NONPROFIT ORGANIZATIONS IN THE ITALIAN HEALTH SYSTEM: EMERGING NEEDS AND VALUE OF HUMAN CAPITAL

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ABSTRACT: *In the Italian experience the nonprofit system represents a wide and diversified realm. Strongly rooted in the economic, social and political Italian eco-system, nonprofit organizations appear relevant mainly in the health sector, through innovative forms of partnership and co-production of essential and also new services.*
The growing need to limit public expenditure, dramatically present in hospitals and health institutions, leads to the extensive search for effective and innovative channels proving able to satisfy the emerging needs of patients.
The aim of this study is to carry out an analytical and critical exploration of the state of the art of the Italian nonprofit system in the light of the outcomes of Ninth General Census of Industry reported by ISTAT- Italian National Institute of Statistics in 2014.
The results obtained show that the major growth trends related to involvement of nonprofit in health system were recorded between 1991 and 2010. These are the years when the process of downsizing of the general system of public welfare started, along with the earliest attempts to reduce health spending.
These organizations appear to be the effective response to problems which the public sector does not have a strong interest to act for, and they also provide suitable professional profiles for Healthcare.

KEYWORDS*: nonprofit organizations, Italian health system, human capital, professional profile, quality of services.*
JEL CODE: *K00, K 32*

1. INTRODUCTION

The identification of the nonprofit galaxy (sometimes defined as "third system") proves quite complex. It has been identified by exclusion within an economic paradigm where the standard organization is the mainstream for-profit enterprise: egoistic, rational and fully informed as textbooks expect. The recent evolution of the world's economies,

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increasingly complex and flexible, widens the scope for action of the nonprofit system due to the growing variety of needs and orientations which such organization can respond to on one hand and to the delicate combination of different disciplines whose methodological approach and technical tools contribute to define its features and values. The economy, and consequently society, is evolving along unpredictable trails, also due to the growing interconnection among various and hgeterogeneous economic, political and cultural systems; in such a dynamic framework the light flexibility typical of nonprofit organizations appears to be advantageous in order for changes to be tackled quickly ad effectively.

In such a complexity, in which a sharp complication is generated by the quick evolution and transformation of the economy and of its social dynamics, definitions may prove controversial and even ignore the action and purposes of nonprofits (Bandini, 2013). Quite often differences among nonprofits are a simple consequence of the different points of view (Salamon and Anhaier, 1997). The common features are well known, focusing upon the non-distribution constraint and the combination of monetary and non-monetary rewards for the members of any nonprofit active in a variety of economic and social sectors. Although endowed with private nature from the regulatory and economic point of view (the no distribution constraint is typically the outcome of a fully adopted power of self-determination), the nonprofit organizations are oriented towards solidarity objectives aimed at responding to the expectations of individuals as such and not merely as paying customers (Colozzi and Donati, 2000). Finally, a further source of interest of social and economic studies is represented by the prevailing labour-intensive structure of nonprofit organizations, which move in a different territory from the typical manufacturing capital-intensive productive structure (Borzaga and Fazzi, 2006). Collective and shared interest prevails (Borgonovi, 1993), and the source of funding is not only taxation (Salamon and Anheier, 1997).

In the Italian institutional and economic framework 474,765 nonprofit organizations were recorded in the the last census of industry and services (IX), reported by ISTAT (Italian National Institute of Statistics) in 2011 (these are the most recent available official figures). On December 31st, 2011 301,191 organizations were active; among them 81,652 (27% of the total) are active in the personal services area, 22,127 of which are active in the health area strictly defined (7%) and 59,525 in the social assistance area (22%). Broadly considering the whole nonprofit system the most diffused action is undertaken in the arts and culture area (77% of the whole system), and the smallest area is international co-operation and solidarity (3%). Between 2001 (previous Census) and 2011 (last census) the nonprofit system has substantially expanded, recording a 36% growth.

1. LEGAL FEATURES OF THE ITALIAN NONPROFIT ORGANIZATIONS

The Italian legislation[1] includes associations, foundations and committees in the nonprofit area. Their taxonomy may depend on multiple reasons, including access to resources, endowment, kind of activity (Montanini, 2007). An association can be defined as a "private collective organization whose members pursue a common ideal, and non-economic goal" (Trimarchi, 1993). Associations are normally active in the recreational,

[1] Civil Code 1992 of the Italian Repubblic.

cultural, religious, sport and assistance fields. They can be chartered or not, depending upon some bureaucratic and formal conditions. Within a rigid legal and regulatory framework nonprofits are often the preferred structure for business opting for a simple tax regime, a less demanding work regulation and an informal organization of resources; the non-distribution constraint, which is the only formal feature requested in order for any organization to establish the nonprofit status, proves a convenient effort in exchange for widely released legal constraints.

Foundations require one or more founders, who intend to devote real estate, built heritage and the like to the pursuit of some ideal, moral (in any case non-economic) goal (Propersi and Rossi, 2004). In the Italian experience foundations cover a wide range of areas, but are mainly distinguished into funding and acting foundations (Montanini, 2007). The former are essentially committed to provide private organizations with financial support, therefore substituting the public sector in activities aimed at the pursuit of general goals. There are also foundations generated by private banks, which are an Italian anomaly, and also the so-called participating foundations, created *ad hoc* in order for many formerly public cultural Authorities to be transformed into formally private organization, although their structure and decision-making processes are quite perfectly designed as public institutions (Ponchio and Trimarchi, 2007). Committees are active just in order for some occasional goal to be pursued (Visconti, 2008).

A further Italian anomaly is the substantial absence of charitable trusts, whose regulations could grant a separation between management and politics, and a clear rigidity on institutional goals and tools aimed at their pursuit. The arm's length principle is somehow neglected in the Italian social action since its adoption would subtract control to the central and local governments, who still consider the nonprofit area as a battlefield where flexible rules and non-structured action can be allowed for and socially accepted. There are timid signals of acknowledgement for the trust as a preferred structure in the service sector, mainly in the health service field, relying upon the recent possibility to refer to any other EU Country's legislation, due to the total absence of such a legal structure in the Italian legislation (Lanfranconi and Trimarchi, 2013).

2. SOCIAL NONPROFITS

Within the nonprofit framework some organizations act in pursuit of their shared goals with a specific attention towards the social spillovers and impact of their action. The Italian legislation, perhaps too much worried about the need for strictly related labels and regulations for each activity, considers these experiences, their formal structures, decision-making processes and tax regimes in detail (Montanini, 2007). The simplest kind of social nonprofit is based upon voluntary action; they have been regulated with a 1991 Act[2] and their preferred areas are health, social assistance, environmental care, recreation and culture. Members' action is voluntary and is not salaried, and outsourced donations are tax exempt; the tax regime is simple and allows for deductions (Colozzi and Bassi, 2003). This detailed regulation reveals the legislator's favour for organizazions whose action appears to be in some degree integrated with public goals, substantally widening its scope for action due to the reliable approach and activity of private substitutes in the pursuit of publicly relevant goals.

[2] August 11, 1991: Act 266, Italian Legislation.

NGOs[3] are active in the international co-operation area, and are periodically monitored by independent authorities, given the delicacy and importance of their action in developing Countries (Bandini, 2013). Aimed at internal welfare and integration are the social co-operatives regulated with a 1991 Act[4], whose explicit aim is the pursuit of community's general interest and citizens' social integration. They are usually active either in the health and education fields or in the market labour access area (Francesconi, 2007). Specific tax relief tools are devoted to the 'ONLUS' (literally, nonprofit organizations aimed at social utility), label that can be obtained by various nonprofits as the acknowledgement of their attention towards the disadvantaged in any social and professional fields (Visconti, 2008). Still, here the public sector widens its action through private action socially oriented. In the Italian experience the nonprofit system is often generated and strengthened within the Catholic Church institutions and milieu, although its strategy and action is not necessarily oriented by religious purposes.

An expanding label for many nonprofits is "social enterprise", whose features, shape and limits have not yet been made clear and agreed upon. Each nonprofit can be considered a social enterprise once it demonstrates that its institutional action is aimed either at producing or providing services, or at exchanging commodities of some social utility (this is the evidently controversial point, leaving the details of such a wide definition to a still intensive discussion among experts and organisations). In any case a social enterprise must operate with at least 30% of its human resources being disabled or disadvantaged (Francesconi, 2007). The 'social' label can be considered the useful semantic box aimed atv including varied and heterogeneous actions whose purpose is consistent with the emerging importance of expectations and rights not yet fully regulated within the institutional framework. In such a respect it reminds the 'merit good' argument for the public production and/or provision of services that private companies or professionals could comfortably produce or provide, but at the centre of new sensitiveness; the 'merit' concept proves highly flexible and versatile, and its definition strongly depends upon the spirit of time. In the same way the 'social' label given to nonprofits may cover undefined but important areas where society's demand is intensively shared and expressed.

3. NONPROFIT ACTION IN THE HEALTH SYSTEM

In 1948 World Health Organization stated that "viewing man in his totality within a wide ecological spectrum, and… emphasizing the view that ill health or disease is brought about by an imbalance, or disequilibrium, of man in his total ecological system and not only by the causative agent and pathogenic evolution". Such a statement, still considered crucially important, on one hand emphasizes which factors can exert an influence upon (and favour) healthy lives, on the other hand acknowledges the need for a plural action, to be carried out by multiple agents sharing the common goal of health (Cipolla, 2004).

[3] Non governmental organizations.

[4] November 8, 1991: Act 381, Italian Legislation.

Among these agents (families, institutions, organizations) the nonprofit ones carry out their action in a variety of fields, such as hospital management, voluntary services, citizens' protection, advocacy, etc.; they are characterised by a wide range of specific purposes, structures, decision-making processes, actions, membership (Bassi and Colozzi, 2001). Their recent expansion has been generated by the economic crisis, the progressive drainage of public financial sources, and the consequent reduction in the dimensions and variety of services that were publicly granted. Associated with such a weaker presence of many services and tools of public health, some features of society itself recorded a radical change: the reduced family width and women's involvement in the job market has drained the traditionally internal praxis to deal with health issues within families, therefore requiring treatments and assistance that neither families nor the public sector could provide people with; new needs were perceived by a wider social spectrum, with a stronger focus on the disadvantaged and poor social groups; life expectation has risen surprisingly, which was good news for individuals and groups but at the same time an unexpected challenge for the health system and for many organizational issues at large.

A wider and more complex demand for health services, and a progressively rigid supply, dried by tighter budget constraints and rising technology (and therefore costs of equipment and professional resources) ended up to worsen the inequality in access and use of health services, also abandoning areas such as prevention and treatment in areas and sectors characterised by low demand concentration (Borzaga and Fazzi, 2006). Nonprofits intensified their action in areas where activities were not able to generate financial flows (Francesconi, 2007). Moreover, the nonprofit orientation often appears to be the effective response to problems which the public sector does not have a strong interest to act for; they also provide many professionals with the right motivation and incentive to regularly offer services raising their efficiency and effectiveness: Barbetta et al. (2011) highlight the role of nonprofits as a growing outcome for specialised employment; finally, nonprofits represent a powerful response to market failures generated by asymmetrical information, since they normally involve final recipients of the services provided in the decision-making processes. Production is associated with strengthened solidarity and social relationships networks.

4. FACING COMPLEXITY

The emerging economic and social paradigm, based upon an unexpected value hierarchy where experience, relationship and proximity are gradually crowding out efficiency, competition and excellence, appears to be a fertile cradle for nonprofits to provide the health system with approaches, actions and benefits it would not be able to get otherwise, not certainly through a mechanically structured balanced (and often conflictual) combination of public and private sectors. Being structurally light, flexible and economically favoured by legislation, nonprofits certainly offer effective action in health (Borzaga and Santuari, 2000) also due to their ability to craft services and action as an effective response to actual needs and expectations, and in the same way to adapt their action and finely tune its features to the evolving profiles of their recipients.

In the past twenty years nonprofits have crossed a stage of radical change, widening their scope of action and at the same time raising the quality of their specialisation from both professional and organizational perspectives. Their successful performance in the health system can be explained considering the absence of profit orientation, the strong

motivation of professionals, the shared productive effort (Borzaga, 2000). Such effective outcome has built a strong reputation for nonprofits whose general perception equals them to State and market action in health. Their formerly residual role has been shifted towards a grid of even relationships and co-operation among the various agents, and has led to formal empowerment on the part of local authorities.

Health management is therefore being the object of institutional experimentations, within a growing framework of innovative legislation[5] providing the health system with adequate rules and tools aimed at facing the emerging problems through synergies between local public institutions and nonprofits; such an alliance can introduce elements of fine-tuning for actions whose standardization ends up to prove harmful for both the health system and its recipients (Santuari, 2012). Rather than a sort of competitive welfare it is a kind of partnership-based action aided by selective outsourcing of services aimed at raising productive and allocative efficiency (Borzaga and Fazzi, 2006).

5. NONPROFIT ORGANIZATIONS: AN OVERVIEW

5.1. A map of health nonprofits in Italy

Every ten years the economic censuses provide an exhaustive analysis of the size and characteristics of Italian economic system with specific territorial details. The data obtained are used to update the archives of production units existing in Italy such as companies, enterprises, nonprofit organizations etc. The last census of industry and services (IX), reported by ISTAT (Italian National Institute of Statistics) in 2011 was characterized by important methodological innovations, and organizational techniques, such as the use of statistical registers assisted by sample surveys, the production of new tools of analysis and study for different subpopulations of businesses and domains of analysis, the development of a multi-channel system to upload the questionnaires[6]. The recent data, presented on April 16, 2014 in Italy describe the nonprofit system and its main features until December 31st, 2011, and provide us with a rich and deep analysis of it.

5.2. Years of foundation

Table 1 offers figures on the foundation year of each nonprofit organization active in the healthcare system, since 1970 until 2011; the most intensive trends of growth have been recorded between 1990 and 2000: in the Nineties the general public welfare system has been substantially restructured, as a result of the first attempt at reducing public expenditure in the health area; the paradoxical outcome of such a trend was a rise in public expenditure in the year 2000, and the symmetrical growth of nonprofit organizations, whose number doubles between 1970 and 1990, and in 2000 it becomes triple with respect to 1970. This is clearly due to the restraint of public services generated by the fall in public expenditure: 61% of the nonprofit active in the health system is created between 1991 and 2010.

[5] See Italian Legislation, act n.502 December 30, 1992; act n. 517 December 7, 1993; act n. 229 June 6, 1999.
[6] See web site http://www.istat.it/it/censimento-industria-e-servizi/industria-e-servizi-2011.

Table 1

Site	Italy						
Year	2011						
Period	1970 and before	1971-1980	1981-1990	1991-2000	2001-2010	2011	All items
Prevailing activity							
Health	1339	1029	1615	2961	3771	254	10969
Hospital services including rehabilitation	77	76	201	491	893	65	1803
Services aimed at long-hospitalised patients	70	65	102	205	360	13	815
Psychiatric hospital and non-hospital services	8	10	82	205	258	16	579
Other health services	1184	878	1230	2060	2260	160	7772

(Source: ISTAT 2011)

5.3. Legal form

Table 2 shows the distribution of nonprofits according to their legal structure in the various sub-sectors of the health system, at the end of the year 2011. The preferred structure is the non-chartered association (45% of the total), the less diffused is the committee (0.35%). The explanation of such a distribution is quite simple, since associations are built as the outcome of a free contract among members, and the non-chartered associations do not require any formality; therefore they can be started also with a verbal agreement and they do not need any patrimonial endowment. This strongly encourages those who are committed to give a hand in healthcare without any initial investments. Although also committees can be created with no formal requirement, their life is bound to the attainment of a specific and explicit objective, which normally makes their life quite short when such an objective is either attained or considered impossible. Moreover, in the health system the final goal (human health) is not precisely measured, and can be usefully pursued only through continuous action whose outcome is imprecise and precarious by the nature itself of health issues, variables and actions. The committees then can not satisfy the needs of the health sector.

Table 2

Site	Italy								
Year	2011								
Legal form	Social co-operative	Chartered association	Foundation	Ecclesiastic organization	Mutual support association	Non chartered association	Committee	Other nonproft	Total
Health	1192	4054	493	174	61	4886	38	71	10969
Hospital services including rehabilitation	528	1355	221	76	24	1499	17	34	3754
Services aimed at long-hospitalised patients	431	313	272	105	1	369	2	28	1521
Psychiatric hospital and non-hospital services	404	220	56	8	1	355	..	6	1050
Other health services	674	3621	239	77	61	4266	36	36	9010

(Source: ISTAT 2011)

5.4. Institutional orientation

The Table 3 shows that 93% of nonprofit organizations active in the health system are institutionally oriented towards public utility, and only the remaining 7% appears to be mutualistically oriented. Health is a typical universal good, therefore it is clearly consequential that the prevailing organisations focus upon the community at large, which includes members but not only; the mutualistic organisations are a small minority, in healthcare, because in this field solidarity actions prevail, being oriented towards the most disadvantaged groups of the population.

Table 3

Site	Italy		
Year	2011		
Institutional orientation	Mutualistic	Public utility	All items
Activity			
Health	803	10166	10969
Hospital services including rehabilitation	147	3607	3754
Services aimed at long-hospitalised patients	22	1499	1521
Psychiatric hospital and non-hospital services	21	1029	1050
Other health services	803	8207	9010

(Source: ISTAT 2011)

5.5. Kind of economic activity

Table 4 shows figures related to the market orientation of healthcare nonprofits, according to the taxonomy based upon health sub-sectors. 51% of such organizations appears to be market oriented[7], i.e. manages to cover more than 50% of the total cost with income generated by prices and charges. The remaining 49% is nonmarket oriented. Both kinds of organizations can adopt a re-distributive price structure, exchanging services with a lower price than the market level. We can observe that such a "market orientation" is likely to just reflect contingent elements rather than a strategic choice.

[7] The economic thresholds according to which the "market" or "nonmarket" label is given are proposed by the European System of National and Regional Counts, which consists of a range of economic relationships, concepts, definitions and accounting rules adopted in the various member States with the aim of facilitating the comparison among the trends in economic policy, and the harmonization among statistical sources.

Table 4

Site	Italy		
Year	2011		
Kind of economic activity	Market	Non market	All items
Activity			
Health	5547	5422	10969
Hospital services including rehabilitation	1849	1905	3754
Services aimed at long-hospitalised patients	990	531	1521
Psychiatric hospital and non-hospital services	682	368	1050
Other health services	4442	4568	9010

(Source: ISTAT 2011)

5.6. Number of employees

Table 5 refers to the total number of employees at the end of the year 2011: their total number is 158,839, of which 18% is active in the general hospital services, normally in foundations (higher percentage); 0,1% works in non chartered associations active in the psychiatric sub-sector (smaller percentage).

Table 5

Site	Italy					
Year	2011					
Legal form	Social co-operative	Chartered association	Foundation	Non chartered association	Other nonprofits	Total
Activity						
Health	54327	12291	46275	7668	38278	158839
Hospital services including rehabilitation	7668	4684	28375	2438	28078	71243
Services aimed at long-hospitalised patients	25530	1692	13100	614	6205	47141
Psychiatric hospital and non-hospital services	7971	284	613	183	507	9558
Other health services	13158	5631	4187	4433	3488	30897

(Source: ISTAT 2011)

5.7. External workers

Table 6 shows the number of external workers, whose wider proportion is active in the "other health services" area; of these 15% work in chartered associations, while 0,04% work in "other nonprofits" and in psychiatric services.

Table 6

Site	Italy					
Year	2011					
Legal form	Social co-operative	Chartered association	Foundation	Non Chartered association	Other nonprofit	Total
Activity						
Health	4755	2625	2093	2066	1104	12643
Hospital services including rehabilitation	1204	497	1493	412	866	4472
Services aimed at long-hospitalised patients	835	96	365	95	148	1539
Psychiatric hospital and non-hospital services	841	109	68	268	5	1291
Other health services	1875	1923	167	1291	85	5341

(Source: ISTAT 2011)

5.8. Temporary workers

Table 7 shows the distribution of temporary workers, of which almost the half (45%) is active in foundations in the general and rehabilitation hospital services area. Only 0,08% works in the long hospitalized services area in chartered associations.

These figures are partial, since for many types of organisation, in Psychiatric hospital and non-hospital services, such as: foundations, non-chartered association and etc., ISTAT does not diffuse data.

Table 7

Site	Italy					
Year	2011					
Legal form	Social co-operative	Chartered association	Foundation	Non chartered association	Other nonprofit	Total
Activity						
Health	376	119	575	63	140	1273
Hospital services including rehabilitation	60	15	345	16	94	530
Services aimed at long-hospitalised patients	123	13	211	1	37	385
Psychiatric hospital and non-hospital services	44	10	..	..	..	54
Other health services	149	81	19	46	9	304

(Source: ISTAT 2011)

5.9. Voluntary workers

Table 8 provides us with the picture of voluntary workers active in the health nonprofit system. The widest proportion is active in chartered associations in the area “other health services”; the smallest (0,01%) works in the type “other nonprofits” in the sub-sector “psychiatric hospital and non hospital services”.

Table 8

Site	Italy					
Year	2011					
Legal form	Social co-operative	Chartered association	Foundation	Non chartered association	Other nonprofits	Total
Activity						
Health	4867	184087	5666	130795	12284	337699
Hospital services including rehabilitation	782	28648	1496	15567	3926	50419
Services aimed at long-hospitalised patients	1276	4392	2938	1718	661	10985
Psychiatric hospital and non-hospital services	1014	1353	83	3147	35	5632
Other health services	1795	149694	1149	110363	7662	270663

(Source: ISTAT 2011)

6. BUILDING HUMAN CAPITAL AIMED AT QUALITY IN HEALTH SERVICES

6.1 Monitoring and evaluating quality

Quality is a multi-dimensional variable. Its definition strongly depends upon a range of elements whose perception and evaluation is tightly linked with subjective and state-contingent aspects of the services or actions at stake. In a broad perspective we can observe that the perceived level of quality is determined with reference to the institutional, social and economic framework: in a poor Country even the simple statement about quality is normally much easier due to a lower threshold allowing some service or action to be attributed the conventional label of quality (Kenneth et al. 2012).

Things become much more complex – and even contradictory – when quality requires some technical feature, together with evaluation of functional ability (e.g. the action attains its expected outcome, a therapy effectively works, some service manages to improve the physical conditions of a place, etc.) and with a further evaluation related to subjective elements (such as the noise, the comfort, the kindness of professionals, etc.); these features act together to form the concept itself of quality, whose definition became more complex in the last decades, when the relevance and the value of personal perceptions, and of relational smoothness were considered crucial in defining the range of rights and expectations of each individual (Sureshchandar, 2002).

In a delicate setting such as a hospital and a place where health care is the core activity such subjective, heterogeneous, state-contingent and evolutionary features prove essential in order for quality to be perceived, and of course to be measured or evaluated as a level. Such a complex concept can be considered the consistent response of actions and services to what legal studies define “subtle rights”. Whatever technical competence the nurse may have, it is taken for granted, but the overall level of quality evidently depends upon the perception of apparently useless aspects.

This complexity can be explained in the light of the slow but solid passage between the manufacturing paradigm, where dimensional and mechanical variables still prevail, and the emerging economic (and social) paradigm conventionally defined “sharing

economy" where the hierarchy of values appears to be dominated by experience, relationship and proximity (Gold, 2004). This implies a progressive loss of priority on the part of material and dimensional variables, and the symmetrical growing importance of the many and diversified variables related to the representation of the self, the awareness and the personal connections: for a hospitalised patient the quality of health services depends upon their contribution to face pathologies, and to feel the clear perception of enjoying full citizenship in the community despite the temporary exclusion from ordinary life. This implies the substantial impossibility to set a unique conventional level of quality: its state-contingent and subjective nature prevails.

6.2. Training Healthcare Professionals

The emerging economic paradigm is being crafted through spontaneous dynamics and powerful intuitions as a response to the irreversible draining of the manufacturing economy, where the functional properties of objects appear to evolve symmetrically to the specialised skills of professionals: deep analytical knowledge and long systematic experience generate the value of human capital. In the manufacturing framework – whose technical features are consistent with its philosophical fundamentals – efficiency arises from competitive orientation and the possibility to safely compare professional action along a single line (OECD, 1999). The emerging economy is being developed along a different strategic orientation, where effectiveness appears as the leading orientation, and individual/collective action arises from urgencies and desires rather than the combination of needs and goals. Professional specialization is being crowded out by versatility, and the related ability to perform real-time reaction to events.

Such a radical change exerts a powerful impact upon the processes aimed at evaluating professional performances, and at the same time upon the training protocols. In the leading industry, which belongs to what is conventionally defined knowledge-based economy and consists of companies active in the digital dimension and providing the markets with info-tech tools, human resources are progressively oriented towards multi-disciplinary approaches, working in asymmetrical and informal teams where unpredictable synergies generate new products and therefore the overall value of corporate action. Although it may sound odd, also in the service economy the rigidity of specialisation is being slowly diluted by the flexibility of width in professions whose more advanced feature is the ability to promptly adapt to a changing environment and to the variety of subjective expectations.

It is not surprising that recent economic studies (Mussa, 2000; Holler, 2013) emphasize the relevance of desires as the new source of individual action rather than needs. It may appear a sort of philosophical game, but it actually portrays the passage from an economic system where the satisfaction of material needs was the explanation of the dynamics between supply and demand, to a new economic framework where the basic material needs have already been satisfied and the urgency of cultural identity prevails.

This does not overcome the fundamental requirements for skills and competences of healthcare professionals. Rather, it makes the processes aimed at building human capital complex and multi-disciplinary. Actually, they need a broader view in which the role of physicians and nurses covers a much wider area of action and behaviour including atmospheric, empathic and interpretational abilities aimed at providing patients and their families with a sort of filter between them (and their worries and fears) and the technical component of the therapy and of hospital life. In such a way patients can be much more

aware of actions, criteria and mechanisms carried out for practical purposes but not anymore in a binary separation (or even conflict) between the technical and the atmospheric features of hospital life.

Of course, such a complex framework requires a more structured organisation of work and action, needing a constant monitoring and evaluation of the outcomes, adopting smooth and eloquent tools aimed at eliciting patients' (and families') feedback on the everyday quality of life in the hospital. This not only implies richer training trails for hospital professionals, but also periodical meetings and laboratories in which the appropriate action can be jointly crafted, starting from the critical evaluation of the relationship between action and feedback recorded for past activity.

6.3. Professional profiles and the value of human capital

The centrality of quality in hospital life and in patients' perception is bound to be reflected in the range of clinical variables and indicators whose combination defines the technical picture of each patient, the stage of her/his disease, and the effectiveness of therapies. The hospital action needs an asymmetrical and fertile synergy among diversified skills and competences, requiring a solid dialogue between internal and external professions. Time, effort and resources must then be finely tuned in order for each patient to benefit from an equilibrated combination of technical skills, relational atmosphere and creative orientations aimed at eliciting her/his urgency of self-representation both in the personal sphere and within the social framework of hospital residents.

This implies a substantial degree of flexibility within the resource organization. It can be established and consolidated through the release of the formal constraints that still tend to rigidly regulate job assignments, mansions and competences in a hierarchical and sequential framework. The emerging needs of hospitals and healthcare institutions can be usefully faced with a more flexible organization, associating the tight rules of medical protocols with the loose orientation of creative and social action whose effectiveness is granted by its ability to adapt in real time to, or even anticipate, the contingent and occasional desires and needs of patients' community and single patients.

This is not bound to generate multi-tasking professionals, but simply a mosaic of skills and actions able to cross-fertilise when necessary, within the synergic framework associating specific organizations to the hospital, in order for their respective actions to prove cross-fertilized in a compatible and consistent way. It ends up to dilute the binary separation between the actions carried out internal and external professionals: of course such a separation still holds for work, fiscal and financial reasons; but it loses its original steadiness since the quality of hospital services strongly depends upon the overall value of human resources as the outcome of no standardised combinations able to provide patients' needs, desires and expectations with a suitable response.

Such a new relationship between complex action and quality of the service does not necessarily require any radical change in the financial framework, since hospital management can comfortably rely upon conventional evaluations related to each single competence and action. Rather, it needs a release of legislative and regulatory constraints, mainly in the area of public/private work contracts and in duties' regulations, in order for the needed equilibrium between stable assignments and flexible action to be granted, avoiding those rigidities whose presence could harm the 'subtle rights' component in patients' expectations and everyday hospital life.

This would be clearly consistent with the present trends in the more advanced layers of industry, where informal relationships and processes aim at generating intangible value in order for any products to respond to contemporary individuals' and groups' views oriented towards the knowledge-based economy paradigm. The rapid evolution of medical research and technology can therefore prove more effective within a socially dynamic framework.

7. CONCLUDING REMARKS

The nonprofit system shows some specific limits, just like every other institution or organization (family, State, market, corporation, even religious communities). It is inevitably constrained by two layers of rules: on one hand the imprecise but strong social sanctions and orientations whose influence proves tighter in a system where shared principles and personal engagement are the leading rule; on the other hand the precise norms aimed at regulating a magmatic and heterogeneous activity with many common and often unmeasurable elements.

Despite such limits and constraints (or, possibly, with them) nonprofit action appears to be crucial in some specific areas where the fast and unpredictable evolution of social and economic relationships makes new inequalities and exclusions emerge. The ability to interpret and even anticipate such a complex range of needs and desires makes nonprofits specifically fit in areas as healthcare in which, as observed above, technical features of action generate value in association with relational and atmospheric features of personal services. The endemic flexibility of nonprofit action not only allows it to promptly respond to the emerging needs, but also to prove finely tuned to diversified expectations coming from various social groups, in particular social layers of excluded or marginal and disadvantaged individuals.

Such a relevant and unique role that nonprofits can play in the realm of personal services and healthcare can also be interpreted as a step forward with respect to the uncertain and residual interpretation of health as a merit good. This was the suitable, although weak, theoretical justification for public action in areas where the technical features of pure public goods could not be tracked. Useful for textbook public economics, the merit good argument has always left the need to fill the box in an uncontroversial way. Of course we can agree that healthcare, as well as education, culture and for many reasons also sport, represents the response to a merit need of contemporary societies; this is not sufficient to identify the borders of the "merit" component of such wide and varied systems, and therefore it cannot provide us with any precise guideline about the criteria, mechanisms and tools that we should consistently adopt.

Such a dilemma can be faced considering the passage between a standardized economy where pubic action needs an objective and technical justification (showing the weakness of the 'merit good' argument) and a more undefined and dynamic system were personal views, individual desires, and multidimensional action appear to be able to redesing the respective roles of public, private and nonprofit action in the pursuit of a synergic combination of resources and services within a strategic orientation. The involvement of nonprofit organizations in the provision of healtcare services aimed at raising the quality of life for hospitalized patients proves effective and successful, and shows an orientation worth pursuing also in other areas of indvidual and social life.

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