REGIONS FOR HEALTH NETWORK

PATROCINIO REGIONE DEL VENETO

World Health Organization
REGIONAL OFFICE FOR Europe

The Veneto model – a regional approach to tackling global and European health challenges

The Veneto model – a regional approach to tackling global and European health challenges

Abstract

Many countries have both national and regional levels of government. The performance and achievements of regions in the area of health, and what promotes their success, have been little studied. The Veneto Region, comprising 5 million people, is situated in north-east Italy. Within the framework established by the Government of Italy, the health-related responsibilities of the Veneto Region include the organization of different services for the protection and promotion of health and the provision of health and social care. The Region has long had a strong partnership with the WHO Regional Office for Europe.

This publication is based on discussions at the conference on positioning the Veneto Region at the core of global and European health policies, which was organized by the Region in Venice, Italy, on 3–4 December 2015. It addresses health policy and practice in the Region and examines how these bring together the aims and efforts of the various actors working in the field of health at different levels – from European to local – in tackling health problems. It illustrates how the Veneto model was developed and how it is continuously being adapted to meet the ever-changing circumstances.

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Foreword

On 3–4 December 2015, the Veneto Region hosted the international conference on positioning the Veneto Region at the core of global and European health policies. It was a very important event with an outstandingly diverse and thought-provoking programme, thanks to the contributions of prestigious representatives of different national sectors and institutions and international agencies. I am proud to present this publication, which reflects the discussions held during the conference.

The conference offered a valuable opportunity to learn how Veneto has become an example of best practice in the health sector, positioning itself as a key player at both the national and international levels. Veneto's case is successful for sure, especially in the face of the current global challenges, but with success comes responsibility: responsibility for living up to the expectations and needs of our citizens, for maintaining the commendable standards reached so far, for staying competitive and open to change, and for keeping up a fruitful dialogue with our people and institutions with health-related mandates.

This publication shares the experiences of our Region, and offers an insight into the decisions we have taken so far and our plans for the future. More importantly, it highlights today's winning factors in the field of public health, namely: participation, healthy financing, the careful integration of health and environment, intersectoral strategies, and the pivotal role of health protection and promotion.

Over the past 20 years, the Veneto Region has achieved much in terms of public health, becoming a true paragon of excellence and a "live" case study. We are very proud of this positive track, which motivates us to do more and better, not only to maintain our record but also to strengthen our health system and health culture so that we are equipped to tackle the multifold challenges we are facing now and will face in the future. In this respect, we are strongly convinced that cooperation among the different levels – regional, national and international – plays a crucial role. In this vein, we were honoured that the WHO Regional Director for Europe, Dr Zsuzsanna Jakab, participated in the conference and we are very grateful for the reflections and insight she provided.

In 2003, the WHO Regional Office for Europe, in collaboration with the Government of Italy and the Veneto Region, decided to open the WHO European Office for Investment for Health and Development in Venice, its main mission being to reduce health inequality. I believe that this mission is fully in line with the vision we have in Veneto: to offer more equitable health services and to place citizens equally at the core of the health system.

The Health 2020 policy framework – whose principles and objectives were mentioned very often during the conference – continues to be a priceless reference tool in our policy- and decision-making exercises, encouraging us to focus on evidence-based initiatives. At the same time, it is important to keep the United Nations Sustainable Development Goals in mind if we wish to be efficient in setting our priorities.

In this context, I am very much looking forward to our future collaboration with the WHO Regional Office for Europe and am confident that Veneto will continue to show its commitment to maintaining its excellent standard in the field of public health. I find it highly rewarding to be able to share the valuable experience of my Region and to see "the road travelled so far" officially documented in a WHO publication.

I hope this report will provide its readers with a strong testimony of our work and our belief that health is an irreplaceable element of paramount importance in the lives of our communities and our people.

Domenico Mantoan
General Director for Health, Veneto Region, Italy

Foreword

I wish to express my gratitude to the Veneto Region for organizing the conference on positioning the Veneto Region at the core of global and European health policies, which took place in Venice, Italy, on 3–4 December 2015, and for providing us with the opportunity to examine the challenges and achievements of the Region, a champion of best practices in public health at both the national and international levels.

The Veneto Region has actively supported the WHO European Office for Investment for Health of the WHO Regional Office for Europe since 2003 and has also been an active member of the WHO Regions for Health Network for a number of years. We very much appreciate the outstanding potential we see in our dialogue with Veneto. There are so many areas in which we can develop this potential together and many public health matters we both consider priorities. Our partnership relies on a common set of values and I am confident that we can look forward to working together in a truly constructive spirit of cooperation in the years to come.

The fact that, from 2016, the WHO European Office for Investment for Health will be housed in the Scuola Grande de San Marco, a treasure of Venetian art and, historically, a symbol of solidarity, is a matter of great pride to us. Actually, the Venetian Scuole (which existed between the 13th and 18th centuries) were originally founded as religious and charitable organizations that encouraged people to join forces to sustain their local communities and most vulnerable citizens. The Scuole were, thus, an important expression of social solidarity and represented a way of addressing the social and health inequalities of their time. The Venetian Republic took a leading part in developing modern values and practice, combining scientific understanding with a sense of place and beauty. It also helped create modern public health; international health regulation is believed to have begun with quarantine legislation enacted by the Venetian Republic in 1377. Venice is an extraordinary example of a resilient community. It was founded in the sea centuries ago as a shelter in times of conflict and still stands strong despite war, disease and fire.

The geography of Venice is reminiscent of WHO. The city appears to be a single entity but in fact consists of 116 islands joined by bridges. Similarly, the

WHO Regional Office for Europe helps create bridges among the 53 Member States in the WHO European Region, which vary greatly but have the same mandate to move forward and improve health. In bringing countries together, events like the conference are vital to improving health and reducing health inequality. The United Nations 2030 agenda for sustainable development includes health as a strong foundation for reaching its goals; Health 2020, the WHO European policy framework and strategy for the 21st century, will be a major source of help in delivering them and in taking human development forward across Europe.

It is vital that the countries of Europe work together at all levels – national, regional and local – because the issues we face in terms of public health call for prompt and integrated responses. We need vision, commitment and the willingness to act.

In this respect, the Veneto Region provides an excellent example of regional action that comes together, providing the crucial link between the national and the local, and operating on a scale large enough to lever significant changes. It has shown its excellence in health-service management, public health, disease prevention and environmental health. The examples of the Veneto Region and the city of Venice are a unique source of inspiration, encouraging us to plan consistently for the future while holding on to our precious roots.

We at the Regional Office are looking forward to continuing our collaboration with Veneto, which we consider to be a mutual learning opportunity. I am confident that there are many ways in which we can continue to grow together and significantly improve the health conditions of our communities and people in doing so. It is our calling, our duty and our vitally crucial mission - at the national, regional and global levels alike.

Zsuzsanna Jakab
WHO Regional Director for Europe

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The WHO Regional Office for Europe wishes to express its appreciation to the Veneto Region for organizing the conference on positioning the Veneto Region at the core of global and European health policies – which took place in Venice, Italy, on 3–4 December 2015 – and for sharing the experiences of the Region in dealing with global and European health problems.

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The report was written by Christopher Riley, Consultant, Leda Nemer, Consultant, and Francesco Zambon, Policy Development Officer, WHO European Office for Investment for Health and Development of the WHO Regional Office for Europe, Venice, Italy.

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Finally, the Regional Office wishes to express its sincere appreciation to the Veneto Region for its valuable collaboration, including its continued support of the work of the WHO European Office for Investment for Health and Development and the WHO Regions for Health Network, and for making this publication possible.

Executive summary

Every country and every region within a country face a variety of health challenges – demographic, epidemiological and environmental. How they respond to these challenges depends on political decisions made and local circumstances at the time.

Health 2020. A WHO European policy framework and strategy for the 21st century (1), and the United Nations Sustainable Development Goals *(2)* have established a context within which all countries can make their own distinctive contributions towards better health for all.

In many countries, responsibility for the health services and other policy areas that influence health has been allocated to the regions. It is clear that in these countries the regions play a vitally important role in creating links between the national and local levels and across the different sectors. Regions are small enough to understand the details surrounding the issues they face and large enough to be able to take action to address them.

This publication considers the case of the Veneto Region in north-east Italy, which serves 5 million people. Its responsibilities in the area of health include the organization of many services that protect and promote health and provide health and social care within the norms established by the Italian Constitution and the Italian Government. The Veneto Region has long had a strong partnership with the WHO Regional Office for Europe and is an active member of the WHO Regions for Health Network *(3)*.

The publication briefly reviews European policy and the current health challenges in the light of Health 2020 *(1)* and the Sustainable Development Goals *(2)*. It describes how the health situation in Italy sets the stage for health-related action in the Veneto Region and identifies the main elements of the Veneto model in terms of protecting and promoting health and providing health services and social care.

The health service of the Veneto Region includes a diversified set of hospitals and community-based services. Health and social-care reforms are being introduced in response to the agenda included in the Region's health and social care plan for 2012–2016, which includes strengthening primary care and developing integrated care, based on an information-led model of population-health risk assessment and team-based services.

The publication identifies ways in which the Veneto experience may be useful to other regions, for example, how policies and services are linked, how the different levels interact, and how priorities can be changed without undermining continuity of purpose.

Introduction

Health is a precious resource, which needs to be protected and promoted throughout the life course, a human right that depends on the shared action of individuals, governments and every element of society. However, delivering health protection and promotion requires effort. Resources are scarce and a continually changing context makes it necessary to constantly rethink and refocus policies and services.

These factors formed the setting of the conference on positioning the Veneto Region at the core of global and European health policies organized by the Veneto Region in Venice, Italy, on 3–4 December 2015. Participants included representatives of national and regional institutions, the health system and patient associations in Italy, other regions of Europe, the media and WHO, as well as historical, legal and technical experts.

Presentations made during the conference addressed the Veneto model of tackling the strengths and challenges of the Region in the area of health and the current state of public health and health care, including the development of integrated and intersectoral approaches to dealing with health support and inequality (Annex 1). The different chapters of the report draw on these presentations and other material to give the reader an insight into the Veneto model and the lessons it offers other countries and regions in Europe.

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Background

In opening the conference, the WHO Regional Director for Europe thanked the Veneto Region for its continued support of the WHO European Office for Investment for Health in Venice and for providing the opportunity to examine the challenges and achievements of the Region in the area of health. Historically, the Venetian Republic took a leading role in developing modern values and practice, combining scientific understanding with a sense of place and beauty. It also helped create modern public health: international health regulation is believed to have begun with quarantine legislation enacted by the Republic in 1377. The city of Venice is an extraordinary example of a resilient community: founded in the sea as a shelter in times of conflict, it has withstood war, disease and fire for centuries.

The city of Venice has always had an open approach in its role as a meeting point for different civilizations and cultures; such an approach is vital today. The countries of Europe must work together at all levels – national, regional and local – because the problems they face, for example in relation to biosecurity, the environment, tobacco use and obesity, to name a few, know no boundaries and need clever, integrated responses. The vision behind this work must come with commitment to implementation, otherwise it is useless.

In this context, the Veneto model has valuable lessons to offer the rest of Europe. It provides an excellent example of integrated action at the regional level, affording a crucial link between the national and local levels and operating on a scale large enough to lever significant changes. The Veneto Region has proven its excellence in the areas of health-services management, public health, disease prevention and environmental health.

Health 2020 and the Sustainable Development Goals

Health 2020, the European policy framework for health and well-being in the 21st century, was endorsed by the 53 Member States of the WHO European Region in 2012. Health inequality at both the national and subnational levels was one of the main drivers in the development of the policy, which has two strategic goals:

1. to improve health for all and reduce the health divide; and
2. to improve leadership and participatory governance for health.

These are supported operationally by four common policy priorities:

1. investing in health through a life-course approach and empowering people;
2. tackling the European Region's major health challenges of noncommunicable and communicable diseases;
3. strengthening people-centred health systems, public health capacity and emergency preparedness, surveillance and response; and
4. creating resilient communities and supportive environments for health and well-being *(1)*.

The Health 2020 policy framework *(1)* helps Europe achieve health gains by analysing the complexity of health determinants, which must be understood if responses are to be effective. Health is vital to human development, a precondition for alleviating poverty, and is both an outcome and an indicator of progress made towards a sustainable society. It is strongly represented in the United Nations Agenda for Sustainable Development, the aim of which is to end poverty by 2030 *(2)*.

The Agenda has 17 Sustainable Development Goals (SDGs) that apply to every country *(2)*. Progress towards them will be closely monitored through 169 targets, nine of which are linked to SDG 3 to "ensure healthy lives and promote well-being for all at all ages". The SDGs *(2)* are fully aligned with Health 2020 *(1)*, which was defined as the regional framework for this new

vision for health at the regional consultation on the post-2015 development agenda, Istanbul, Turkey, 7–8 November 2013 *(4)*.

The SDGs do not stand in isolation. Achieving SDG 3 will help to achieve some of the others and vice versa. For example, the implementation of health target 3.4 to "reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being" will require collaboration between the health sector and the sectors responsible for education (SDG 4) and economic growth and employment (SDG 8). Health target 3.8 on achieving universal health care will contribute directly to the attainment of SDG 1 to "end poverty in all its forms everywhere", SDG 10 to "reduce inequality within and among countries", and SDG 11 to "make cities and human settlements inclusive, safe, resilient and sustainable" *(2)*.

The aim of the Agenda is to work on sustainable development in an integrated way, simultaneously addressing all three pillars of sustainability – economy, society, environment *(2)*. This links to the health-in-all-policies (HIAP) approach *(5)*. As already mentioned, action on each goal/area will contribute to that on other goals/areas in a bi-directional relationship; this will require good governance across the intersectoral agenda. The Agenda *(2)* provides a huge opportunity to renew public health, energize effort and ensure its alignment across countries.

Responding to health challenges

The current challenges facing health systems provide the context for the SDGs *(2)* and Health 2020 *(1)*. The *European health report 2015 (6)* summarizes recent progress in Europe, demonstrating that within only a few years of the development of Health 2020 *(1)*, increasing numbers of countries are adopting and using its principles and approaches to improve population health and well-being. During the conference, these matters were discussed in four themes: ensuring healthy lives and reducing health inequality; creating a people-centred health-care system; tackling environmental threats; and creating a high-performing health system.

Ensuring healthy lives and reducing health inequality

Investing in health through a life-course approach is of key importance in the Health 2020 strategy. This approach is emphasized because the effects of health inequality accumulate over the life course and transfer across generations. A life-course approach increases the effectiveness of interventions, promoting timely investments with a high rate of return for public health and the economy.

The WHO European Region is on track to achieve the Health 2020 target to reduce premature mortality from cardiovascular diseases, cancer, diabetes mellitus and chronic respiratory diseases by 1.5% annually until 2020 *(6)*. Most of the progress in the European Region is the result of improvements in countries with the highest rates of premature mortality.

Despite these improvements, alcohol consumption, tobacco use, overweight and obesity remain major public health problems in Europe where rates of alcohol and tobacco use are the highest in the world; WHO estimates show increases in the prevalence of overweight and obesity between 2010 and 2014 in almost all countries. A great deal has been done to tackle these issues *(6)*. Although complex conditions have complex causes, the main preventable factors are few – unhealthy diet, inactivity and tobacco use - and yet still too little of the available funding is committed to this area. Taking action is also difficult because different sectors are involved in the costs and benefits

of intervention. Innovative approaches are needed to raise awareness and influence behaviour (Box 1).

Box 1. An innovative approach to smoking in Bibione, Italy – the smoke-free beach

In 2011, the local council of Bibione in the Veneto Region prohibited smoking along a 6-km beach. Promoting this initiative not as a ban but as an opportunity to breathe clean air, the aim was to provide a beach where residents and tourists could be free from exposure to second-hand tobacco smoke. The initiative was tested in two sites in the summer of 2011 and positively received. It was fully launched at the opening of the season in May 2014.

The initiative focused on the most populated part of the beach; from the first row of parasols down to and including the water, areas where many people, including children and pregnant women, spend a considerable amount of time. The smoke-free zone is 5–30 m wide, depending on the erosion of the coastline.

The initiative was made possible because of collaboration between the economic sector, the local authorities, the tourist centre and the health and environment sectors. The result has been an extraordinary change in behaviour: the number of stubs collected each day (250 000 in 2011) having fallen dramatically.

Source: Bibione. Breathe by the sea. The story of a smoke-free beach in Italy (7).

Europe is seeing a resurgence of communicable diseases, including some of those that were previously eradicated. For example, despite high overall measles-vaccination coverage in the European Region, immunity gaps persist, resulting in ongoing endemic transmission and some countrywide outbreaks of the disease. The targets for vaccine coverage are outlined in the European Vaccine Action Plan 2015–2020, adopted unanimously at the 64th session of the WHO Regional Committee for Europe in 2014 *(8)*.

Measured by social determinants, such as infant mortality, life expectancy, primary-school enrolment, and unemployment, inequality in Europe has shrunk. Preliminary data suggest that this positive trend has been sustained since 2010, although absolute differences between countries remain large. Inequality can be measured by the gap in terms of life expectancy. In the WHO European Region, this gap is 11 years *(6)*. The nature of the differences at the regional level in the European Union (EU) countries can be explored using the interactive atlases of health inequalities developed jointly by the WHO Regional Office for Europe and the European Commission *(9)*.

Creating a people-centred health-care system

There are practical reasons for strengthening people-centred health-care systems. The evidence suggests that services working with the public can contribute to increasing people's trust and their ability for self care, reduce hospital admissions, and improve the effectiveness of care. More tools and strategies to support this approach are becoming available, but the ways in which staff and services are organized and information is provided need to change. Public engagement is also important and one way of promoting this is to encourage its active involvement in developing health plans and policy (Box 2).

Box 2. A regional development strategy in Sweden – open Skåne 2030

Traditionally, regional strategies in Sweden have focused on business and infrastructure, but recently Region Skåne, the biggest region in Sweden after the Stockholm Region, decided on a more open, social approach. Those with an interest in health wondered whether this might result in marginalizing it, but the approach allowed many voices to be heard, making its case from many sides.

The participatory process was huge and included 35 seminars with 1300 participants. The Skåne panel involved 4000 citizens. Lessons learnt illustrated not only that a process like this can lead to revealing the real issues, but also that it is a difficult one. Having a common purpose is vital as is the sense of shared ownership, which results from open leadership.

Source: Taking a participatory approach to development and better health: examples from the Regions for Health Network (10).

If the public's role in relation to health is to be respected, much more openness and transparency are required around health matters. When decisions with a possible health impact are being considered, it is necessary to anticipate public reaction. For example, in the case of a health hazard, the evidence suggests that public reaction is provoked not so much by the nature of the hazard, or the scientific facts related to it, but by emotion, which is influenced by many factors and can produce a sense of outrage. This is particularly true if the hazard is perceived to be unfairly confined to a limited group and if information provided by the authorities about the nature of the problem appears to be contradictory. With this in mind, the competent authorities should take steps to ensure that the situation is properly explained, that there is full transparency, and that the public

has the possibility of participating in an eventual decision-making process, giving them the chance influence the outcome.

In managing interaction with the public, it is essential to avoid abstract language and tedious descriptions of decision-making and communication processes; the focus should preferably be on getting the message across, using stories, pictures and numbers, if necessary, to inform people about the likely impact of the decision to be taken. It might be useful to organize training workshops for journalists to help them understand different health issues and aspects of risk communication *(11)* (Box 3).

Box 3. Participatory health planning in the Trentino Region, Italy

In connection with developing its health plan for 2015–2025, the Trentino Region identified communication with the public (explaining health issues and listening to the concerns of the people) as being of fundamental importance, facilitating broader discussion about health rather than limiting it to health services.

The Region organized open meetings with the public over a three-month period and, taking their ideas into consideration, rewrote the health plan. The meetings revealed that people do understand health matters and that their views can be used. The updated plan, which supports this finding, is written in clear and concise language and should enable people to find the information they need to help them improve their own health and use of the services available.

Source: Health and environment: communicating the risks (11).

Tackling environmental threats

Today's health problems are seldom linked to a single cause. In fact, current understanding embraces the complexity of health determinants in our environments. Health problems are seldom simple with simple solutions. Ecological public health looks at the composite interaction between the physiological, biological, social, economic, behavioural and environmental causes of the problems; however, complexity does not mean that people cannot understand what is happening, or absolve them from the need to take action. While macro-level environmental factors may be outside individual control, most of them are amenable to effective action at different levels.

A major shift in human development occurred with the Great Acceleration – the increasingly stark impact of human activity on the planet as a result of the rapid increase in economic development and food production since the 1950s. This has affected the physical environment, with an increase in the emission of greenhouse gases, the pressure on natural processes, and the depletion of natural resources. This was manageable for a time, but now it appears that we have exceeded certain planetary boundaries, leading to potentially dramatic and unforeseeable adverse effects.

Climate change can be addressed through measures to reduce or prevent the emission of greenhouse gases, or through adaptation measures, for example, to manage climate-related risks, protect communities, and strengthen economic resilience. Climate change may significantly harm health by causing:

1. a disruption in food supplies, leading to malnutrition;
2. storms and floods, resulting in injuries and death;
3. water scarcity and contamination, resulting in illness;
4. heat waves; and
5. changes in the incidence of diseases, such as malaria and dengue.

Everyone could be affected but vulnerable groups, including people who are poor, isolated, very young or old, or those with certain medical problems, are at particular risk.

This sets new challenges but people must not, as a result, forget that there are other environmental problems. For example, despite the fact that there is clear guidance on clean water, it remains the case that 10 deaths occur per day in the European Region as a result of inadequate water and sanitation *(12)*. Moreover, people need to recognize that creative intersectoral action for policy and investment can provide simultaneous benefits for the areas involved (Box 4).

Box 4.The many benefits of cycling and walking

Thirty minutes of walking or cycling per day has been shown to reduce mortality by around 10% *(13)*. Despite the concern sometimes heard that active travel can result in more accidents, various studies have indicated that its health benefits outweigh the risks. Active travel has a positive impact in many contexts. It can enhance road safety, air quality and noise level, reduce congestion, energy consumption and carbon dioxide emissions, as well as the need for more expensive infrastructures for cars, and improve accessibility to and quality of life in urban areas.

At an informal meeting of EU ministers for transport in 2015, cycling was declared a climate-friendly mode of transport. It is also easy, equitable, and time efficient for many journeys, requiring minimal investment of household income. There could be economic benefits too. A WHO study suggested that over 76 000 new jobs could be generated if the cycling levels in 56 major cities in the European Region were similar to those in Copenhagen *(14)*.

Sources: Systematic review and meta-analysis of reduction in all-cause mortality from walking and cycling and shape of dose response relationship (13); Unlocking new opportunities: jobs in green and healthy transport (14).

Lang and Rainer *(15)* have proposed a definition of "ecological public health" that addresses this new understanding of complexity and would aim:

> *to comprehend the composite interactions between the physical, physiological, social and cognitive worlds that determine health outcomes in order to intervene, alter and ameliorate the population's health by shaping society and framing public and private choices to deliver sustainable planetary, economic, societal and human health.*

Important lessons have been identified through the European environment and health process (EEHP) to eliminate the most significant environmental threats to human health. EEHP comprises a series of ministerial conferences, held every five years, bringing together different sectors to shape European policies and actions on environment and health *(16)*. The process started with the first conference in Frankfurt-am-Main, Germany, in 1989, during which the *European Charter on Environment and Health (17)* was adopted. The Sixth Ministerial Conference on Environment and Health, which will take place in 2016, will set the environment and health agenda for the next 25 years and propose a new streamlined governance mechanism for the process.

Creating a high-performing health system

Achieving good health requires action across society. In some places, this has translated into regional strategies targeting the mobilization of whole communities towards not only better health, but also a better life for all.

Many factors contribute to a high-performing health system but of late the real concern has been its sustainability and, particularly, the continued ability to fund it. Growth in expenditure on health care in countries of the Organisation for Economic Co-operation and Development (OECD) has all but stopped. Fortunately, there is now evidence – for example, from the European Observatory on Health Systems and Policies *(18)* – pointing to what could be done. There are five options.

The first option would be to protect the health budget, acknowledging that health supports economic productivity and that the health sector is valuable to the overall economy.

Option 2 would be to increase public funding in the recognition that spending more on health is countercyclical and would, therefore, help to offset the impact of downturn. This might involve raising (additional) statutory resources, perhaps in the form of sin taxes (for example, on tobacco and alcohol).

Option 3 would be to ration coverage, for example, by cutting benefits, excluding some of the population, and increasing co-payments. The problem

with this option is that it might actually cause inefficiency. Studies have found that countries that have taken such action have done so in different ways. Most of them have increased the patient's share of the cost of medicine, which has resulted in an increase in the number of people in Europe who feel excluded from some aspects health care.

Cutting coverage could be valuable if it were applied to ineffective treatment. This would improve performance, as would option 4, to enhance the cost-effectiveness of delivery by squeezing efficiency and cutting costs through improvement, and option 5, to tackle health determinants by mobilizing assets and effort across government and society and improving governance across the system.

Within these broad options, countries have a range of policies to choose from. Table 1 lists possible interventions towards fiscal sustainability.

Table 1. Possible interventions towards fiscal sustainability

Low-hanging fruit	Tougher nuts to crack
Delaying investments	Integrating care
Rationing benefits	Conducting an economic assessment of benefit packages
Introducing price control	Reviewing skills mix
Excluding population	Finding information technology (IT)/e-health solutions
Introducing user charges	Developing clinical guidelines
Cutting staff	Taking public health action
Cutting training and research	Introducing performance-related payment
Reducing salaries	Rationalizing hospital services
	Introducing structural reforms

It is clear that to pursue fiscal sustainability only by cutting expenditure would be the wrong objective; cost containment is not the same as efficiency. The low-hanging fruit listed in Table 1 may have a short-term effect, but would not solve the problem in the longer term and would probably be harmful if used in isolation. A combination of effective coverage and cost-effective delivery is needed. However, savings may not be immediate; for example, those from hospital mergers or structural reform could take a long time to materialize.

Capacity, vision and leadership are central to success in undertaking complex reforms, which depend not only on implementation measures, but also on the involvement of and communication with health staff and citizens. To sustain better performance, transparency is also vital, for example, through hospital benchmarking.

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The Italian context

The national health service in Italy

Italy is the sixth-largest country in Europe. Its health-care system is a regionally based national health service that provides universal coverage largely free of charge at the point of delivery. Its main source of financing is national and regional taxes, supplemented by co-payments for medicine and outpatient care.

The central Government plays a stewardship role in setting the fundamental principles and goals of the health system and determining the core-benefit package of health services available to all citizens. The national level has the exclusive authority to determine the package, which is guaranteed throughout the country free of charge, or through cost sharing, using resources collected through general taxation. It is delivered at three levels: public health; community-health medicine and primary care; and hospital care.

The 20 regions of Italy are responsible for organizing and delivering primary, secondary and tertiary health-care services, as well as preventive and health-promotion services. At the local level, geographically based local health authorities deliver public health and community-health services and primary care direct, and secondary and specialist care either direct or through public hospitals or accredited private providers.

The regions are mandated to provide nationally guaranteed services and may, if they wish, provide services beyond those specified in the national basic package. In addition, within a rather broad national framework, the regions are allowed to redesign health-service supply systems and the boundaries of local health units.

National funds are distributed to the regions using formulas that aim to ensure coverage of the full scope of public health care, including primary care, hospital care and community-health services, taking the age structure and health needs of the local population into consideration *(19)*. Italy has

the second-lowest total health expenditure, as a percentage of gross domestic product (GDP), among the EU15 countries *(20)*.[1]

Italy has an active Healthy Cities network, comprising 71 cities. In the WHO context, healthy cities are those that make a public commitment to improve the health of their residents. In Italy, the cities work with and through local actors of national agencies to tackle health problems affecting communities. Projects have covered areas as diverse as training, ageing, breastfeeding, child obesity and blood donation.

The Italian Healthy Cities network helped develop the Milan Urban Food Policy Pact launched in October 2015 *(21)*. Many Italian cities have signed a commitment to take action on its themes and a set of institutional arrangements, including a secretariat, is being established to help take the work forward.

Health in Italy

The life expectancy for Italian men and women is well above the EU15 average; in 2012, Italy had the highest proportion of population aged 65+ of all EU15 countries (21%) *(20)*, but its rates of mortality and premature mortality were among the lowest *(19,22)*. There are marked regional differences for both men and women with respect to most health indicators, reflecting the economic and social imbalance between the north and south of the country. The main diseases affecting the population are circulatory diseases, malignant tumours and respiratory diseases *(20)*.

In 2014, the rates of overweight (58.8%) and obesity (21%) were high, above the European average, and they are increasing *(23)*. Smoking prevalence has decreased slightly in Italy, in line with the EU15 average *(20)*.

The Italian national and regional prevention plans are fully aligned with Health 2020 *(1)* and address issues, such as health inequality, intersectorality, and governance; they build on participatory approaches that mobilize society around common goals.

[1] EU15 countries: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, Sweden, United Kingdom.

Italy has a number of programmes and mechanisms, their common focus being on influencing the impact of unhealthy diet, physical inactivity, alcohol and smoking on health by promoting healthy lifestyles and modifying working and living conditions. These areas are included among six national strategic objectives, along with surveillance, support for healthy choices and behaviours, empowerment, and the promotion of coherent health policy.

The national prevention plan is now in its third phase, covering 2014–2018. It has 10 objectives to be adopted and monitored across all 20 regions of Italy, 19 of which have agreed their regional plans. Italy is seen as having one of the best systems of monitoring environmental contaminants, but communication around pollution could be enhanced.

In managing the Italian health system, legal issues are important. Legislation must conform to the Constitution or it can be struck down. Articles 2 and 21 of the Constitution guarantee the human rights and freedom of expression, respectively. Article 32 states that the Republic protects health as a fundamental right of the individual and in the public interest, and that no one can be obliged to receive treatment unless it is required by law. These are important considerations in relation to questions pertaining, for example, to vaccination and refusal of treatment on religious grounds. There may be conflict between these points and areas, such as individual freedom, privacy, and economic enterprise. An additional complexity may arise because of European treaties *(24)*, which may be seen to impose requirements that appear, in certain circumstances, to undermine the provision of health care.

Health-care challenges

The major issues facing Italy in recent years with regard to health-system organization and service delivery have been the relationship between politics and top management, the need to update and strengthen primary care, and the tension at the local level between administrative control and freedom to innovate. The last decade has been dominated by two intertwined issues: regional fragmentation and the need to maintain financial control within regional health systems. Faced with the current economic constraints and the resulting need to contain or even reduce health expenditure, the greatest challenge facing these health systems is to achieve their budgetary goals without reducing health services for patients *(19)*.

While Italy spends less on the provision of health care than its peers, its results are good, implying that it uses its funding well. Even so, 8% of the population is not able to access care because of cost. The system has eliminated deficits in recent years but in a time of economic crisis finances are tight and more innovative action is needed. Some of the points suggested for inclusion in a reform agenda are:

- better governance of changes in health units and more transparency of aims and progress;
- patient analysis with a view to grouping people according to their needs: those in good health; those with occasional problems, the chronically ill; and long-term care clients;
- redesign of units to ensure that catchment areas match clinical safety levels and patients are treated by competent experts in suitable facilities, and that operating units failing to meet the standards defined by the catchment area are merged to safeguard clinical competence (safety and quality);
- reduction/redesign of small hospitals to allow the concentration of complex cases in fewer sites and better overall use of resources;
- use of information systems and technology to clarify workload-related factors in terms of staffing, clinical and patient behaviour, and outcomes;
- creation of new structures for public agencies to diversify internal governance (management and accountability structures, for example, need to fit the local circumstances);
- introduction of essential changes in staff management to respond to staffing shortages and ageing (through active measures to mould the workforce and create suitable conditions).

With regard to the first point, the number of health units across Italy is falling, but the rationale for this is not clear. It is necessary to clarify this to ensure the right decisions are taken. At the same time, there is a need for greater homogeneity in the quality and quantity of services. Costs for administration and support services should be reduced and knowledge-management processes expanded.

Overall, health and the health services in Italy are good although there are social and geographical inequalities, as in other countries. The health-care

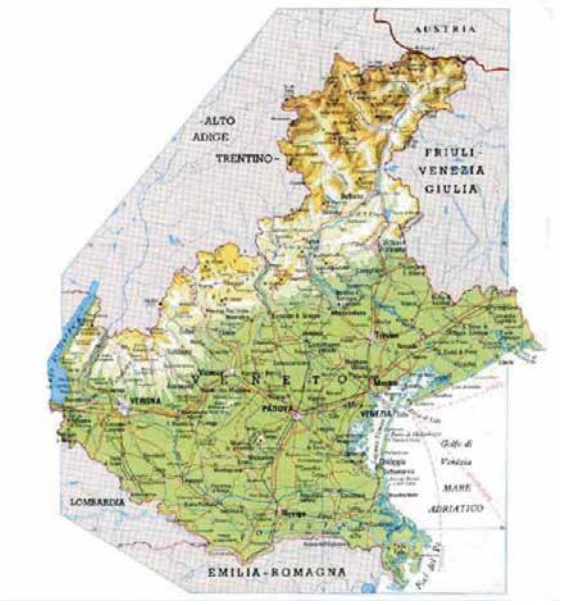
system has its challenges. Power is divided between the national level and the regions and ensuring the coherence and integration of policies and practice at both levels is important. An example of this relates to vaccination: the regions are looking to the national authorities to take the lead and provide support through communications and the establishment of a national register to monitor vaccine coverage. In Italy, this is decreasing due to anti-vaccination campaigns. Therefore, there is a need to focus on monitoring vaccine coverage every six months, ensuring multifaceted communication with the public, and management of parents' perception of risk.

The Veneto model

The Veneto Region

The Veneto Region (Fig. 1) is one of the richest regions of Italy with a population of just under five million.

Fig. 1. Map of the Veneto Region, Italy



Source: Ferré, de Belvis, Valerio, Longhi, Lazzari, Fattore et al. *(19)*.

Life expectancy for both men and women is slightly higher than the national average, while mortality rates in the Region are comparable to those at national level. The major causes of death are cardiovascular diseases and cancer.

The Government of the Veneto Region (Giunta) is responsible for the health system through the departments for health and social services, which receive technical support from the General Management Secretariat. Health care is provided by 21 local health and social-care units, two hospital enterprises, two national hospitals for scientific research, and private accredited providers *(19)*.

At the political level, in terms of health and the environment, synergy and integration are considered vital. This also applies to the need to ensure that policies and preventative measures are aligned and that there is no conflict between development and environmental protection. The departments for health and environment work closely together and with the local health units and the Regional Agency for Prevention and Protection of the Environment to develop clear, easily implementable rules that are based on the latest scientific approaches.

The Veneto Region has a high population density and has seen considerable growth and industrialization. It has a complex relationship with water at different levels, which poses many technical and political challenges. In 2006, EU adopted the Groundwater Directive (2006/118/EC) on the protection of groundwater against pollution and deterioration (25). It established standards for the quality of groundwater and introduced measures to prevent or limit the input of pollutants into groundwater. The Veneto Region has taken action accordingly (Box 5).

Box 5. Intersectoral collaboration in the Veneto Region to protect the health of the population

During the summer of 2013, as a result of a series of experimental studies carried out by the Ministry of Environment and Civil Protection of Veneto on potential "emerging" pollutants, the presence of harmful perfluoroalkyl substances (PFASs) was identified in the groundwater in some parts of the Veneto Region. PFASs are resistant and bioaccumulable chemical substances and those found in the Region had probably resulted from industry in Vicenza 50 years previously. It was estimated that the contaminated area covered 180 square kms.

The Veneto Region took an integrated approach to dealing with this issue. They established an intersectoral working group, set performance limits and installed carbon filters to remove the PFASs, also in private wells used for drinking-water, where necessary. A biomonitoring system was set up involving six health centres and an unexposed control area. Performance limits in the area have not increased since this action took place and have even decreased in some parts of the Region.

The Veneto Regional Prevention Plan covering 2014–2018 was agreed in May 2015. It focuses on a coherent, programmatic approach rather than on separate projects and is oriented towards settings, the life course, intersectorality and

health inequality. It fully recognizes that communication (for example, with schools), training, updating skills, surveillance, and evaluation are essential to progress.

In response to the Plan, each local area is required to prepare its own plan reflecting the circumstances of the area. This is being done under the leadership of specially appointed local coordinators who received training through a programme supported by the Ca' Foscari University of Venice and the WHO European Office for Investment for Health and Development. Monitoring mechanisms are in place to ensure that efforts across the regions are appropriately coordinated and followed up. Efforts are being made to ascertain that, for each objective, partners with important contributions to make are identified and engaged.

Health care in Veneto

The health and social-care plan for Veneto Region

The aims of the current health and social-care plan for Veneto Region (2012–2016) include:

- placing greater emphasis on intersectoral action for health promotion;
- developing community-based services;
- promoting continuity of care via a local communications point;
- strengthening integrated health and social care;
- reorganizing hospital care around a hub-and-spoke model;
- conducting individual needs assessments;
- organizing clinical networks and care management;
- improving procurement and service contracting;
- carrying out more rigorous investment analyses;
- developing patient and performance dashboards *(26)*.

More detailed measures that have since been added include:

- reprogramming of hospital beds, intermediate structures and long-term facilities;
- organizing general practitioners (GPs) into medical teams.

An overview

The health and social-care plan needs to be constantly adapted to respond to challenges and changes related to life expectancy, economic growth, employment, density, health inequality and health services.

Tools to manage and implement the plan include: standards for hospitals, staff and prevention; expenditure ceilings; and health-technology assessment. These are used in core processes related, for example, to prevention, hospital care, intermediate care, primary care, pharmaceutical and social care, and in connection with support services (staffing, finance, infrastructure, management and procurement).

The Veneto model of care settings has four levels:

1. acute care (17 000 beds organized in a hub-and-spoke structure, and a network arrangement);
2. intermediate care (3000 beds in rehabilitation centres, hospices and community hospitals);
3. residential care (30 000 beds: 75% low intensity; 25% medium intensity);
4. domiciliary care (covering 120 000 people with chronic problems).

The hub of the hospital network includes two regional centres (in Verona and Padua), five provincial hospitals and a regional cancer centre. The spokes are made up of 17 general district hospitals and three private hospital centres. The network includes 40 units, 23 of which are private.

Outside the hospitals, services are organized at the district level; this includes units dealing with primary care, family and child health, palliative care and mental health.

The prevention model involves plans at all levels – national, regional and local – and ensures coherence across them, as well as appropriate engagement and oversight at each level.

After a period during which funding rose steadily up to 2009, it is now almost flat, actual cuts having occurred in 2012 and 2014. Health expenditure in the Veneto Region is lower than the Italian average, which fell by 1.6% in the period 2009–2013 *(27)*; in 2014, it was 6.9% of GDP (against 9% in Germany) *(28)*.

Cancer incidence has fallen slightly in Veneto since 2002 *(29)*. Decreasing vaccination rates are something of a problem, though they are still generally above 90%, except for measles vaccination, which has dropped to 88.6% *(30)*.

The number of beds in Veneto is decreasing *(31)*. The hospitalization rate in Veneto is below that for the rest of the country, thanks to the well-developed community-based services in the Region *(32)*. It fell by an extraordinary 15.6% in the period 2010–2014 *(32)* and admissions were expected to fall by 11.3% between 2010 and 2015 *(33)*. Outpatient treatment fell by 9% between 2012 and 2014 *(34)*. The services are meeting their targets for waiting times with respect to specialist treatment *(34)*.

Ageing is a big challenge and has led to a change in the needs profile. Some 20% of the Veneto population is over 65 years, 10% is over 75, and there are around 7 people over 65 for every 5 under 15. A quarter of the population has a chronic health problem, including 65% of those over 65; over 25% of those aged 75–84 and over 57% of those above that age group have a disability *(35)*.

To manage resources and meet the needs, the Veneto Region uses the Johns Hopkins adjusted clinical groups® (ACG®) system *(36)* to understand, map and measure what is needed across its territory. This system entails analysing data related to people's diseases and the services and costs involved; people are grouped according to the constellation of diseases they experience and the support they require, from those in good health, for whom the appropriate interventions are health promotion and screening, through to those requiring end-of-life care.

Primary care is organized by grouping GP practices around small defined groups of about 15 000 people to provide an integrated medical team with

24-hour support. A new coordinating arrangement, the "centrale operativa territoriale" (COT) (local communications point), provides a link between primary care and hospital services, thus strengthening the intermediate care sector. It also involves a common IT infrastructure, enabling professionals to share patient information.

Other initiatives in primary care include the analysis of resources needed for each patient in hospital and measures to reduce pharmaceutical costs and ensure that staff skills match changing needs and circumstances. New drugs that can extend life but are very costly pose a particular problem for the future. IT systems have eliminated paper prescriptions and the need for other documents, and they protect confidentiality. An array of IT-based approaches is being used at three levels: prevention and telephone support; telemonitoring and assistive technologies; and telemedicine.

Finally, as the existing managerial arrangements in Veneto's health sector are 20 years old, a new system has been proposed at the regional government level to strengthen governance. This is now under consideration.

The primary-care model

A regional programme supporting the primary-care model in Veneto has been developed through a participatory process, involving professionals, voluntary groups and citizens, to create a shared approach. The aim of the programme is to deal with need wherever it arises by drawing on greater doctor–patient trust and proven good practice. This approach utilizes team work to achieve patient-centred care and care pathways, pooling patient information in a centrally coordinated system, and it guarantees local access points and public participation in the governance system. The model promotes collective responsibility for the integration of community and hospital care to provide coordinated continuity of care.

COT is responsible for handling the complexity of the system. Operating on a 24-hour basis, it facilitates the application of clinical pathways and monitors their use. It moves patients through the system, coordinating transfers between locations or service levels to ensure smooth pathways, and mobilizes resources as necessary to deal with problems or needs encountered.

However, although the overview provided by COT helps ensure the smooth running of the system and can contribute to improving it over time, lessons already learnt show that it cannot manage the task alone. The responsibility for care and care pathways needs to be shared with those in charge of specific functions in hospitals and the community, each component of the system keeping a firm grip on its own role.

At the local level, the key element involved in the process is the integrated medical group (IMG), which offers a comprehensive, continuous, equitable and people-centred service, from prevention to palliative care, and takes responsibility for the health of the community in conjunction with other local actors. This is seen as an investment in and for the community, mobilizing local resources and improving access to services and public participation in governance. Currently, there are 27 IMGs, involving 244 GPs (7.47%) who cover 329 490 patients (7.75%)).

There are 3265 GPs involved in the provision of health services in the Region either:

1. as part of a multiprofessional team of GPs (IMG GPs);
2. as part of a group of GPs sharing the same practice (group GPs);
3. as part of a group of GPs working in separate practices and networking electronically (network GPs);
4. in association with GPs working in their own practices and providing health services to patients outside their practices in the case of non-deferred health care (association GPs); or
5. through their own practices with no formal links to other GPs (single GPs) (Table 2) (35).

Experience suggests that success factors in primary care include: good local coordination; shared goals, which may be hard to determine but are essential; well-functioning care pathways; a streamlined information system; training on the health objectives; work sharing; and audits.

In moving forward, an understanding of the local context and the vital role this model can play in assisting the GP to manage the pathways are key

considerations. The pathway approach requires an analysis of the processes needed, reengineering them as necessary, and an understanding of the needs and resources available to meet them. To follow this approach through, it is necessary to find ways of promoting participation and developing/coordinating responsibility, as well as predictive tools to tailor individual care needs. All of this should be in the context of creating an alliance with the local community to enable it to understand and become involved in the new approach, recognizing that health care is less and less a service provided and, increasingly, one created through common effort.

Table 2. Distribution of forms of GP engagement in primary health care in Veneto Region, Italy, 2015

Forms of GP engagement in primary care	%
Single GPs	15
GPs in association	10
Network GPs	27
Group GPs	32
IMD GPs	16

Source: Anagrafe Unica Assistiti Regionale, Venice, Italy (35).

Integrated care

Multimorbidity is the norm in Veneto Region's ageing population. Care for those affected is often fragmented and expensive. Traditional care programmes fail when many chronic conditions are prevalent at the same time. Patient expectations are changing, needs are increasing and resources are decreasing. Integrating care can help improve health, the care experience and value for money.

The collection and analysis of data through the ACG system will not only provide retrospective information on the population but also support individual care, allowing a better understanding of the burden of disease, how it is distributed and, therefore, the resources needed to deal with it. Data analysis has shown that, while people with high or moderate health-care

needs comprise only 21% of the population, they account for 75% of the service costs.

This opens the way to considering alternate methods of providing care in a population-focused but people-centred manner, targeting those facing high or emerging risks in particular. The approach adopted is evidence-based and, drawing on existing validated models, aims to provide comprehensive, personalized care based on team work and continuity of care.

A primary-care programme has been designed, which includes a care manager, qualified in nursing, whose task it is to assess patient needs and preferences and, in dialogue with the GP, design and regularly update evidence-based care guides and action plans. In addition, the care manager: supports patient self-management, monitoring the patient proactively and educating and supporting family caregivers; facilitates access to community services; supports a smooth transition between care settings; and coordinates with the providers, including hospitals, emergency departments, specialty clinics, rehabilitation facilities, home-care agencies, hospice programmes, and social-service agencies.

The programme has been tested in the 21 local health units, where the care manager in each followed 20–40 patients with complex conditions. Patients have to consent to entering the programme and their preferences are an important element in designing their care. In an initial evaluation of the programme, 97% of the patients, 93% of the care managers and 72% of the GPs expressed a moderate or higher level of satisfaction, suggesting that it is working well.

The next phase

During the next stage of the programme, the Veneto Region proposes to concentrate on a number of activities to strengthen governance and streamline administrative procedures. They will be carried out within a new central body, which will have two functions, namely, to undertake management tasks of a technical and specialist nature, and to coordinate the work of the service providers. The regional Government will retain responsibility for the programme's direction, scrutiny and overall control. Anticipated results

are the standardization of costs and procedures and the centralization and rationalization of back-office functions.

Issues and challenges

The patient perspective

Although Veneto has a very good health system, it is not optimal for dealing with people with chronic conditions. New approaches are needed, based on the active role of the patient in working with professionals to implement care pathways.

Shifting to a patient-centred approach would benefit patients as it requires a better understanding of their needs and how best to meet them. There is also a need for improved communication skills among health professionals, as well as changes in primary care. It is important that securing patient consent to treatment is understood not as a bureaucratic requirement but as an opportunity to explore the issues and options that might influence what treatment most meets the patient's circumstances. Patients may not always have the resources and tools they need to follow the advice they are given.

Today many older people, who are the main users of health services, do not have ready access to independent sources of health-related information and advice. Some, through education and the use of smart technology, are already more aware and assertive and their number will grow. People may become less deferential to clinical professionals, and policy and practice will need to respond to cultural changes.

The professional perspective

Working in multidisciplinary teams is already the practice in hospitals but less so outside. Therefore, as such teamwork will be very new to many professionals, it will be important to proceed carefully. The Region includes many different sorts of communities, from cities to remote valleys, and their needs will differ. In addition, many professionals in the Region have been in practice for years and may find change difficult. Thus, it will be necessary for those aiming to develop new ways of working to do so in close collaboration

with both the professionals and their trade organizations. Ensuring the safety of both patients and professionals will have to be a central concern, and talk of "putting patients at the centre" must not result in neglecting the need to support staff at a time of change.

The national perspective

Veneto is an example of a successful region managing within its own financial resources, coping with both supply and funding – a major innovation. There is also evidence of cooperation between the health and social-care services. A health system must be flexible and Veneto's is, offering benefits beyond the basic national health entitlements. It is an example to other regions.

However, to maintain its position, the Veneto Region must continue to innovate itself. To meet the challenges it faces, bold changes will be required in the next round of restructuring the health-care system. This will take time and it would be advisable to start at the beginning of a legislative cycle. The first step could be to define measurable objectives and intermediate steps towards establishing a risk-accepting culture for change. Benchmarking between the units of the Region and a programme for developing the necessary competences to support change should also be considered.

Lessons learnt from the Veneto model

Health 2020 *(1)* and the SDGs *(2)* have reinforced the understanding that health threats are complex and ever-changing, making it impossible to take the view that protecting and improving health is a simple, straightforward matter. The conference on positioning the Veneto Region at the core of global and European health policies provided an opportunity to learn how one geographically defined part of Europe has come to terms with and responded to this.

Four important lessons can be learnt from Veneto's experience; these are described below. None is entirely new but all add clarity.

A systematic approach

The first lesson is that improving health and reducing health inequality requires a sophisticated, multifaceted approach. The Veneto experience shows how the different elements of the Health 2020 framework *(1)*, including a focus on measurable improvement, action to deal with the determinants, a cross-sectoral aproach, environmental awareness and protection, and the mobilization of civil society, can be taken forward simultaneously.

The Veneto model is based on a scientific understanding of the health problems in the Region and what the solutions might be, as well as on the recognition that the importance attributed to health is rooted in its institutional arrangements. Discrete responsibilities are allocated to relevant agencies that are expected to understand each other's activities and work together.

There is, therefore, a functioning, visible governance system, which recognizes the overall expectations of the health system and monitors its performance.

All levels together

The second lesson is the importance of multilevel coherence. The conference included representatives of the Italian Government, the Veneto Region,

local government, local health units and WHO. These were not perceived as parallel, separate layers; rather, their active interaction was understood as being vitally important in terms of sharing information on problems and solutions and ensuring that the contributions of the different levels are combined to the best effect.

It is important to the Veneto Region that its efforts and achievements are understood and appreciated. It is important to the Italian Government to know that, despite the challenges of population ageing, changing expectations and austerity, there are regions of the country that are tackling their responsibilities effectively within the resources available to them. It is important to WHO to be able to point to an example of successful whole-of-government action.

The conference demonstrated ways in which prevention goals identified at the national level are interpreted and implemented at the local level and how local and regional difficulties requiring national support are communicated to the national level.

Each level has its own responsibilities, tasks and ambitions; working with the other levels renders it stronger with more chances of success.

Everyone's business

The conference illustrated how the efforts of the Veneto Region to improve health are rooted in an understanding of the human dimensions of everyday life. Participants included journalists who play a valuable role in supporting and molding public understanding of risks and opportunities. One of the participants was a historian who helped ground the discussions on the longer-term identity and achievements of the Region and its communities.

The Region's people-centred approach was seen not as a dry, procedural issue, but as a way of mobilizing people to manage their own life chances. Examples presented at the conference from outside the European Region illuminated how the participation of the public can help fashion new ways of managing public affairs, and a national example (Bibione (7)) showed how progress can be achieved on a contentious issue through public involvement and education.

Within the Veneto health system, the focus on personal care and support, and the development of health planning at the municipal level, constitute evidence of efforts to marry technical expertise and public engagement at the grass-roots level in a true partnership for health.

Thus, the third lesson is that encouraging everyone to contribute helps form the basis for a whole-of-society approach to improving health.

Flexibility is important

In Italy, prevention planning is regularly renewed from the national level down. The health system in Veneto is being restructured in response to its changing financial and demographic context and every aspect, from staff training through clinical process management to information collection and utilization, is being reviewed and updated. It is clear that the Veneto model is a work in progress.

The fourth lesson learnt from the Veneto model is that flexibility and the ability to react to changing needs without disrupting or forfeiting achievements already made are important strengths. Action to address new problems, such as environmental contamination, in a serious and focused way is the sign of a dynamic and creative way of thinking.

Conclusion

The Veneto model is not perfect, but it shows strength and vitality in recognizing that challenges will constantly change. It has a web of assets that enables it to adapt to and cope with an environment that is in constant flux. It is a model to watch.

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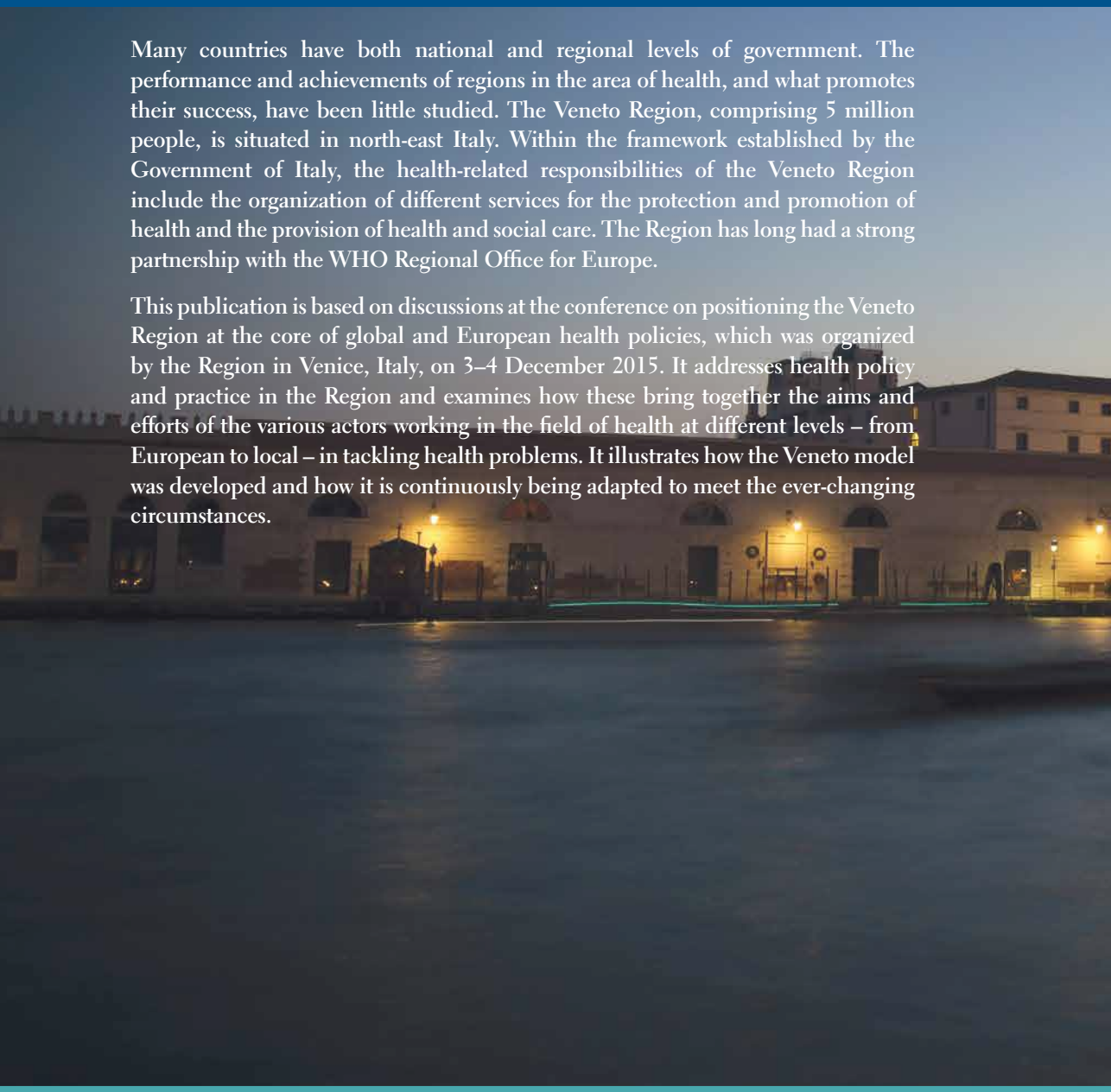
Annex 1. Speakers and presentations

Session	Topic and *speaker(s)*	Moderator
Opening	Introductory comment *Zsuzsanna Jakab, WHO Regional Director for Europe* *Gianpaolo Bottacin, Regional Environment Minister, Veneto Region, Italy*	
Session 1. Positioning the Veneto Region at the core of European health policies	Health 2020 and the post-2015 development agenda *Zsuzsanna Jakab* Facing and overcoming challenges: the Veneto health model *Domenico Mantoan, General Director for Health, Veneto Region, Italy*	Ranieri Guerra, General Director for Prevention, Ministry of Health, Rome, Italy
Session 2. Ensuring healthy lives and promoting well-being for all at all ages	Intersectoral work for better health: positioning Bibione as a setting for "healthy holidays" *Pasqualino Codognotto, Mayor of San Michele al Tagliamento, Italy* Coherent action across Italy: the National Prevention Plan *Ranieri Guerra, General Director for Prevention, Ministry of Health, Italy* The Regional Prevention Plan: an opportunity for strengthening multisectoral partnerships *Francesca Russo, Director for Prevention and Health Promotion, Veneto Region, Italy* The Trento health plan 2015–2025 and Health 2020 *Luciano Flor, General Director of the Provincial Enterprise Healthcare Trust, Trento, Italy* Improving mobility, promoting physical activities, preserving the environment: are all these incompatible? *Francesca Racioppi, Senior Policy and Programme Adviser, Division of Communicable Diseases, Health Security and Environment, WHO Regional Office for Europe*	Piroska Ostlin, Director, Division of Policy and Governance for Health and Well-being, Acting Head, WHO European Office for Investment for Health and Development, WHO Regional Office for Europe

Session	Topic and *speaker(s)*	Moderator
Session 3. A systematic approach to creating a people-centred health-care system	The patient's point of view on health care and health *Roberto Messina, President of Federanziani Senior Italia, Rome, Italy* Empowering citizens and communities: the primary care model in Veneto *Maria Cristina Ghiotto, Director for Primary Health Care, Veneto Region, Italy* Integrated care in practice: from population health to care-management *Maria Chiara Corti, Director for Integrated and Intermediate Health Care, Veneto Region, Italy* The role of medical doctors in multidisciplinary teams *Maurizio Scassola, General Practitioner, Vice President of the National Board of Physicians, Venice, Italy*	Juan Tello, Programme Manager, Division of Health Systems and Public Health, WHO Regional Office for Europe
Session 4. Preserving our world in the third millennium: the importance of environment in the sustainable development goals 2015–2030	Public health and environment in the context of sustainable development *Srdan Matic, Coordinator, Division of Communicable Diseases, Health Security and Environment, WHO Regional Office for Europe* Preserving our water resources, preserving our planet *Mario Carere, Researcher in the Department of Environment and Primary Prevention, National Institute of Health, Rome, Italy* Putting citizens' health first: a systemic approach to environmental hazards *Francesca Russo* Communicating risk regarding environmental hazards: the outrage factor *Luca Carra, Journalist and editor, Zadig, Milan, Italy* The right to self-determination and health protection *Francesco Lippiello, Magistrate, Member of the Ethics Committee Veneto Region, Italy* The strategic role of cities in health and in the Milan Urban Food Policy Pact *Simona Arletti, President of the Italian Healthy Cities Network, Modena, Italy*	Walter Ricciardi, President of the National Institute of Health, Rome, Italy

Session	Topic and *speaker(s)*	Moderator
Session 5. Improving performance in the health system – a task for all	Balancing improved performance with financial sustainability in health systems *Josep Figueras, Director of the European Observatory on Health Systems and Policies, Brussels, Belgium* Emergent trends: a new service portfolio for a high value health-care system *Francesco Longo, Professor of Department of Policy Analysis and Public Management, Bocconi University, Milan, Italy* Participatory approaches to health: an effective mechanism to empower citizens and improve community resilience *Elisabeth Bengtsson, Director of Public Health, Region Skåne, Sweden* Sustaining the right to health in the face of human and financial constraints *Chiara Cacciavillani, Professor in Administrative Rights, University of Padua, Portugal* The financial sustainability of the regional health system: innovative solutions to tackle unprecedented challenges *Mauro Bonin, Director of Planning Financial Resources, Veneto Region, Italy*	Stefano Campostrini, Professor of Social Statistics, University Cà Foscari Venice, Italy
Concluding remarks	An historical perspective on the Serenissima in conserving and protecting health, lands and waters *Maria Grazia Siliato, Professor of History and author, Lanuvio, Rome, Italy* *Zsuzsanna Jakab, WHO Regional Director for Europe* *Domenico Mantoan, General Director for Health, Veneto Region, Italy* *Luca Coletto, Regional Health Minister, Veneto Region, Italy*	



Many countries have both national and regional levels of government. The performance and achievements of regions in the area of health, and what promotes their success, have been little studied. The Veneto Region, comprising 5 million people, is situated in north-east Italy. Within the framework established by the Government of Italy, the health-related responsibilities of the Veneto Region include the organization of different services for the protection and promotion of health and the provision of health and social care. The Region has long had a strong partnership with the WHO Regional Office for Europe.

This publication is based on discussions at the conference on positioning the Veneto Region at the core of global and European health policies, which was organized by the Region in Venice, Italy, on 3–4 December 2015. It addresses health policy and practice in the Region and examines how these bring together the aims and efforts of the various actors working in the field of health at different levels – from European to local – in tackling health problems. It illustrates how the Veneto model was developed and how it is continuously being adapted to meet the ever-changing circumstances.

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