REGIONE DEL VENETO
giunta regionale

VENETO REGION
(Italy)

CONTRIBUTION

TO THE REFLECTION PROCESS FOR A NEW EU HEALTH STRATEGY

REGIONAL HEALTH AND SOCIAL DEPARTMENT

OFFICE FOR INTERNATIONAL PUBLIC HEALTH AND SOCIAL AFFAIRS

VENICE

SUMMARY

PART ONE

Veneto Region contribution to the reflection process for a new EU health strategy

In response to European Commissioner Byrne's invitation – which the newly appointed European Health and Consumer Protection Commissioner, Markos Kyprianou, has also taken up and decided to act upon – the Veneto Region willingly agrees to engage in the reflection process for a new EU Health Strategy. The Veneto Region thereby agrees to partecipate in the discussions underway, contributing and putting forward its own observations and proposals in the interests of the Italian Regional Health Care system, especially in light of its policy of openness and willingness to confront itself with the very best European experiences.

In actual fact, the importance of proceeding in this direction emerges most evidently from the European framework of regulations. The basic principle underlying this concept is now clearly expressed in the new European Constitution, signed earlier in 2004 by all Member States in Rome.

1. Toward an European Strategy

The thesis sustained in the reflection process for a better and more competitive health strategy in Europe is echoed in the Veneto Region health system which has, among its key objectives, the intention of bringing the Veneto to Europe. The implication here is for effective management of the health care system and its constant development in conformity with EU norms and regulations, in a spirit of positive competitivity with the very best European health care practices.

In this persepctive it is no longer apt to consider health care in terms of costs, of negative account balances which are constantly in the red, but rather in terms of a valid resource for development. If a population enjoys good health and has good access to health care services if needed, it is in a position to focus its energies, both physical and mental, on daily life and on greater productivity. This in turn leads to a continuous and sustainable development, the main aim of an enlarged Europe

The Veneto Region shares in this vision, and acknowledges the fact that such a vision may only be attained through a "rationalization" of coordination processes of social health protection systems and the ensuing implementation of a sound European strategy based on an "*open method of coordination*".

The added value of an "*open method of coordination*" is intrisically a political tool for promoting convergences and consensus agreements between the Member States on policies in which European Institutions have a coordinating role. The objective of the MAC should be to facilitate relations and dialogue in view of the future transfer of responsibilities in the area of health care in question to the European Union. What is

implied is a methodology able to adapt readily to health care Policies and acknowledge the role of the MS, to identify common problems across the European Union, to encourage a healthy confrontation between different administrative and financing systems of the various national systems, which could be overcome by stimulating greater interaction between the various health care and protection systems.

In actual fact, according to what has already been observed on numerous occasions during the most recent EU Council of Health Ministers' Meetings, many of our European health care systems are faced with very much the same challenges and problems.

The progressive ageing of the European population – one of the most revealing sociological data in the last decade – forces us to invest heavily in the concept of health care system management, thereby imposing an altogether new vision of health promotion which needs to be conceived, primarily as a means of better ageing, reduction in illness and disease. However, the phenomenon of ageing is far more complex than that. If, on the one hand, rapid development of technologies and clinical practice have implied a progressive increase in management costs, on the other, better-informed patients have ever-greater expectations of what health systems ought to deliver, refusing, for example, long waiting lists. This phenomenon, generally encapsulated in the notion of "patient mobility", is assuming ever greater important in the ongoing debate on the integration between Health Care Systems and on the working of a European strategy for Health. It is particularly relevant in the light of the numbers of patient who look abroad for alternative health care, never hesitating to turn to the European Court of Justice in order for their rights to be recognized. In all above-mentioned cases, however, a fundamental element in all health care systems is brought into play, i.e., their financial sustainability and their ability to guarantee quality health care accessible to all.

To deal with such problems, quite distinct health care policies have been developed in the various Member States which affect health system management, and more generally the health of European citizens, but, at one and the same time, without the development of a global strategy to cope with the various aspects of the problem.

The consequence of this is the qualitative differences in accessibility between the various national health care systems. These differences, more often than not, disorientate the European citizen who is attracted by better hospitals and treatment outside his/her own Country which may offer better treatment and access to services.

This, then, is the source of substantial inequalities, which in turn impedes the free movement of persons and patients who are faced with little guarantee of the homogeneity in high quality health care across the European Union.

Considering the importance of maintaining good health for the European citizen, and the problems of financing and practical management faced by the various administrators, the Veneto Region is agreed upon the need for a global European strategy wherein processes of political cooperation and coordination already being developed over the past few years can be consolidated

In our opinion, through an open method of coordination, political forums for debate and technical discussion groups should take place with greater frequency, and involve all the major European stakeholders of Public Health. Together, these groups

need to be guided and coordinated by a United European direction, so that they can become real forums for the exchange of experiences and ideas. These should then be able to foster greater integration between different systems and bring the various local and national political visions in line with a more European and international vision of challenges at stake, all with the common aim of arriving at a common strategy to:

- encourage the development and modernization of the provision and financing of health care systems;
- to deal with the mobility of patients and health care professionals in an enlarged Europe;
- to foster cooperation between the different regions and European health care systems;
- to promote the integration of European policies which guarantee high levels of human health care protection.

These processes, based on the explicity recognition of the subsidiarity and diversity of national health care systems, can facilitate the exchange of information and experiences, and enable a constant evaluation of political developments and pinpoint better practice models.

Naturally at the basis of such a strategy three main lines of action highlighted by the EC need to be followed which will lead to the possible reform of health care in Europe:

– Accessibility to health care based on sound principles of universality, equity and solidarity which takes into account the needs and difficulties of different groups and the more disadvantaged in our societies, and of those who require long and costly treatment;
– Provision of high quality health care which goes hand in hand with scientific research, which adapts to the diverse needs relating to ageing and is based on an evaluation of the advantages for good health;
- Measures which ensure the longterm financial sustainability of health care provision and a greater efficiency of the system.

2. Health generates Wealth: The key points

It is evident from the objectives of the 2003-2005 Regional Health Care Plan that the Veneto shares wholeheartedly the idea of good health and economic growth. In particular, the Veneto Region agrees that health must become, in an enlarged Europe, one of the cornerstones of economic development, and this considered, it attributes great importance towards improving health and physical wellbeing of its citizens.

In order to reach this objective, however, it is important that, on the one hand, the implications for health, i.e. the management and financing of health, are taken into consideration when attempting to define and implement political actions both on a national and European level. On the other hand, it's important to work on a number of strategic elements, in particular:

A - Health Prevention and Promotion

The European population has never, up to now, enjoyed better levels of health.

These successes stem from a combination of factors related to social and economic development, to a marked improvement of the health care services network, and to a reduction in some patterns which are harmful to health.
Currently, the greatest problems of health in European citizens come from two main sources: a) harmful behaviour and lifestyles and b) infectious diseases.

i) Concerning harmful behavioural patterns, a sound health care strategy for the future must reinforce the study and the contrast of the so-called health "determinants", in particular:
- *Bad eating habits* often prompted by economic and commercial mechanisms which do not take into account their adverse impact on health, and by costs which can determine in the longrun the determinants of diabetes and obesity;
- *Lack of regular physical exercise* and/or the adoption of social lifestyles which impede a balance between working activity and the necessary rest required by the body;
- *Alcohol abuse and smoking* which are the main causes of disease in EU Countries and are therefore at the basis of ill-health especially in the younger age-groups, thereby affecting life expectancy in individuals .

The Veneto Regional Health Care System has placed at the very centre of its priorities the fight against alcohol abuse and smoking. It firmly believes that they can be modified by adopting primary and secondary prevention strategies which are combined with the high quality and good accessibility to health care and diagnosis.
To achieve any positive results at all, it will be necessary for prevention to be consolidated and coordinated at the EU level. In particular, this action should be developed along three main strands, at the same time acknowledging that the health system is a variegated, organic and integrated system:

- analysis of the health status of citizens;
- definition of action priorities;
- drawing up of strategies and projects.

ii) As concerns infectious diseases, the priorities shall be preparatory measures against the threat of pandemic flu, and promptness on a European level to combat emerging infectious diseases (in particular SARS and bird flu) and the fight against HIV/AIDS. The latter has assumed a renewed importance since it has struck the EU and bordering countries significantly. To deal with this phenomenon, an intensification of medical HIV research is being proposed (combined with an increase in investment for researchers and laboratories), both in terms of preventive actions and information transmission in particular in the categories at risk: young people, women and immigrants. Obviously, to achieve real success in such actions it is necessary for them to be integrated and coordinated, possibly at the European level and carried out in the single Member States. These conclusions have been confirmed by a recent study carried out by researchers of the Veneto Region in the area of Public Health, co-financed by the European Commision (Immigrants from European Southern and Eastern borders: HIV/Health risks, Social conditions and Service re-orientation). The results from the study show that:

1. The policies and interventions in all countries studied (Italy, Spain, Greece, Germany, Austria and the extra-EU bordering countries) have seriously been impeded due to the lack of a coordinated and standardized data collection system able to provide not only complete information on siero-positivity, but also on a more general level, on the health status and needs of the immigrant populations.
2. Knowledge of the rights of access to health services is among the greatest of problems: even where immigrants have rights to health care services, many are unaware of it. The vulnerability of illegal immigrants is highlighted: they have a fatalistic attitude towards HIV and tend to use health services to a lesser extent because they know little about them, convinced that they have no rights of access to such services . Health care workers are insufficiently informed on the rights of immigrants to health care.
3. Information on the rights of access to health care services, and their availability, on ways in which HIV/AIDS is transmitted or prevented are priorities on all countries. Where information campaigns to immigrant populations have been carried out hasn't necessarily lead to a significant drop in high risk behavioural patterns. The reason for this can be found in the lack of involvement in the immigrants themselves, on the part of the health authorities, of the ONGs and of the diplomatic representatives from the countries of origin or transit. To obtain more effective results, levels of involvement across the board need to be reinforced.
4. HIV/AIDS is apparently not the main concern of immigrants, and nor is health. What is of greater concern is to be legalized, to find work and a place to live. Consequently, integrated programmes are needed which take into account social, economic and environmental factors which determine the health of immigrants.
5. The problem of HIV needs to be considered in a wider context of sexual and reproductive health, for example a high level of abortions (IVG) was observed in our sample. This indicates a high level of unprotected sexual relations, despite what is declared during interviews. A global strategy on sexual and reproductive health would enable preventive measures to be integrated not only against HIV, but for sexually transmitted diseases in general, for IVG, contraception and pregnancy, thereby improving the impact and reducing costs.
6. The vulnerability of the group of prostitutes is particularly evident in this study: the know of and make use of health care services to a lesser extent than other immigrant women, and comparatively, they are no more informed about HIV, or about other STM; more than 30% don't use condoms with their partners (who aren't their clients). It is therefore important to develop street activites (outreach) for this target group: in countries where the prostitutes interviewed have been summoned through the social services, and increase in compliance to HIV testing has been witnessed. In the world of prostitution high risk groups are emerging: transsexuals with a high level of unprotected sexual relations, homosexual male prostitution which could act as vehicles of disease to the enlarged migrant community, and to their clients.
7. The cultural variable plays a determining role in the effectiveness of health care and social services in general, and of those geared towards preventing HIV and STMs in particular. Counselling is urgently required everywhere, and this should be carried out with the specific cultural needs in mind: in fact, low levels of pre and post test HIV counselling have been noted, together with inadequate cultural preparation for improving

the effectiveness of interventions. It is therefore necessary to carry out specific training of health care workers in this sector.

B – Improvement of quality in services and technological innovation

All health care systems are faced with an almost impossible challenge: to improve the quality of services, despite limited resources available.

To tackle this a comprehensive strategy of organizational and technological rationalization will need to take place, combined with a re-engineering of information systems on health, and a more extensive use of telemedicine.

According to current technological advances emerging an innovative approach should focus on an increased integration between information systems within and among the various Health Care Systems of the MS. At the same time a system of technological and semantic standards which enable inter-operability between management and government systems will be necessary, with the aim of offering higher quality services to citizens, and also optimizing on the use of available resources [1].

C – Health Care Research

Research in the medical field is a further element in need of reinforcing in order for the quality of services to be improved, and to be in a position to offer better health for all. In a modern society with an increased knowledge and awareness, the development of systems and their competitivity depends on the constant innovation of processes and products. Research must, therefore, be motivated, increased and coordinated at all levels in the EU. In light of this, for the 4th consecutive year, the Veneto Region has launched a specific programme of research financing in the bio-medical field, bringing areas of financed research in line with those supported by the Ministry of Health, and correlating them with the strategic objectives of the new National Health Plan, and especially with research areas foreseen by the European Commission in the context of the VIth Framework Programme of research and technological development, as well as a demonstration of the European Area of Research (2002-2006).

[1] An example of this could be provided by the IESS Project of the Veneto Region, aimed at enabling direct access on the part of the citizen through telemedicine to essential services of the Regional Health Care System; the Constitution of the Personal Health Care Dossier where performance data on the individual (hospital, day hospital, medical, pharmaceutical, etc.) as well as access to such information on the part of clinical and general medicine personnel are provided, with standardized security mechanisms built-in. This all serves to guarantee continuity in health care provision. The project foresees the use of information systems to provide the citizen with direct services as follows:

- booking of services at the CUP (Central Booking Office), Pharmacies, Territorial hospitals, Doctors of General Medicine, through the contact-center and via INTERNET. The latter is made possible through the creation of a portal from which information on the availability of services of the two main hospital trusts can be accessed and visualized. The system also enables the payment of the health surcharge by the citizen, also by Credit Card, or through the use of the CNS, which has already been experimented in the Netlink project;
- transmission of medical reports to territorial hospitals and to doctors of General Medicine via a Website equipped with secure-systems typical of the "double-card" systems of the health care operator and the citizen;
- direct transmission, in electronic format, of prescriptions, from the doctor of General Medicine to the Pharmacies for pharmaceutical prescriptions, to the Territorial Hospitals to the Central Booking Offices (CUP) for the booking of services, with in-built systems of authentification.

The scheme to be adopted is aimed at integrating as far as possible bio-medical and regional health care research with that of the EU and other national institutions which finance RlA research in Europe, in order to provide researchers precise lines of intervention, and to examine areas of medicine which are deemed to be of greater impact and international interest. In this sense, it is believed that the EU should promote further, and reinforce research programmes such as ERA-Net, whereby cooperation between Governments and/or Regional Institutions of the MS that invest in research and innovation programmes is financed and motivated.

D – Development of Human Resources

Health care personnel takes on a significant role in actions and interventions directed at the improvement of public health and of health care services to citizens.

This is a fundamental role, both from the point of view of economic growth and wellbeing (in fact, employment in the health sector is on the increase in all MS) and in Health System management.

This fundamental element of the health care machine is, nevertheless, threatened by the effects of ageing and by the increased shortages of health care personnel. Ageing of the population has significant consequences for the organization of health care systems themselves. In 2002, health care to the cronically ill represented approximately 10% of the health care workforce in the EU-15 countries. A large chunk of this workforce, however is currently leaving the world of work and will retire in the next 10 years.

Consequently, the problem of turnover and of personnel training of new workers is urgent in all MS. An increase in the demand for health care workers and the decrease in the provision of services would become a difficult problem to resolve in a short time-span.

In light of this, the EU should examine more closely the question of the mobility of health care professionals (one of the discussion themes of the *High Level Group*) so as to guarantee, not only the provision of health care services, but also to provide equivalent levels of health care personnel training, combined with limited administrative formalities for those going from one working environment to another, and also to ensure quality and surveillance of services provided abroad.

E – Mobilising different actors: Partnership for health

In conclusion, we would like to highlight the main reason why the Veneto Region wants to intervene, also in the interests of the Italian Regional Health Care System.

The Coordination of Italian Regional Health Ministers has for a long time believed in the significant contribution to European political reform of a global strategy which modernizes and develops the health service in the EU in a harmonious, integrated and coordinated fashion; this should take into account the position and role that Regional Institutions and local Communities carry out in the various national health care systems. Such a position has been highlighted by the Committee of Regions in a statement made on 30th September, 2004, relating to Memos 3001/04 and 3004/04 of the European Commission, according to which "*in many MS the responsible parties for health care and health care provision are local and regional institutions …*" making it therefore necessary"*… to do more to guarantee that local and regional authorities responsible for health care are involved and participate in areas of health care and medical care provision …*".

In light of this, the proposal for "*an open method of coordination*" by which the health service is open to shareholding on the part of civil society and all stakeholders which are active in the field of health, must become the key of future EU strategy in Health Care.

Consequently, the Italian Regional Health Care System deems it necessary to integrate more effectively the Regional role in the process of EU policy consultation and decision-making. Therefore, on a European level, experience and good practice models which have emerged in the Regions in recent years need to be evaluated, many of which have already activated[2], in the respective MS, models and open methods of coordination and could, therefore, contribute further towards the success of an open method of EU coordination.

With this in mind, it is necessary that the three political-institutional levels, i.e. regional, central and EU, which represent the links in the decision-making chain, develop innovative forms of dialogue and collaboration among themselves with the aim of increasing their effectiveness on EU policy-making.

Currently, the Regions in an increasing number of MS assume important roles, both administrative and political, in the area of public health and health system management. Faced with this increased importance of the roles of the Regions and of the economic costs of the functions carried out, decisions at the EU level in the realm of health care policy-making are still the result of collaboration between European Institutions and National Ministeries of the Member States.

Consequently, in order to implement the above-cited "*method of open coordination*" and encourage the implementation of the principle of subsidiarity, (which has an important role in this sector – see arts. 5 and 152 EC Tr.), it is considered to be of vital importance that the Regions are integrated into the EC decision-making process through a specific programme of consultations.

To this date in the EU real institutional opportunities for meetings between health ministers of the Regions belonging to the EU and European institutions involved in public health are few and far between. This is, to our mind, a serious gap which could be bridged by an open method of coordination, and by a new European strategy.

The Veneto Region hereby proposes to move in this direction and work intensely towards bestowing the largely territorial dimension of local administrators and managers with the more international and multicentric vision of the European Commission and of international organizations operating in the health sector (WHO, OCSE, European Observatory on health systems and policies, etc.).

The current proposal of the Veneto Region is part of a precise strategy directed at reinforcing the regional level in Europe. This strategy can be outlined in the following ways:

- To increase, especially, participation in the EU decision-making process in order to enable regional stakeholders to know, discuss and influence the European political debate on health care reform in the MS of the EU which sets out to guarantee accessibility and quality of care for all;

[2] Often we are dealing with models of coordination which the Regions use positively to tackle and resolve problems and institutional relations in the respective MS which are similar to those under discussion at the European level, and which form the very basis of a possible European strategy for health.

- On a second level, widespread stakeholding in public health actions in the EU needs to be developed through the partecipation in a EU Plan of Action for Public Health– 2003/2008 which needs to be reinforced by the EU and vested with greater financial possibilities. Participation in projects co-financed by the EU, in fact, operates in the direction of an open method of coordination insofar as it fosters cooperation and interregional partnerships which allow the various health care systems to introduce themselves, confront one another, exchange examples of good practice and hence progress in innovation.
- Finally, on a third level, it is necessary to work towards the creation of a European partnerships and networks, both on the technical and the political level. Such networks, on the one hand, must concentrate on coordination and political-institutional initiatives. On the other hand, the partnership must operate in such a way that the European Regions with responsibilities for the management and financing of health care systems are fully represented in the EU working groups of reflection and in the boards of European stakeholders in the health care sector.

Conclusions

More and more often, the European Union is attributed with specific powers in the area of Public Health and Prevention (this is evident following the setting up of a European Centre for the Control and Prevention of Infectious Diseases). Obviously, the attribution of such powers needs to be discussed with all institutional stakeholders which are responsible for health-policy making, thereby making integration with the Regions, that are being vested with ever-greater responsibilities for the management, organization and financing of health care systems vital.

In this light, considering the responsibilities and powers that the Treaties already attribute to the European Union in Health care matters, the Veneto Region has positively evaluated the possibility of bestowing the European Commission with a more important role of coordinating and directing health-policy making, in line with what is stipulated in art. III-179 of the new European Constitution.

To stimulate this progressive process, the Veneto Region firmly believes that the application to health care of the "*open method of coordination*" constitutes the very first step towards attaining greater involvement of the European Institutions in health care policymaking, and therefore to define a common framework which supports and sustains the commitment of the MS towards the reform and development of health care provision in an enlarged Europe.

In this perspective we hereby propose that in the elaboration of a global European strategy for a high-quality, accessible and sustainable health care system:
- the experience of the Regions and local Communities in health care system management is taken more into account;
- meetings and exchanges of experiences and good practice should be increased particularly with regard to the themes of "Centres of Excellence", "Patient Mobility", "Free movement of health care professionals in the EU", "Patient Safety", the definition and harmonization of the "Essential Levels of Health Care Provision on a European level" which foster the equal entitlement of citizens to health services in Europe;

- new forms of financial support are examined, based on a system of structural funds and resources for regional policymaking, with the aim of motivating the Regions of the MS to improve health care facilities and implement information campaigns to citizens on the themes of prevention, health promotion, and infectious diseases;

Finally, we hereby propose the institution of a permanent Conference or of a discussion Group among Regional Health Ministers on European Public Health (this could be modelled on the Coordination of Italian Regional Health Ministers currently operating through periodic technical commissions and meetings). Such a Conference or Forum would have task of improving Regional partecipation in EU decisionmaking processes and encourage the implementation of an open method of coordination with the Regions and local Communities through the healthy exchange of good practice examples and the analysis of common problems.

PART TWO

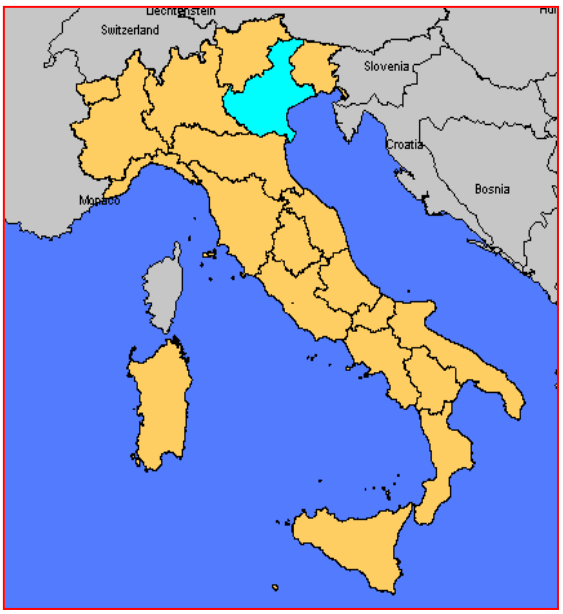
VENETO REGION OVERVIEW

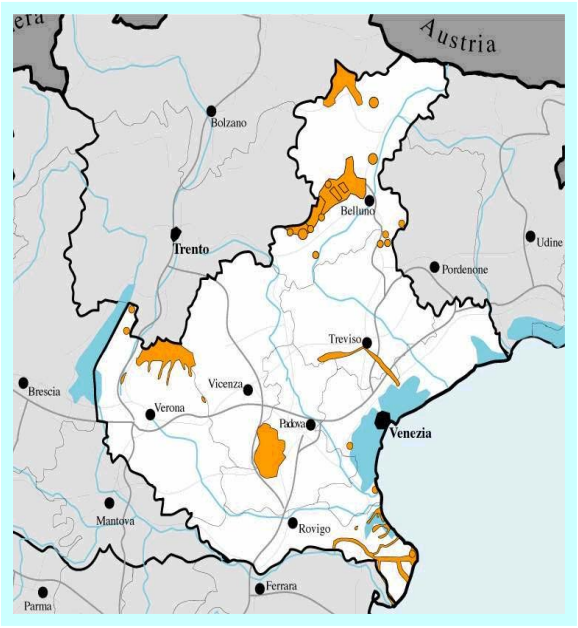
1. ***Introductory Overview on Veneto Region***

The Veneto Region is situated in the North-Eastern part of Italy and is limited to the North-West by the lake of Garda and the Dolomites and is divided into seven provinces. It covers an area of 24.840 km² and has about 4,5 million inhabitants that live in 580 municipalities. About 71% of the population live in small towns with less than 30.000 inhabitants and the average population density is 244,2 per km². The Regional Government is based in the city of Venice.

Veneto is one of the Italian regions with a positive growth rate (0,5%) due to a favorable social rate (5,7%) and an increasing population above the age of 65 (17,5%) that gives an elderly population index of 132,6%.

Veneto Region





2. Organizational structure of the Health Care System in Italy

Italy's health care system is a regionally based national health service that provides universal coverage free of charge at the point of service. The system is organized at three levels: national, regional and local.
The national level is responsible for ensuring the general objectives and fundamental principles of the national health care system.

Regional governments, through the regional health departments, are responsible for ensuring the delivery of a benefit package through a network of population-based health management organizations (local health units) and public and private accredited hospitals

The parliament approves framework legislation, which lays out the general principles for organizing, financing and monitoring the NHS. In particular, a National Health Plan (during three years) prescribes that the whole NHS should be organized according to the principles of:
Human dignity. Every individual must be treated with equal dignity and have equal rights irrespective of her or his personal or social characteristics.
Health need. Everyone in need has a right to health care, and resources should be allocated with priority given to satisfying the basic needs of the population.
Equity. NHS resources should be used to eliminate geographical and/or economic barriers that constitute an obstacle to citizens' demand for appropriate services. Behavioural and information gaps among the population should be reduced to provide the same opportunity for access to health care services.
Protection. The NHS should give highest priority to protecting and promoting citizens' health status.
Solidarity with the most vulnerable people. Resources should be allocated primarily to the individuals, groups or groups of diseases with the most relevant social, clinical and epidemiological impact.
Effectiveness and appropriateness of health interventions. Resources must be channelled to services with scientifically demonstrated effectiveness and to individuals who can benefit the most from them.
Cost-effectiveness. Services should be provided by the organizations pursuing financial balance through efficient and effective behaviour.

3. Health status

In Italy the structure of the population has changed significantly between 1990 because fertility rates declined and life expectancy increased. Italy has one of the lowest total fertility rates in the world: in 1998, it was 1.19. The population growth rate is therefore very low, 1.8% annually (1997), one of the smallest in the EU, and immigration causes most of the growth.
As in the rest of Europe, the populations are aging. This phenomenon is particularly significant in Italy where there are125 people aged 65 years or older for each 100 people 14 years or younger, the highest ratio in the EU (figures referred to 2000). The percentage of the population 65 years or older is increasing steadily: 18.0% of the population in 2001, with 22% aged 80 years or older This is a result of persistent low fertility and a corresponding increasing of life expectancy at birth continually rose substantially since 1980s.
As far as the mortality, cancer is the most frequent cause of death for people 64 years or younger, followed by cardiovascular diseases. However, when all ages are considered, cardiovascular diseases cause more deaths than does cancer. Age-specific mortality patterns show that up to 88% of all deaths in each age group have three main causes: accidental or other injuries (by far the main cause until age 35 years), cancer and cardiovascular diseases. Mortality from breast cancer is at the EU average and that caused by cervical cancer is very low, even though standardized

death rates for all types of cancer among people aged 0–64 years and for lung cancer are still high.
Given the existing north–south economic imbalance, regional differences in demographic and health indicators are also marked. In 1999, the proportion of the population aged 65 years or older ranged from 15.3% (Sardinia) to 24.7% (Liguria). In addition, fertility rates ranged from the 0.94 of Emilia-Romagna to the 1.57 of Campania, while birth rates ranged from 6.6 per 1000 population (Liguria) to 11.9 per 1000 (Bolzano). The highest death rate is 13.9 per 1000 population in Liguria and the lowest 7.8 in Campania. Infant mortality, in turn, ranged from 9.0 per 1000 live births in Sicily to 3.4 in Trento. In 1997, the highest and lowest regional life expectancy figures differed by 2.0 years, both for males (74.2 versus 76.2) and for females (80.6 versus 82.6). Certain population groups often differ significantly, such as men and women, and overall measures do not detect these differences. For example, women's life expectancy at birth was 81.2 years in 1999, 5.4 years longer than that for men (75.8 years). The gender gap has widened slightly over the last decade. As for perceived health, 77% of a sample of Italy's population self-assessed their health status as being good in 1999. In particular, more men claim good health status than do women. Self-assessed health status decreases with age: only 29% of people aged 75 years or older stated that their health status was good.

The total number of smokers has declined in the last decade, and in particular, the proportion of the population that smokes has remained stable at about 25% during the last 5 years. However, men and women have different trends (the women's rate is still growing). Young people are smoking less than before (declining from 17.1% to 9.5% among people between 14 and 17 years of age during the 1990s). However, only the consumption pattern of men seems to reflect that found in other industrialized countries, where the decline in consumption has been led by young people from the higher socioeconomic classes. In contrast, upper-class women are more likely to start smoking and less likely to give up than women from lower social classes.

The growing prevalence of obesity in Italy in recent years (8% of the population), in particular among children, has been related to increasing caloric intake resulting from changing dietary habits, including more snacks and reduced time for eating lunch. The Mediterranean diet, even if still the most prevalent, is losing ground to fast food. Only 19% of the population states that they regularly practice some kind of sport, but another 38% admits carrying out some physical activity during leisure time. During the 1980s and 1990s, beer consumption has been increasing in association with a reduction in wine drinkers. Beer is the preferred alcoholic drink of young people, whereas people older than 35 years mainly drink wine.

A recent significant phenomenon was immigration. By the end of ninety, more then 1 250 000 foreigners were officially registered as residing in Italy; less than 1 million were non-EU citizens and the rest from the EU. Some 70% of the immigrants are young adults (aged 18–40 years), the age category that usually enjoys the best health status. The most widespread diseases among immigrants are infectious diseases, especially sexual transmitted infections. Immigrants usually access the health care system through specific immigrant health offices created inside local health units and through some voluntary centres delivering health services for immigrants only.

4.1 *Veneto Regional Health Care System: Organizational structure*

With reference to the health system, the Veneto Regional Government provides health and social services to the resident population through 21 Local Health Units and 2 Hospital Trusts (See also paragraph 4.2).

Local health units are responsible for managing contracts with GPs and directly manage polyclinics, hospitals and other healthcare and social service outlets, health promotion and prevention of communicable diseases in the area they are responsible for. The healthcare system is founded mainly through general taxation. Hospitals in the Region are mainly public and are founded through a budget fixed in advance at the beginning of the year. GPs are paid mainly by capitation. The Local Health Units as well as the Hospital trusts are managed by a General Director who is appointed by the Regional Government.

The Regional Community Health Plan is the master plan which defines the guidelines for the development of the Regional Health System in the next three years. An important issue emphasized in the Plan is the study of other health systems within and outside the European Union to draw lessons from other's experience in identifying needs and priorities in the delivery of healthcare.

The priority actions foreseen in the Plan for the years 2003-2005 are:

- The control and treatment of diseases having a major social impact;
- The health of mothers and their children, the protection of minors and action regarding adolescents;
- Mental health: psychiatry, neuropsychiatry in childhood and adolescence, and related disabilities;
- Prevention, diagnosis and treatment of cancer;
- The fight against kidney diseases;
- Urgent treatment of neurosurgical patients;
- Accident prevention and safeguarding of health in the home and workplace;
- Food safety;
- Protection of elderly and disabled;
- The prevention of drug addiction and action to promote social integration.

The Regional Government aims to have a better control on the demand and on the provision of healthcare to individual patient, from Primary Care upwards. To achieve this objective the Regional Healthcare Information System is currently undergoing a vast redesign and reengineering process. The priorities identified are:

- Upgrading of human resources on the use of the new technologies;
- Redesign of health information flows;
- Implementation of a data transmission infrastructure;
- Realization of a private network using a public network infrastructure, through the development of a dedicated middleware;
- Introduction of smart cards for citizens' identification and storage of emergency data;
- Improvement of interoperability among all regional health services, including emergency ones;
- Deployment of a booking system to improve healthcare information and access for citizens.

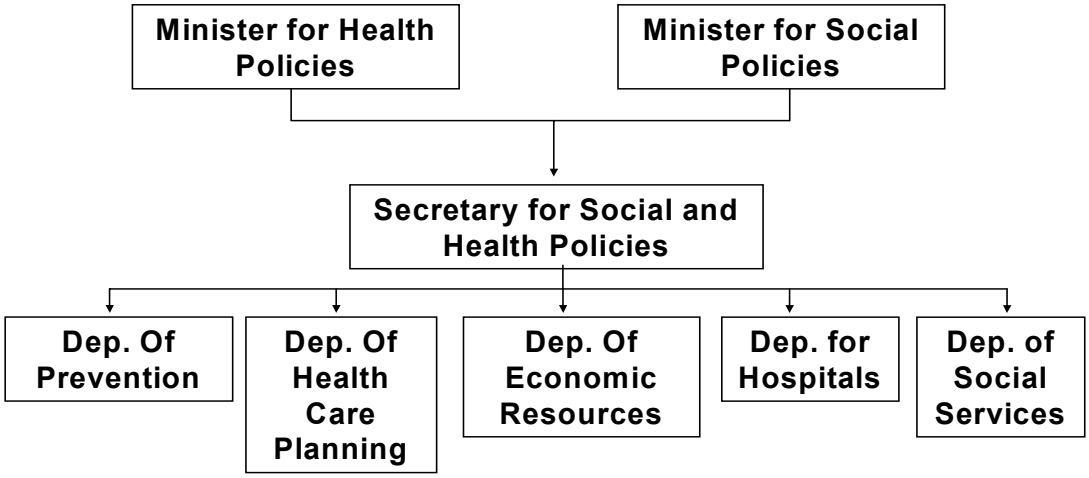
4.2 Challenges related to the Regional system

The expected challenges for the Veneto Region Health System will be the following:

- Increase in both EU and non-EU citizens' expectations;
- Ageing of the population and consequent increase in service demand;

- Continuous rise in costs of services determined by scientific and technological innovation;
- Restrictions imposed in public funding by commitments towards maintaining EU stability treaties.

5. ***Veneto Region Social and Health Care System – Organization Chart***



The Regional Health Care System: dimensions

- 21 Territorial local health units

- 2 Hospital trusts

89 Centres for patient admissions

1076 Specialist health care service providers (for approx. 65 million service provisions a year)

1307 Territorial Pharmacies

3600 General Practitioners

250 Residential homes for the elderly *(for approx. 22.000 patient beds)*