEs. The Regional Department of Health is limited only to suggesting a "non-numerous" composition (an indication which is therefore not always respected), "for the purpose of ensuring the operation" of the CCM (Internal Administrative Act no. 10/2010). All the members of the JCCs are designated by the corresponding LHE/HE. Those belonging to the voluntary sector must belong to organisations entered in the provincial Register of voluntary organisations[4] and are designated on the proposal of the organisations themselves "according to procedures agreed at organisational level".

Besides being entered in the Register of voluntary organisations, associations represented in a JCC must demonstrate, "in documentable manner, that they are active in the healthcare and social sector", while the selected members must not have any work relationships with the LHE or HE which the JCC belongs to, nor can they be members of "institutional, directing or collaborating bodies" of any public or private healthcare organisation in the Region (Internal Administrative Act no. 10/2010). The JCC members who represents the NHS are to be chosen from among the medical and nursing personnel; within the JCC, furthermore, the participation must be favoured of a general practitioner and of a representative of the local government institutions, such as the mayor of the biggest town in the area.

All the JCC members are chosen by the corresponding LHE or HE and appointed by their Chief Executives. Members are selected by co-optation from the top: this gives formal legitimacy to the consultative body but does not provide representativeness, which is uncertain. Moreover, co-optation from the top runs the risk of promoting collusion and self-referencing behaviour (see also Altieri 2011).

The method adopted for selecting the JCCs members is connected with the general conception of the Joint Consultative Committees, which are considered a constituent part of the LHE/HE. This element appears several times in the Regional documents. Internal Administrative Act no. 3/2005,

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[4] The requirements that the organisations must satisfy for entry in the voluntary sector registers concern the absence of profit motives and of all forms of remuneration of the members, elective and free offices and services to be provided free by the members. Moreover the organisations have to present their accounts and the democratic nature of their internal structure has to be evident.

for example, repeats "the JCC belonging to the LHE or HE...This 'belonging' contributes to defining the sphere of action of the JCC within the health needs of the citizens managed by the Regional Health Service and underlines the Committee's role of active collaboration in the solution of the problems". The JCC must therefore be "considered a resource" by the LHE/HE, by which it must therefore be "fostered, supported, listened to".

The Committee therefore does not set itself up in opposition to the LHE/HE, but as "a privileged interlocutor"; for this reason the public healthcare organisation needs to identify opportunities of debate with the JCC and "forms of interaction with the managing Board". This is a case, however, of a very particular interlocutor, given that at the same time the JCC is doubtless also a constituent of the LHE/HE. The ambiguity of this position is evident and has already been noted by the literature, which has underlined the risks of fully incorporating the JCC into the public healthcare organisation.

5. Case study: the Imola Local Health Enterprise

The Imola Local Health Enterprise is located in the Emilia-Romagna Region, in the Centre-North of Italy, about 35 km east of Bologna. Created in 1994, it is a middle-sized LHE with over 1,700 staff (5% of the total workforce in the area), split amongst a general hospital mainly providing acute health care services, a highly specialized rehabilitation hospital, a community hospital and several outpatient and community care services. It covers an area of ten municipalities, with about 135,000 inhabitants altogether. Imola LHE is not only a provider healthcare organization but also a commissioner, which purchases services on behalf of its population, from Bologna public and private hospitals and from private outpatient diagnostic and treatment located in its territory. The general hospital (410 beds) is located in Imola, the biggest municipality (70,000 inhabitants) in the area; it provides health services mainly for the population living in the LHE area. The small rehabilitation hospital (158 beds), located in the small Montecatone municipality, provides highly specialised neurological rehabilitation services for patients from all over Italy. The community hospital (about 50 beds), provides mainly long-term and low-intensity care, with units managed mainly by general practitioners and nurses, instead of specialist doctors.

5.1. The Community and its hospital

As emerged from the interviews, the Imola local community has a strong tie with its hospital, rooted in the local history. In the past centuries and until the end of the seventies three mental institutions were concentrated in Imola and in the neighboring municipalities; therefore healthcare was an

important occupational source especially for nurses and care professions. One of the main objectives of social movement pressure, the Mental Health Reform Act approved in 1978 (the same year as the NHS institution) which closed psychiatric hospitals in Italy (Foot, 2014), was a traumatic event for this community, although the Imola hospital has kept a well-regarded mental health ward and a highly professional mental health Department in the LHE.

The concentration of mental health institutions fostered the development of a great many voluntary associations and third sector organisations in the social and health care sectors, with a membership presenting a high number of retired or still employed nurses and social workers. These organisations are widespread not only in the psychiatric area, where they played a very important role in integrating mentally ill people into the community after the psychiatric hospital closures, but in the healthcare sector as a whole.

Considering that Emilia-Romagna is a Region with a high (though declining) level of civicness and social capital by Italian and even international standards, partially due to a historical and long-term legacy (Putnam 1993), local government as well as social and health care public institutions may rely on a local community and, especially, a third sector organizational environment which are highly motivated and willing to cooperate, but, at the same time, provided with a high level of expectations from public services.

Moreover, the Imola local community has an emotional attachment to the hospital which is considered a constituent part of its identity. This attitude, which is common especially in small and medium size towns not only in Italy (Moon and Brown 2001), is strengthened by the historical rivalry with the Bologna area. Periodical attempts by the Regional Department of Health to merge Bologna and Imola LHEs are frustrated by the Imola community's fierce opposition, fearing the closure or downsizing of its local hospital.

The attachment to the local hospital does not emerge only in terms of opposition to rationalization plans, but it is expressed also in the everyday hospital activity, as reported by an Imola LHE manager:

Imola citizens consider the hospital as a local community property. The hospital belongs to them. You can't think of re-organising any element of a hospital service, move a medical device, change the visiting hours, even temporarily, without their consent or at least without giving them their say…you can't do anything without their knowing…

In some ways this attitude has also consequences in terms of monitoring or, rather, in terms of "social control"

If something wrong happens, if a doctor doesn't behave properly or a nurse is rude to a patient or his family, the information spreads very quickly, someone comes here to tell you and ask for an explanation. This has been very helpful in identifying some cases in which professionals promoted their private practices at the expense of the NHS services and, of course, it can be useful in introducing little improvements in the hospital services, let's say in the signage inside the hospital. However sometimes it is difficult to tolerate if you're not used to it…especially elderly retired people think they've the right to come here to be heard, complaining and asking for an intervention. And if they don't feel satisfied, they go to the mayor who calls you and asks for an "arrangement".

In the following pages we will describe the Imola JCC activities, showing how the relationship between the hospital and the local community influences and partially shapes the way institutional mechanisms for collective user involvement work in the Imola LHE.

5.2. The Imola Joint Consultative Committee

The Imola JCC was instituted in 1995 by the LHE. At the beginning it had 20 members, 13 users representatives and 7 NHS representatives. However the membership was progressively widened under the pressure of the voluntary sector and user associations and, as a result, there are currently 26 JCC members, among which 19 represent voluntary and user associations. Moreover, some associations agreed to "share" the same seat within the Committee, choosing one common representative or alternating their representatives at the Committees: for example the blood collection association representative interchanges his participation in the Committee meetings with the blood transfusion association representative. In this way the LHE tries to ensure the participation of all relevant user and rights protection organizations in the area, without creating an unwieldy and ineffective body.

JCC meetings take place once a month. Absence rate by LHE representatives is very low, thanks to the rule introduced in the middle of the 1990s, to accept members substitutes delegated by "official" members. Within the JCC, Imola LHE is represented by high level managers from both hospital and outpatient services, while the current CEO usually takes part in the meetings as a "guest member".

As mentioned above, JCC essential tasks concern service quality control from the users' point of view. The JCCs has to cooperate with the LHE/HE, and especially with the Office for Relations with the Public, by implementing:

- methods of measuring quality from the user's point of view;

- initiatives for measuring user satisfaction and/or initiatives of education, health promotion and risk protection;

- initiatives for quality improvement, consequent on the analysis and evaluation of data reporting user dissatisfaction;

- updating the Patient's Charter, monitoring the respect of the standards and targets set in the Charter.

The Imola JCC was engaged in performing these tasks by undertaking a wide set of activities, as emerged in the interviews and the documents examined. Some of these activities seem to concern the method of working, such as "examining documents and legislation", "activation of workgroups", "comparison/confront with experts" or even "taking part in training activities".

Training is considered a very important task by JCC members since it is preparatory and necessary for fully understanding the characteristics of healthcare services and Regional policies. Even Regional official acts (such as the Internal Administrative Act no. 3/2005) lay down among the operating instructions for LHEs the commitment which they must undertake in training the JCC members CCM.

Therefore, after the creation of the Imola JCC in 1995, its members decided to devote most of the time, for the first two years, to training activities which have continued to be very relevant.

Training was and is mainly carried out by Imola LHE managers and clinicians. The risk is obviously that training assumes a character that is hardly transparent and not neutral, if not manipulative, coming from the same organisation in which the JCC members are called on to assess the quality of the services provided. As far as we understood from the interviews, at the beginning the information and education process was mainly unilateral, with the user representative merely playing a passive role. However, the process has become much more interactive over the years: many users have become more expert and are often able to effectively interact and discuss with managers and professionals.

One of the main Imola JCC activities has always been taking part in identifying and experimenting with indicators on access and service quality; this is especially true for standards and targets which are inserted into the LHE Patient's Charter. The Imola JCC played a very important role in creating the Patient's Charter in the second half of the 1990s, and then in its periodical review. This concerns in particular the definition of the indicators and standards relating to service access, or aspects relating to quality such as waiting times, communication between operators and users, access and transmission of personal clinical documents by patients, hotel comfort and maintenance of the hospital rooms.

In the process of creation of the first LHE Imola Patient's Charter, after the initial fine-tuning, the JCC members went personally to check standards and targets which they had contributed to identifying.

We went ward by ward to check standard and targets…at the beginning the staff weren't happy to see us and sometimes it was very difficult to be accepted. But most of doctors and nurses soon realised that we weren't there to check and criticise them, but to help them…we weren't inspectors or spies sent by the management. We were only people who could help them to make things go better, without evaluating the way they do their job

Staff opposition has been completely overcome over the years in most of the health service units, insomuch as, according to the ORP coordinator

Volunteers are requested by wards...when staff has to explain to patients some changes they introduced in the service organisation and to check how it works, the consultant calls us and asks us to send a JCC member there.

Direct standard monitoring in the first Patient's Charter enabled JCC members to take part actively in the revision and selection of the indicators and standards identified, providing a new Patient's Charter version which was more manageable and useful for users.

Monitoring indicators in the first Patient's Charter proved very hard…we certainly learned an incredible amount of things about how the hospital works and what the doctors and nurses do, but none of us wanted to think it was possible to repeat that kind of job…certainly not in that way. So we agreed with pleasure to the ORP coordinator proposal to reduce the number of monitored indicators and to provide a shorter Charter.

The Patient's Charter creation and review clearly highlight a central aspect of the Imola JCC activity, which takes place in close collaboration with the LHE offices, especially with the Office for Relations with the Public. This cooperation is evident, also in a physical manner, given that the JCC share the same rooms with the ORP and JCC members have quite free access to the ORP. This choice was deliberately made by the Imola LHE management in the 1990s and it was subsequently confirmed and kept until now, becoming a sort of taken-for-granted element in the internal organisation, which also resisted attempts to weaken the cooperation, carried out by some LHE managers over the years. In the words of the ORP coordinator

This is not my office…this is my office and at the same time JCC members' office…they come in and out whenever they want, everything is open here. I cannot keep secrets from them, it would be simply impossible and, maybe, it wouldn't be fair

This choice, deliberately made by the LHE management, has positive and negative consequences on the daily work, but the trade-off seems to be acceptable to the ORP coordinator and staff

When the volunteers [JCC members] come in, you often have to interrupt what you're doing and listen to them…you know, they're often people with their wife or son suffering from a illness, or they're patients themselves. There is also a JCC member, a patient belonging to a mental health association, who often comes here, sits at the desk near mine and works for hours with the PC, and if you need to have a meeting with other hospital staff members, it is very difficult to make him understand he has to go out
However, if you ask them to do things like interviewing patients for a survey, checking the new signage in the A&E department or inserting survey data for hours and hours, they do it without any complaint and they're even happy to collaborate

This close collaboration between LHE offices and user representatives is not widespread. In some LHEs and HEs the relationship between the two parts appears to be problematic, as emerges both from some research performed in the first part of the 2000s and from a regional seminar on JCC held in March 2014.

Beyond the Patient's Charter, many other activities frequently mentioned by JCC reports concern quality monitoring and assessment: "participating in monitoring signals of service failure and detecting emerging critical situations", "defining, detecting and analysing indicators in the LHE for the quality assessment from the user's point of view", "taking part, if appropriate, in LHE surveys about customer satisfaction".

JCC reports often illustrate in detail the role of its members in performing these activities: this information was confirmed by the interviews. For example JCC members are involved in "drawing up the Check List for measuring perceived quality in the hospital wards" or in "monitoring access at the A&E Department…over 18 out of 24 hours, from which it emerged that some of the accesses were not carried out in proper condition", or in "checking the signage in the hospital wards and in the outpatient services…which resulted in some significant improvements".

In the JCC reports there is also a very extensive analysis of the report on claims and notifications made available by the ORP. From the analysis the Committee has drawn up a short document

addressed to the LHE management, where specific cases are pointed out and proposals for improvement are set out. In some cases this process resulted in "visits" into the wards, carried out jointly by JCC members and LHE managers, to discuss the problems highlighted by users directly with professionals and workers. In others, specific JCC suggestions have been adopted by the LHE. The JCC pays also great attention to the reports on waiting times, which is traditionally a critical issue and a reason for discontent by users and citizens. In this case, JCC suggestions and recommendations to undertake substantial measures to reduce waiting times and waiting lists are found difficult to accept, at least until recent times, as we will describe below.

5.3. Impact on employment conditions and work practices

Suggestions and recommendations made by the JCC may directly or indirectly bring LHE to carry out "Improvement Actions" on service organisation and activity. Improvement action impact should not be exaggerated, often concerning small changes in the services provided, but it should not be undervalued, as frequently happens. By fostering or contributing to promote improvement actions, JCC has an impact, though limited, on employment conditions and work practices. Some improvement actions can be described to illustrate this point.

1. In 2010 the JCC and the ORP undertook a survey on mental health departments, monitoring the service quality perceived by patients and their families. After being specifically trained, JCC members took part in the questionnaire definition, data collection and insertion, as well as the subsequent meeting to discuss the results with professionals. Some recommendations provided in the report on survey results, jointly drafted by ORP and JCC, were converted into improvement actions, such as those aimed at allowing visits by other mental health patients within the psychiatry hospital ward and extending the visiting hours for patients' families and other friends. These changes entailed staff working in the psychiatric hospital ward partially modifying their work shift distribution, to allow a greater staff presence in the extended visiting hours.

2. From a survey carried out on patients attending the obstetrics and gynaecology outpatient unit in 2012, attendance at pre-maternity courses was shown to be impossible by a significant number of pregnant women and their partners because they were arranged during the morning or early afternoon. This critical situation was reported by JCC, which underlined the consequences in terms of health inequalities, given that that situation clearly disadvantaged some population groups, such as immigrants or manual workers. Thanks to an improvement action, and despite some initial staff opposition, the LHE re-arranged its pre-maternity courses concentrating them in the early mornings or in the evenings. As a consequence, staff units in the obstetrics and gynaecology partially changed their work shift and working time organisation.

3. Between 2013 and 2014 many complaints were reported to the JCC and the ORP about the "drug direct distribution Service", that is the LHE Service directly distributing medication to patients with chronic pathologies (LSEs directly buy these drugs, which are completely free of charge to patients, in order to get cheaper prices from the pharmaceutical companies). Main complaints concerning the recent reduction of the service opening hours, due to staff shortage. JCC put pressure on the hospital and LHE management to deal with this problem, which was determining an increasing dissatisfaction. The CEO and its staff are currently preparing an improvement action aimed at re-extending the opening hours of the drug direct distribution Service, involving in this task the hospital service in charge of distributing all the drugs for inpatients within the Imola hospital. The staff of this hospital service will have to partially change its work shift distribution and workload will be intensified as well.

As shown above, a typical impact on work conditions by user pressure concerns working time and work shift. This will be the case also of the extraordinary waiting lists plan carried out at Regional and local level in autumn-winter 2014, which should be implemented in the next months.

Thanks to the extra-fund provided by the Regional Department of Health to tackle waiting lists, Imola LHE decided to extend to Sunday morning the outpatient service for procedures with very long waiting lists (e.g. MRI scan and several ophthalmology procedures). This should be the first step to provide outpatient procedures in the morning and afternoon through the weekend.

It is certainly true that the Region took this resolution under the pressure of the Regional elections taking place in November 2014, but user pressure played a role in the decision both at Regional and a local level. In Imola, the local JCC contributed to address to LHE management to the choice of extending the public service opening hours, limiting the purchase of contracted services by private providers.

Beyond these and other similar cases, JCC activity is having a general effect on work practices, fostering standardisation and formalisation. Critical issues emerging from complaint analysis and from surveys carried out in many wards concern procedures for hospital admission and discharges, which resulted too discretionary and erratic in both cases. This prompted the LHE management to draw up two procedure manuals respectively for patient admissions and discharges, in recent years. According to what emerged from the interviews, implementation of formally defined and very detailed standard procedures determined both an improvement and a homogenisation in work practices. Complaints and conflicts with users declined, despite an increase in the administrative workload. Similar effects have been more recently reported by the introduction of a standard pain record sheet among the documents to be inserted within the nursing documentation.

5.4. JCC and social dialogue

In Imola, Local Health Enterprise Joint Consultative Committees as the established form of collective user involvement, on the one hand, and social dialogue institutions, on the other hand, are separate entities, so reflecting the national regulation on user participation and NHS organisation. Although recommendations and suggestions made by the JCC as well as issues debated in its meetings can have an indirect impact on work and employment relations, it is the LHE management which deals with the unions. JCC has no relationships with trade unions and JCC members as well as LHE managers seem to take for granted this well-established arrangement.

However, separation of JCC and unions is not complete: pensioner union members are included within the JCC members, representing one of the most important categories of health service users. This double membership puts pensioner union representatives in a difficult position within the JCC. On one hand, other JCC members often criticise them for adopting a confrontational stance, which would not be proper in a consultative and cooperative body. Moreover, they are accused of having a partisan attitude, while JCC members should think themselves as representing the "general interest".

As soon as the meetings start, they start contesting the management and spend their time making specific claims targeted for pensioners and elderly people. They believe they are at a bargaining round. Most of them don't understand they are in a Committee meeting, where they have to make the effort of representing the general interest of the users and of the community. They should cooperate, not waste time in useless debates with doctors and managers.

On the other hand, JCC non-trade union members, both user and LHE representatives ask pensioner union representatives to perform as a sort of "mediator" or to make pressure on their workers' union "colleagues", when JCC and the LHE want to promote service changes which could meet union opposition because of the negative impact on work conditions. This happened, for example, in the above mentioned dispute on the drug direct distribution service, or in the case of the JCC periodical requests for extending the administrative office opening hours, which have not had any result so far. Pensioner union representatives JCC are reluctant to play this role, which puts them in an embarrassing position and highlights the potential conflicts between users and workers, instead of the opportunities for cooperation. However, JCC non-union members do not seek a direct relationship with workforce trade unions: this is an exclusive competence of LHE management. Quoting the words of a JCC member

It is the management board which deals with unions…it is not our business. They have different tables, different meetings and I've never thought we should be invited or involved.

Despite this common and very rooted belief, the cases briefly mentioned above and in the previous pages show that there are common issues which, in some ways, can be dealt both with service user involvement bodies and social dialogue institutions and therefore there are potential linkages between the two entities. However, none of the involved parties (user representatives, LHE managers, trade union members) seems to be aware of the existence of these connections and of the possibility to build on them.

Probably one of the main reasons why service user involvement and social dialogue institutions are viewed as completely separate is rooted in the same JCC institutional arrangements. The model of institutional user participation represented by the Joint Consultative Committees is of a strongly inclusive and indeed encompassing nature, incorporating user representatives within the Local Health Enterprises. User representatives and their bodies are not considered entities distinct and separate from the LHEs, but they represent a constituent part of them.

This view, recommended by official Regional documents, is shared by LHE managers and, above all, by most user representatives who do not consider themselves as a distinct and potentially opposing party from LHE but, rather, an LHE entity which is supposed to cooperate with the management, in some ways like any other office belonging to the organisation, with a view to pursue the public interest. Therefore they criticise the few JCC members who do not to share the same attitude, that is pensioner user representatives, who are seen as "partisan" members, representing interests of a single group of users.

As a consequence, JCC user representatives do not feel the need to take part in social dialogue institutions. In some ways, they are represented by the LHE managers in social dialogue and, when this doesn't happen properly, it does not imply that they have to search for direct representation.

This rooted belief is supported both by regulatory and cultural elements. Selecting the JCC members by co-optation from the top management contributes to user representatives incorporation within the public healthcare organisation, and initial training carried out mainly by LHE doctors and managers acts as a socialization mechanism for the new members. Moreover, in the case of Imola, cooperation between public managers and user representatives is fostered by the relevant diffusion, though declining, of social and cultural values inspired by trust in public institutions and on a common feeling of pursuing the general interest of the community.

6. User involvement in the Education sector

6.1 Historical background

Italian school institutions have historically represented a highly centralised hierarchical organisation, by and large corresponding to the dysfunctional bureaucracy described by Michel Crozier (1963). Unlike the Italian NHS which was highly decentralised from its inception, public schools, which comprise the great majority of Italian schools, were (or were supposed to be) the final loops of a command-and-control system headed by the Ministry of Education. School management was completely attributed to the central, regional and provincial offices of the Ministry of Education, with most powers concentrated in central Departments. Single school autonomy and discretionary power in teaching, organisation and human resource management was completely absent as well as user involvement mechanisms.

This organisation has been partially changed by reforms introduced in the last decades, although the system has always shown an extraordinary resistance to change. In 1998-99 schools were attributed autonomous powers in management and organisation, to the detriment of regional and provincial offices of the Ministry of Education. However these changes only marginally concerned human resource management: in particular, schools do not have any power in choosing headmaster, teachers and the rest of the staff (technical, administrative and auxiliary staff), who are directly employed by the Ministry of Education (about 990,000 employees only in schools) and continue to be appointed, distributed and transferred by central and peripheral ministerial offices, according to national, highly uniform rules.

This often causes highly dysfunctional situations, which are well represented by the case of temporary teachers with one-year contract. Such temporary teachers are widespread in Italian schools, although recently declining in number (presently they amount to about 150,000 teachers, out of about 800 thousand teachers in all), due to legal and financial constraints on hiring and staff turn-over periodically implemented in the last two decades in the school sector as well as in public administration as a whole. Rules for appointing one-year contract teachers have been shaped over many years responding to several contradictory demands. Therefore they are extremely complicated and constantly raise trade union and teacher association protests, as well as a great number of legal disputes. Nearly every year the Ministry of Education introduces changes aimed at solving the most controversial problems but, as in the Crozier bureaucracy, this causes new disputes and protests.

As a result, the teacher appointment process, performed by Ministerial offices, is extremely complex and highly controversial, requiring a great amount of time, which leaves many schools as

well as students and their families in a state of uncertainty about the final composition of the teaching staff[5].

In this situation, user involvement is often viewed as a means of breaking the bureaucratic and self-referring school organisation, as is clear analysing the 1974 reform which introduced user involvement within Italian schools.

6.2 The Joint Management model and its evolution

The first structural attempt to change this bureaucratic and in many ways self-referring system dates back to the 1970s and was focused on user participation. Under the pressure of the social and political movements which asked for greater democratisation and citizen involvement in schools as well as in other public institutions, the central government and Parliament approved six acts between July 1973 and May 1974, known as the "Delegated Decrees[6]".

Among these acts, the main innovations for our purpose were included in the Decree of the President of the Republic no. 416/1974, which introduced the "collegial bodies" including user and staff representatives. These were consultative and deliberative bodies, which had to represent the cornerstone of the new school governance at organisational and territorial tiers, inspired by a model defined as "joint-management democratic participation". The 1974 legislation created collegial bodies at several levels:

1) at the level of provinces, which are the traditional local government elected bodies placed between Regions and municipalities, Province School Councils were created covering a population of between 10,000 and 200,000 inhabitants, according to choices made by Regions. Province School Council members comprised representatives of municipalities, school management, staff and students' parents. Staff representatives had to be at least 50% of the total Council membership and parent representatives 25% of the members. Both staff and parent representatives were directly elected. The Council, whose mandate lasted three years, had mainly consultative functions in school organisation within the Province area and in this respect their counterparts were the Province Department of the Ministry of Education (Articles 13-15, DPR no. 416/1974);

2) at sub-province or town level there were the District School Councils, covering a population of under 100,000 inhabitants. The District School Councils, renewable every three years, comprised 44

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[5] The current Italian government promised to stop this situation by permanently hiring 140-150,000 temporary teachers by 2015-2016. This decision was also determined by the judiciary case promoted at the European Court of Justice by some unions against Italy for violation of the European regulation on temporary work. The European Court of Justice sentence just released (November 26, 2014) directed Italy to hire or compensate all the teachers which worked with renewed temporary contracts for more than 3 years.

[6] Delegation Law no. 477/1973, Decree of the President of the Republic (DPR) no. 416, 417, 418, 419, 420, all approved in 1974.

members representing various different groups: school management (4 members), teachers from public and private schools (6 members), parents (7), secondary school students (6), the District municipalities and province, as well as representatives appointed by "most representative non-school worker trade unions…by most representative autonomous worker associations", one "entrepreneur" and representatives from cultural territorial institutions selected by the province. School management and teacher representatives as well as parent and student representatives were directly elected by all the members of their group every three years.

Therefore within the District School Council there were both user and interest organisation representatives. However, these bodies did not have any direct competence in social dialogue matters. Created to ensure "the democratic participation of local communities and social forces to the schools and to their management", the District School Council had consultative and deliberative powers on extra-curricular activities, such as the activities taking place within schools out of school hours (especially sports or cultural activities); school support activities such as school medicine; vocational guidance services and adult education (Articles 9-12, DPR no. 416/1974);

3) at school level, School Councils were created, including teacher and other staff, parents and, in the secondary school, student elected representatives. In the 1974 framework School Councils were the principal collegial bodies, with both consultative and deliberative powers on school management and organisation. Their main competences concerned (Article 6, DPR no. 416/1974):

a) the approval of the school internal regulation;

b) the definition of the general criteria for planning and carrying out extra-time school activities, with special attention to extra-time courses for students, excursions and special activities;

c) the definition of general criteria for class composition, school time and school timetable;

d) the promotion of school participation in cultural, sport or spare time activities characterised by "special educational interest";

e) the promotion of relationships with other schools or educational institutions;

f) the approval of the necessary interventions to adapt the school calendar to local needs.

These competences are shared with the "Board of School Teachers", the school teacher body which includes all school teachers and is in charge of all teaching issues, and with the headmaster. These bodies have a prominent position compared to user involvement bodies, in all teaching issues and in the organisational matters concerning school time and school time activities. However, even in this matter the 1974 regulation allows user representatives to make proposals and suggestions, as well as to have some relevant veto powers. Therefore the "joint-management democratic participation" model within schools is based on a partnership between the main school governance bodies. These

are not all in a position of equality and do not have the same powers and responsibilities, but the regulatory framework presumes they work in close cooperation.

The School Council members were 14 or, in schools with more than 500 pupils, 19. The membership included the same number of teacher and parent representatives, respectively 6 or 9 according to School Council dimensions. Teachers and parent representatives were both directly elected by all the school teachers and students' parents. Membership comprised also the school headmaster and 1 or 2 non-teacher elected staff representatives, while in the secondary schools (15-18 year-old pupils) the parent representatives were reduced to include 2 or 3 student elected representatives. School Councils were renewed every three years, when elections took place in schools.

The collegial bodies within schools were completed by the class councils, including all the teachers in a class, two elected parent representatives and, in the second level secondary schools, two elected student representatives. Class councils had certain tasks in coordinating class activity and promoting extra-time activities, or excursions classes.

As already mentioned, institutional forms of collective user involvement depicted by the 1974 regulation seem to give parents and students a significant role in the school governance at local and, especially, at single school level. Using Arnstein's framework, user participation can be interpreted as "partnership" and maybe also as "delegated power" by public school authorities. Power in school organisation and management is shared with traditional public institutions (Ministerial peripheral offices, school headmaster and school teacher bodies); citizens seem to be able to condition school decision making and have their say in teaching and educational issues. Moreover, unlike the user representatives in the healthcare sector, users within the school collegial bodies are highly representative because they are selected by means of direct elections by their constituencies, so they are granted a high level of legitimacy. Three-year Council renewal by elections should also provide these bodies with a certain degree of accountability.

However, collegial bodies' competences did not deal with employment relations or work condition issues and did not have any direct relationship with social dialogue institutions. It is true that user and trade union representatives were both members of the District School Council, but these bodies did not have any competence in employment relations issues. This "separation" was connected to the competence distribution within the Education Ministry: main powers in human resource management and employment relations issues were concentrated in the central Ministerial offices, that is at a decisional level where any institutional user involvement body or mechanism was absent. The governance arrangements set up in the 1970s assumed high participation levels to work properly. Not by chance they were designed and implemented in that decade, under the pressure of

mass social movements in which university and secondary school students had played a leading role, revealing a great ability in mobilization.

In the 1980s, when participation strongly declined, school collegial bodies showed all their deficiencies. Council participation to election for parent representatives quickly declined to 10-15% of the potential voters and it was often hard to find parents willing to run as candidates, especially for the Province or District School Councils. These Councils weren't able to play a significant role in school governance; neither Ministerial office representatives nor staff and union representatives nor other social forces involved found any interest in giving importance to these bodies, which ended up being only bodies where decisions already taken elsewhere were formally approved.

The School Councils were able to play a greater role within schools, but they were usually subordinated to the headmaster and the Board of School Teachers. In particular, even in the cases of higher participation, they showed a lack of necessary expertise to interact with the headmaster and the teachers on an equal level. Therefore they worked mainly as consultation bodies, with limited or no relevance in all the choices concerning core activities (essentially teaching), performed during school time, as well as in their management and organisation. This was also due to the centralised school organisation, which allowed the other school governance bodies only very limited discretionary choices on these matters.

Parent and student representatives were able to play a more active role promoting initiatives and concretely influencing decision making only in the extra-curricula activities, for example in organising courses not included in the ordinary school teaching and national curricula, such as theatre or, in many kinds of school, music, or organising seminars open to parents and students with educational and civic purposes such as "Learning Disabilities" or "Education to Legality".

As a result, in the 1990s the collegial bodies were reformed (Legislative Decree no. 297/1994; Legislative Decree no. 233/1999). The District and Province School Councils were abolished and had to be replaced by a Local District Council, at municipal level, and a Regional District Council. These Councils have exclusively consultation functions. The Regional District has to be consulted by the Regional Education Office of the Minister of Education in the choices concerning staff and its distribution. However, these Councils have not been created so far. Their institution was always postponed to a new collegial bodies reform, considered necessary after the 2001 Constitutional Reform which decentralised some competences to Regions also in the education sector. Several collegial bills   on this matter have been presented in the Italian Parliament over the last fifteen years with different orientations, but they have never been approved so far.

Therefore, since 1999 the only existing collegial body is the School Council. Its powers were strengthened by making the annual school budget as well as the "Educational School Plan",

including all school teaching and educational activities, subject to its mandatory approval (Legislative Decree no. 233/1999).

Beyond these new and potentially relevant attributions, after 1999 the role played by School Councils was supposed to increase because, as mentioned above, single schools were attributed a greater autonomy from Ministerial offices in school organisation and management, although this did not concern employment conditions and human resource management (Law no. 57/1997; Legislative Decree no. 112/1998; Legislative Decree no. 275/1999). The school autonomy reform provided room for arranging courses or other activities not included in the national teaching and educational programs, as well as for undertaking partnerships and initiatives with other schools or public and private institutions aimed at developing specific educational and teaching activities. The School Councils were directly invested by these new competences and directly interested in exploiting these opportunities.

However, as far as we know, this did not change the subordinate position of the user participation bodies in the school governance. Moreover, potential room for promoting extra-time activities was seriously limited by the lack of resources, due to the austerity policies which have affected the School sector over the last decade and especially in the last years, severely limiting individual school autonomy.

7. Case study: the Leopardi school

The first-level secondary school or middle school (11-14 year old pupils) Giacomo Leopardi is located in Castelnuovo Rangone, a small municipality (about 15,000 inhabitants), in Emilia-Romagna, in the Centre-North of Italy, about 45 km west of Bologna. The school is part of a "comprehensive school institute[7]", as it is called in the administration language, which took the name from the existing middle school. The comprehensive institute includes two kindergartens, two primary schools and one middle school, that is Leopardi middle school, all located in Castelnuovo and in the neighbouring municipalities.

While Italian schools are traditionally single and distinct entities, all subordinated to the Ministry offices within a traditional hierarchical (and bureaucratic) organisation, comprehensive school institutes were introduced in 1994 to merge state kindergartens, primary and secondary schools in one single administrative entity (Law no. 97/1994). Comprehensive institutes were originally planned for service rationalization in rural areas and highlands, but they were soon considered as a means to promote innovation, by supporting continuity of education over different age groups as

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[7] Comprehensive school institutes were introduced in 1994 to merge state kindergarten, primary and secondary schools in small municipalities, especially in mountain areas

well as by encouraging professional exchanges and experience sharing among different kind of teachers. Therefore, the Minister of the Education promoted their creation throughout Italy, especially in the years following the 2000 school reform (Legislative Decree no. 30/2000) and again in 2011-12, when they were about to be universally adopted as the standard school organizational model. However, in June 2012 the Constitutional Court stopped this process for violation of Regional autonomy (Judgment no. 147/2012). Currently about 30% of the schools are gathered within comprehensive institutes.

As a whole, the comprehensive institute has about 1,500 pupils in each year, from 3 to 14 years old; the Leopardi middle school is the biggest school in the institute, with 490-500 pupils distributed in 21 classes; this school houses the management team (the headmaster and two headmaster assistants) and administrative staff headquarters.

The Leopardi school has 42 teachers and 4 janitors for the school year 2014-15. In all, the comprehensive institute has 192 employees for the school year 2014-15, including the headmaster, 151 teachers, 11 management and administrative staff members, and 30 janitors. It is worth noting that, as for all Italian public schools, no staff members are employed by the comprehensive school institute or the single schools; teachers are directly employed by the Ministry of Education and janitors partially by the Ministry of Education or private firms for outsourced service. Beyond direct employment, human resources are directly managed by the Ministerial central or peripheral departments, with very limited possibility of autonomous choice by the schools, as detailed below.

User involvement in the Leopardi middle school is traditionally very low, as is normal in Italian schools. However, in the last years some relevant initiatives have been promoted in order to re-vitalise parent and school participation, prompted or supported by the new Headmaster. The main purpose of these initiatives is not to increase user influence and power, but rather to strengthen the relationship between the families (parents and students) and the school, which has become more and more difficult over the years.

In the following pages these initiatives will be described, as well as the traditional form of user participation in the Italian school, that is the collegial bodies, showing some of the limited impacts made by user involvement arrangements on work and employment relations.

7.1 The Leopardi School Council

The Leopardi Institute School Council comprises nineteen members: the headmaster, eight teachers, eight parents, two janitors. Except for the headmaster, all the other Council members are elected every three years among the groups which they represent, according to national regulation. The Council was renewed in November 2014; parent participation amounted to 20,6% of those entitled

to vote (that is all school pupils' parents). In 2011 parent participation had been nearly 5 points higher, arriving to 25%. However, participation rate is still higher than the national average, which is around 10-12%. Although it is certainly allowed, in the School Council elections there are no alternative lists of candidates, but only one list for any member category. Parents usually choose candidates belonging to their school.

School Council meetings usually occur 5-6 times a year; 4-5 parent representatives usually take part in the meetings, while teacher participation is higher.

In the words of a parent representative in charge also of previous Councils:

People usually start with much energy, making many suggestions and bringing many ideas into the meetings. But soon they understand their ideas are difficult to put into practice: there is no money, teachers don't agree, janitors are not willing to help...so they lose any enthusiasm and after some meetings some prefer to stay at home...in the past this also depended on the Principal's attitude which was not so helpful or open to our demands, however, since the new headmaster has been in charge, things have started improving.

The new headmaster, who took office in 2012, promoted a series of initiatives to improve the relationship between school and families.

I spend a great part of my time speaking with parents coming here to complain or protest, this has become common in our schools since about ten years ago. Most complaints concern individual cases and problems, they complain about bad marks, about how teachers treat their children...they don't trust them, so they come directly here or even go to the School Provincial Office [the local Ministerial Department]...however they feel the school doesn't listen to them and this is what we have to work on.
On the other hand, teachers increasingly complain about families. They say families don't cooperate with them, simply defending their children or, otherwise, completely relying on teachers and the school to solve the children's problems, problems which often have nothing to do with school.

Therefore, the headmaster prompted the School Council and the Board of School Teachers to carry out initiatives to investigate the school-family relationship and to improve it. These initiatives directly or indirectly entail a greater user involvement in the school management and activities.

One of the first projects being implemented was the Pact for Co-Responsibility. Following some cases of acts of violence and bullying in schools, with younger students being the victims of older students, which caused great public concern, the government promoted a program which included the definition, within each school, of a document called "Pact for Co-Responsibility" (Legislative Decree no. 235/2007). The Pact for Co-Responsibility should include rights, duties and commitments by all the parties within a school (students, parents, teachers and the school as institution).

In 2012-13 the Leopardi middle school undertook a significant process including lessons and specific meetings aimed at drafting and approving the Pact, which provided the opportunity to open an initial debate on the state of the relationships at school. In 2013-14 the School Council, along with the Board of School Teachers decided to make a survey on the same issue, preparing a questionnaire distributed to parents and teacher. Questionnaires are being drawn up and results will be available by June 2015.

At the moment, the first results are quite surprising. According to the headmaster:

the majority of the families are satisfied or very satisfied with the relationship with the school and the teachers. I'm so used to listening to people coming to my office to complain that I had thought they represented the majority...instead, it's the teacher group that it is worried about the families' behaviour. Many teachers answer that families aren't able to build a partnership with them aimed at helping their children. According to teachers, families feel unfit to deal with their teenage children and to treat them properly...they defend them unconditionally or they unburden their problems with them on you.

Another set of School Council initiatives regarded the extra-curricular activities, performed in the afternoon and in the evening. As above mentioned, this is a traditional field where School Councils express their creativity and parents can play an effective role, especially after the attribution of an autonomous status to schools at the end of the 1990s.

However, in the last decade the space for extra-curricular activities has been progressively reduced by austerity policies. Cuts in available funds and in the staff have limited the possibility to arrange courses or other educational activities usually performed out of the ordinary school time.

As a parent representative clearly explains:

We'd need to arrange afternoon courses for students with learning disabilities and for students with serious risks of failure, but we don't have enough money to pay teachers for that. School funds for

extra-time courses are used to pay temporary teachers hired to cover maternity leave and we're not sure to have enough money even to pay these teachers.

Difficulties in arranging extra-time courses are not only due to the lack of money, but also to the lack of teachers willing to undertake the courses. Teacher work has become more intensive in the last years. Needs for savings and school rationalization forced the Berlusconi government to reduce the school hours: in the first-level secondary school the "extended time" with lessons distributed in six mornings and two afternoons has been abolished (except for some special situations) and replaced by the "ordinary time", that is the traditional school time, with lessons concentrated only in the morning, for six days. This allowed to reduce the number of teachers needed within a school, but reduced also the number of hours in which two teachers are together in the same class which could have been split into groups to work with students with difficulties. At the same time, the minimum and maximum number of students for class were increased: in the middle schools the first increased from 15 to 18 and the second from 25 to 27, with the possibility to arrive to 28-29 (Law no. 169/2008 and Decree of the President of the Republic no. 81/2009).

As a result of all these changes, work conditions worsened and teachers are less willing to undertake extra-curricular activities. As a teacher said:

When the school time was distributed over some afternoons, we had more time for optional projects and extra-time activities. This is a paradox: now there aren't any lessons in the afternoon and we should have more time to carry out optional projects, but school work has become more intensive… we need to concentrate on our classes and our ordinary work.

In this context, extra-time activities were simply abolished in many schools. In the Leopardi school, courses (such as theatre, dance or some sports) are arranged and performed by volunteers, who are often students' parents, at 14.00 in the afternoon. From 13.00 to 14.00 students registered in the course can eat a packed lunch at school, under the supervision of some parents, who are usually School Council or class representatives. Therefore, extra-time afternoon activities are made possible by the link with the community, which has been strengthened in other ways: short courses organized by voluntary associations are taught in the school time (for example in technical matters, or safety courses) and have great success.

Voluntary and third sector associations are widespread in the area and they consider school courses as an opportunity to make themselves known and to build partnership with an important institution.

There are many voluntary organizations asking to come here to offer brief courses…they want us to know them and recognize them. However, it is the school's duty and, especially, our duty as teachers to select them and choose only courses with a real educational content and purpose.

7.2 Student involvement between school and local community

As in some other Italian municipalities, in 2004 the Castelnuovo Rangone municipality created the "Municipal Council of Girls and Boys of Castelnuovo Rangone" which comprised 11-14 year-old students elected, after brief electoral campaigns, by all the students belonging to the Leopardi School[8]. The Council had 32 members, representing the 16 school classes and had meetings once or twice a year, in the presence of the Mayor. It was part of a project on Education to Democracy and Active Citizenship, carried out by the municipality and the school.

Students were organized in six Commissions on a topic base (environment, sport, news, culture, solidarity, spare time) and, in the afternoon hours included in the extended time, they worked with teachers to prepare proposals and suggestions to be presented in the Council meetings. The initiative had a great success and, since younger students were the most enthusiast attendees of the project, it was extended to 10 year-old children in the primary school, who created a Student Council.

The municipal administration accepted some relevant suggestions which were put into practice. For example, the decision to build a bike lane from Castelnuovo to the Montale municipality (12 km.) or, more simply, to put new small drinking fountains in the local park originally emerged from student suggestions.

Over the years the municipality partially lost interest in supporting the initiative. At the same time, the Leopardi school tried to address this experience of student involvement mainly for school purposes. The council was renamed as simply the "Council of Girls and Boys" and focused on school issues. Moreover, after the abolition of the extended school time, the space for the Council activity is significantly reduced and it is difficult to work on the project. As the project coordinator (a teacher) says:

Students who are Council members usually have meetings in the afternoon but sometimes they have to go out from their classes during the school time. Some of my colleagues are bothered by this situation, although it happens only 4-5 times a year.

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[8] 15-17 Castelnuovo teenagers had other symbolic forms of representation within the Municipal Council, but they were more difficult to involve and to gather, because they attend secondary schools which are all based in other municipalities or, when they are 16 years old, start working.

Since 2013-14, the Council of Boys and Girls activity focused on the Pact for Co-Responsibility. Together with some teachers, students are preparing a questionnaire on school-student relationship to be distributed to students, following those made for parents and teachers.

7.3 Impact on employment conditions and social dialogue

So far, user involvement impact on employment conditions and work practices has been nearly absent, except in some cases.

In the debate for the definition of the Pact for Co-Responsibility, there have been widespread demands to change the organization of the weekly hour devoted to meeting students' parents, as well as to change the organisation of the general teacher-parent meetings taking place twice a year. Parents asked to have more than an hour a week to meet teachers, as well as a different organization of the general meetings, when long queues usually occurred. The school accepted these demands, which required a change in the working time organization, currently tested by most of the teachers.

It was not easy to make teachers accept these changes, especially for the weekly meeting hour, and the headmaster had to play the role of the "mediator" in this situation.

At the beginning teachers could hardly think that more than one a hour a week, that is a well-established and rooted tradition, could be devoted to meeting parents. They did not accept that parents' demands could interfere with these elements of school organization. However, when they understood this could substantially improve the relationship with parents, most of them accepted the change and stopped grumbling.

Moreover, changes in the working time organisation and in the work shift for janitors are necessary when parents and volunteers arrange an extra-curricular course in the afternoon. The need to change the working time organization has always represented a serious constraint in arranging these activities. Janitors don't easily accept changes in their work shift and in working time organization, but things are slowly improving. As a parent representatives in the Council reported:

The new headmaster was very good at persuading janitors that opening the school in the afternoon was possible... they were not used to deal with these kinds of requests in the previous years and at the beginning they were quite surprised the headmaster was taking them into consideration and was even willing to accept them.

In these situations users did not directly deal with the workers, although user and worker representatives are all present in the School Council. It was the headmaster who dealt with both parties, acting as an intermediary between users and workers.

As parents, we didn't think that we could discuss working time and work shift in the School Council meeting. The headmaster had to do it, there was no question about that.

Trade union workers were not involved, because the headmaster discussed and in some ways negotiated directly with the teachers and the other workers. However it is possible that trade unions will be involved in similar situations in the future, especially if and when an improvement in the economy and in the public finances provides more resources to schools, which will have more freedom to take autonomous initiatives.

Therefore, user involvement bodies and social dialogue institutions have been separate entities so far, but this does not mean some links would not be necessary or desirable.

8. Concluding remarks. Service user involvement and social dialogue: a difficult but promising integration?

At the end of this Report, we can summarize a few points.

a) Broadly speaking, over the last decades in both sectors under examination (health and education), and generally in all public services, there has been an increased attention in public debate and public policy as well to service user involvement, although framed within quite different cultural ad political discourses. In the 1970s, in connection with the mass social movements of that period, the key-word was 'democratization', and the emphasis was mostly on users *as* citizens and on user involvement *as* a form of democratic participation, instrumental to a deeper 'democratization' of society and public institutions. This was particularly clear in the complex and dense institutional architecture of collegial bodies in the school sector (*organi collegiali*) as well as in the formal links between health structures and local communities (Regions, provinces, municipalities). After difficulties in implementation and the decline of 'collective enthusiasms' in the following decade, in the regulatory framework of the three public service reform waves of the 1990s and 2000s, to some extent inspired by the new public management approach, the role of service user involvement was mostly framed within the key-words of 'consumer's choice', 'transparency' and 'performance evaluation' as means to achieve a greater efficiency and effectiveness of public services. The two case studies suggest, however, that despite this shifting emphasis in the public discourse between

the two periods, the two sets of principles – 'democratization' and 'consumerism' – are not necessarily mutually exclusive, but can coexist in the actual experience of public services; the health sector case study is particularly instructive in this sense.

b) This undoubtedly increased emphasis on service user involvement, with the rich network of institutional bodies and procedures that have accompanied it, has remained, and still remains, formally separate from the institutions and procedures of social dialogue, at least to a significant extent. On the whole, the two case studies suggest that the impact has probably been significant on the organisation and functioning of public services, much less on social dialogue. Formal, systematic, direct links between the two channels are absent, they are not included within the institutional design neither of service user involvement nor of social dialogue machinery. On the one hand, trade union representatives as such are not included in the regulatory framework of service user involvement, although trade unions were mentioned in the 1970s legislation regarding the education sector (but not any longer in the reforms approved in the 1990s). Nor, on the other hand, service user representatives as such are included in social dialogue institutions, even less in collective bargaining procedures. As both case studies show, and many interviews stress, dealing with trade unions is (not only formally) outside the competencies of service user involvement bodies even when their initiatives have implications on work practices and employment relations; dealing with workers and trade unions is exclusive responsibility of hospital managers and school headmasters.

c) If a direct impact of service user involvement on social dialogue institutions is limited or absent, both case studies show, however, that this is not the case with regard to the impact on work practices. Both in the hospital and the school that have been surveyed, service user representatives help raise issues in the interest of patients, students and their families, the solution of which implies consequences on the organisation of work and employment conditions. Typical examples in the school case-study are the demands to extend the weekly hours devoted to meet students' parents, or to promote extra-curricular activities in the after-noon. Corresponding demands in the hospital case-study regard the pressures to extend visiting hours, or to re-schedule the timetable of pre-maternity courses in hours such as to avoid discrimination effects on some population groups, or to enlarge service opening hours in the distribution of medication to patients with chronic pathologies, or, again, to extend also to Sunday morning the outpatient service for procedures with very long waiting lists. All these demands and pressures put forward by service user representatives require, in order to be satisfied, a re-organisation of working time and working shifts of employees – doctors, nurses, teachers, janitors –, and in some cases an intensification of their workload. In all these cases, a connection between the development of service user involvement and changes in the

working conditions of employees is rather apparent, despite the absence of formal channels of communication with social dialogue institutions and practices. The hospital case-study shows that, occasionally, an informal link can be exerted by the presence among the service user representatives of pensioner trade union members. But, precisely, it is an informal link, since these individuals are there as service users not as trade union representatives. Their legitimation is grounded on their being patients and service users, belonging indeed to one of the most numerous groups of patients, not on being trade union members. The case-study shows that this double role of service user and pensioner trade union member can also be controversial, or even counterproductive.

d) Finally, the case studies show that for trade unions, even in a region characterized by a high level of civicness, the development of service user involvement can be a challenge to their traditional culture and strategy. Satisfying users' demands might threaten and compromise the 'vested interests' of employees and union members. However, precisely the potential impact on work practices and employment conditions suggests that to see only a challenge and a threat, and not also an opportunity for renewal, could be in the short run a myopic attitude on the part of trade unions, and in the longer run a self-defeating strategy.

Integrating service user and workforce involvement can be a problematic process, but also a promising way to revitalize social dialogue institutions and practices.

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Appendix 1: legal framework for user involvement in the health and education sectors

Sector	Years	User regulation	Main general regulation
Health	1978-1992	Law no. 833/1978	Law no. 833/1978 (NHS institution)
Health	1992-1999	Legislative Decree no. 502/1992 (Art. 14)	Legislative Decree no. 502/1992 (managerialisation and managed competition)
Health	1999-	Legislative Decree no. 502/1992 (Art. 14); Legislative Decree no. 229/1999 (limited influence)	Legislative Decree no. 502/1992; Legislative Decree no. 229/1999 (managed cooperation); Constitutional Law no. 3/2001 (NHS high level of regionalisation)
Education	1974-1994	Collegial bodies: Decree of the President of the Republic no. 416	Law no. 477/1973, Decree of the President of the Republic no. 416, 417, 418, 419, 420, all approved in 1974 (Delegated decrees)
Education	1994-2000	Decree of the President of the Republic no. 416; Legislative Decree no. 297/1994; Legislative Decree no. 233/1999 (Collegial body reform)	Law no. 57/1997; Legislative Decree no. 112/1998; Legislative Decree no. 275/1999 (Autonomy reform)
Education	2000-2007	Decree of the President of the Republic no. 416/1974; Legislative Decree no. 297/1994; Legislative Decree no. 233/1999 Legislative Decree no. 235/2007 (Pact for Correspondibility)	Law no. 53/2003 (Moratti reform)
Education	2009-	Same legislation of the previous priod	Decree of the President of the Republic no. 81/2009 (Gelmini reform)

Appendix 2: User involvement bodies in the health and education sectors

Forum/Body	Sector	Level	Status/ constitution/ rights/ frequency of meetings	Members: staff; users	How elected (and term)	What info provided to them?	What issues can they address?
Local Health Enterprise Joint Consultative Committee (JCC)	Health	Single employer LHE	Voluntary but mandatory in the analysed Region (monthly meetings)	Selected by co-optation from the top (LHE management)	Not	Information provided by LHE and Region	Service access and quality
Regional Consultative Committee for Quality	Health	Region	Voluntary but mandatory in the analysed Region (monthly meetings)	De jure members: JCC coordinators; members appointed: Regional and LHE management	Not	Region	Service access and quality
School Institute Council	Ed: school	Single school institute, which is not the employer	Mandatory	Parents, staff and the headmaster	All members elected (three- year term) except for the headmaster	School and Ministerial offices	Various issues (financial, organisational matters, teaching general principles) but especially extra-curricular activities
Council of Girls and Boys	Ed: school	Single school, which is not the employer	Voluntary	11-14 pupils	All members elected by pupils within classes (three- year term)	Public information – school	All the community issues; extra-curricula activities for school