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The Health Assistance in Hospital and at Home

The Italian Situation

Lifelong Learning Programme

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The Health Assistance in Hospital and at Home
The Italian Situation

Sabrina Grigolo, Tania Re
Presidio sanitario gradenigo, Cipes Piemonte
Turin, Italy
sabrina.grigolo@gradenigo.it, iuhpe-cipes@cipespiemonte.it

Abstract

In Italy, the healthcare system organisation was born in the Middle Ages, when the first hospital for patients and beggars was built. The actual National Health System was born in 1978 with the Law n. 833, to safeguard the physical and psychic health of people as a fundamental right for person and community. The next changes of law and the Constitutional Chart implemented the devolution process and, now, the Italian Regions have the power to make law in the health context. This report describes the main aspects about the story of our NHS, the integration of home care, the hospital and territorial continuity and the social system. A particular focus is dedicated to human resources and professional training pathways on the health promotion, which are very important for the Italian NHS.

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1. Introduction

1.1 Italian National Health System

The Italian Republic safeguards health as a fundamental right of the individual and as a collective interest, and guarantees free medical care to the indigent. No one may be obliged to undergo any given health treatment except under the provisions of the law. The law cannot under any circumstances violate the limits imposed by respect for the human person.

- The founding principles are:
- Public responsibility for healthcare
- Human Dignity
- Equal access to healthcare for all citizens
- Cost-Effectiveness in the use of resources
- Public financing of healthcare through general taxation

Since the founding of the Italian NHS (SSN) in 1978 (Law 23, 833), it has undergone two major reforms: the first in the early nineties (Legislative Decree no. 502/1992 and no. 517/1993) when the Regions were granted greater responsibility and autonomy regarding health matters and the Local Health Units and Hospitals were transformed into Agencies; the second reform in the late nineties (Legislative Decree no. 112/1998 and no. 229/1999) was focused on the decentralization of health governance from the Central Government to the Regions, including the control of healthcare expenditure, and the modification of the NHS (SSN) structure and organization.

The Italian NHS is governed both at a national and a regional level. At national level, through the Central Government and the Ministry of Health, for matters regarding the fundamental health principles, set down in laws and guidelines, and the determination of the essential levels of health care, first established in 2001, which are the services that the NHS is expected to deliver to all citizens, free of charge at the point of access or upon payment of a co-pay fee (ticket) and for which the Ministry of Health is guarantor at national level. At a regional level, through the 19 Regions and the 2 autonomous provinces, as the general legislative and administrative authorities, for the establishment and organization of health structures and services. The Regions are also directly responsible for the local healthcare offer which should be specific also to territorial requirements. The Conference State-Regions unites the national and regional authorities to ensure equal rights in healthcare for all citizens.

The National Health Plan, prepared by the Ministry of Health, the Regions, the syndicates and other stakeholders, identifies the guidelines for the Italian health policy which must be approved by the Conference State-Regions.

1.1.1 Short history of the National health care system

With the law No. 259 of 1958, the 2nd Fanfani government established for the first time in Italy the Department of Health separating it from the Home Office. The first owner of the ministry had been Vincenzo Monaldi.

With the law No. 132 of 1968, the so-called Legge Mariotti, the hospitals that until then, and in most cases, depended on the assistance and charity authorities, undergone a sea change and went recognised as hospital authorities. This led to the achievement of the rights to health protection under the article 32 in the Constitution and to the clearing of the historical concept of the assistance and charity authorities.

In 1970, regions with ordinary status and political local authorities were established. In accordance with the constitution they are owners of the proficiencies about health assistance. In 1974 the government assigns to the regions the competence in the matter of Health Assistance. Regions try to play a role in planning.

In 1977 a first step was made with the liquidation of the local authorities of the National Health Service as administrators of the health activities, but the Health Service total reform is headed to accomplish only after 1978 with the establishment of the SSN.

With the law of the No. 833 of 1978 called “Legge di riforma sanitaria” (Health care reform law), the National Health Service is established to safeguard physical and mental health of the people as a fundamental right of the individual and as a collective interest (article 1)

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The right to health sprang from being a worker rather than being a citizen: before 1978 in fact the Health Service was based on several local authorities for workers (Casse mutue), which were more or less riches depending on the citizens, among whom several differences and inequalities existed.

1992 and 1993 reforms are focused on:

- corporatisation principle: establishment of “local health enterprises” (USL enterprises and Hospital enterprises) which have legal status and organizational, administrative, financial, accounting and technical autonomy. USL changed over from an operative structure of the municipality (L.833) to an Enterprise with acknowledgement of legal status. The choice is to set up a public self-governing subject overburdened for the nature of its corporate and for the objectives based on logics of efficiency, effectiveness, productivity, quality of the production processes. It is stated that in spite of the autonomous structure of the Enterprise, the right-duty of the representative bodies to express the socio-medical need of the local communities remain unchanged. The mayor or the assembly of the mayors: it is confirmed the need of a role in the local autonomy towards USL in order to assure a specific level of local planning and to check the general progress of the USL activity, communicating the assessment and the proposals to the chief executive and to the Region.
- the reduction of the Usl numer from 600 to 200;
- the separation of responsabilities between the suppliers and “procurers” (i.e. USL). A sort of competition is this way introduced within the management of the services, as those can be given from the public organisms (AUSL or Hospital enterprise) as well as private organisms, private nursing homes etc…
- the funding coming from the payment for the supplied performances, on the basis of the fares established from individual regions, the cost of those same performances considered (once the payment took place with the so-called “out-of-pocket expenses” method, that is all that had been spent was paid back);
- citizens’ free choice: the citizen can choose the place for its health treatment as in any case the performance is paid following a national plan of charges specified from the Ministry and completed by the regions.
- the introduction of the Healthcare Business Manager and the Administrative Manager figures, directly named from the General Manager:
- the introduction of an accreditation system with an opening in the health market, theoretical at least, to the free competition between public and private structures;
- the systematic use of a check and review method for the quality and quantity of the performances; the introduction of efficiency and quality indicators.

The programme for the territorial activities forecasts the localization of the services; it establishes the resources for the socio-medical integration and the amounts to be paid by ASL and municipality. As regard the socio-medical activities the programme is approved by the general manager with the mayor's committee of the district. The mayor’s committee passes a judgement on the remaining subjects and contributes to the check and the achievements of the health outcomes of the Programme. Maybe this latter is the sole circumstance where it is possible for the municipalities to affect the healthcare choices adopted by the ASL, playing on the need of the arrangement that let suppose something more than a simple judgement. The article 3 quater D. Lgs. 502/92, introduced with the D. Lgs. 19.6.1999 introduces the District in the ASL territorial articulation and involves that the organization and the working of the district mayor’s committee are regulated by the Region. The D. Lgs. 229/99: the third healthcare reform. The first observation coming from the reading of the Decree is the offbeat net line with respect to the previous law. The general principles of the third healthcare reform are:

- the confirm of the importance of SSN as a tool through which the organization carries out the constitutional task of health safeguard. Principles and objectives of the former healthcare reform are thus reasserted and pursued.
- the completion of the corporatisation and regionalization system and the healthcare structures;
- the strengthening of the municipalities’ role
- the purpose to quickly reach the exclusive working relationship for the doctors.

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- the reduction of the retirement age.

1.1.2 SSN healthcare and social professions

It's up to the Government to identify both professional figures with the respective profiles and didactic organization and the establishment of new registers.

The Italian government recognize healthcare professions and, by virtue of a qualifying title, carry out prevention, diagnosis, care and rehabilitation activities.

The field of activity and responsibility of the healthcare professions is established by the contents of the Ministerial Decrees establishing their professional profiles and of the Educational Systems of their Degree Courses and postgraduate training courses, as well as by the specific codes of conduct.

In the field of nursing, midwifery, rehabilitative, technical and healthcare professions and of prevention, regions have jurisdiction concerning the identification and formation of the profiles of public health operators that cannot be traced back to the healthcare professions abovementioned; however, the identification of new healthcare professions to be included in one of the areas referred to in Articles 1, 2, 3 and 4 of the Law of August 10, 2000, no. 251 (nursing, midwifery, rehabilitative, technical and healthcare professions and prevention), the exercise of which must be recognized throughout the national territory, takes place during the transposition of EU directives, that is on the initiative of the State or of the Regions, in consideration of the requirements related to the healthcare objectives provided for in the National Home Health Plan or in the Regional Health Plans, which do not find correspondence in already recognized professions. The definition of the functions characterizing the new professions takes place by avoiding procedures and overlaps with the professions already recognized or specializations of the same.

The Ministry of Health is involved in programming both qualitative and quantitative needs of the National Healthcare Service for medical personnel with diploma and specialised degrees and in training programs in the field of general medicine. The goal of the Ministry and the Regions is to achieve correct estimates according to the needs of health care facilities and according to an actual correspondence of graduates in the world of work, also with particular regard to those professions for which there is a great need. […] In this field, it is important to highlight the opportunity, on the one hand, to rationalize the powers of the existing professions (which sometimes overlap, giving rise to gray areas between one profession and the other), and, on the other hand, to find new healthcare professions, which the system needs (by way of example, it is worth mentioning Opticians, Dental Technicians, that currently are assistants of healthcare professions, as well as other operators such as Chiropractors).

Associations and Colleges

Some healthcare professions are gathered in Associations and Colleges, based in each province of the national territory. Together with the professions already constituted in Associations (doctors-surgeons and dentists, medical doctors-veterinary surgeons, pharmacists) and Colleges (midwives, TSRM radiographers, professional nurses, healthcare assistants and IPASVI childcare supervisors), the most recent provisions in the field of healthcare professions provide for the transformation into Associations of the professional Colleges that already exist, as well as for the creation of Associations for those professions that currently do not belong to any Association. Currently, the 22 recognized health professions are carried out by approximately 500,000 professionals working in the nursing, midwifery, rehabilitative, technical and health-care fields and in the area of prevention. Within the meaning of the Law of August 4, 2006, no. 248, the new rules on advertising is now entrusted to the Associations, which must ensure compliance with the rules regarding professional correctness so that advertising is done according to the criteria of transparency and truthfulness of professional qualifications and of absence of any ambiguity, to protect the interests of the users.

Hereinafter, you will find the profiles of healthcare professionals involved in healthcare promotion and continuity of care.

Hygiene and Preventive Medicine (or Public Health) Practitioner

Hygiene and Preventive Medicine Postgraduate Training lasts four or five years. There is a limited number of places for each Course. Graduates with a four-year degree in Medicine and Surgery are allowed to participate in the Competition for admission to this Training Course. Its main purpose is to train doctors to promote community and individual health; to monitor and prevent the risks to human health in the environmental, behavioural and engineering fields; to work on the Planning, Management and Evaluation of Healthcare Services.

Physician Responsible for Home Care

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He is responsible for home care. He coordinates the medical, nursing and welfare personnel in charge in his service. To carry out his activities, he uses methods that can be traced back to case management since he involves many resources of other services and organizations from a functional point of view.

General Practitioners and Family Paediatricians

They represent the first contact the person, the family and the community have with the health care system and therefore they represent an important reference point for the choices relating to healthcare services, education to healthy lifestyles and adoption of appropriate behaviours in case of illness and rehabilitation. They offer a valuable contribution to the health promotion strategy.

The nurse

The nurse is the caregiver who, in possession of the qualifying university diploma and member of the relevant professional register, is responsible for general care nursing. The preventive, curative, palliative and rehabilitative nursing care is technical, relational, and educational. Its main functions are the prevention of diseases, the assistance of sick and disabled people of all ages and healthcare education. The university diploma in nursing enables the graduate to exercise the profession, after registration to the relevant professional body.

Among the areas of postgraduate nursing training for specialist practice, which is intended to provide general care nurses with advanced clinical knowledge and skills to enable them to carry out specific nursing performance, there is the public health sector (public health nurse).

IPASVI is the College in charge of the national representation of nurses in Italy. To carry out his activity, a nurse has to be a member of the College. The National Federation coordinates the Provincial Colleges, whose task, among other institutional tasks, is that of keeping record of the professional registers. After the establishment of the degree in nursing, the College is being transformed into a professional Association, just to crown the evolution of the role of the nurse as an independent healthcare professional.

With the transformation of the Colleges into Associations, already provided by the law 43/2006, the abbreviation of IPASVI, that is now outdated and obsolete, will certainly disappear, because already today it refers to three categories which have been transformed; indeed, IP (“professional nurse”) has been replaced by the term “nurse”; AS is the acronym for “healthcare assistant”, a professional bound to be merged in the Association of technical professions in the field of prevention; finally, VI indicates a professional that no longer exists, that of the “childcare supervisor”, who was replaced in 1997 by the “paediatric nurse”.

The Psychologist

The profession of the psychologist is recognized by the State through the Law no. 56 of 1989. The Article 1 of the Law contains the following definition of the profession of the psychologist: "The profession of the psychologist includes the use of cognitive and intervention tools for prevention, diagnosis, enabling, rehabilitation and support activities in the psychological field targeted at people, groups, social agencies and communities. To practise psychology, it is necessary to have pursued professional licence by taking State exams and be a member of the appropriate professional body. The practice of psychotherapeutic activities is subordinated to a specific vocational training, to be acquired, after graduating in psychology or in medicine and surgery, through specialisation courses of at least four years providing adequate education and training in psychotherapy”. The law, then, recognizes the profession and regulates the activities that can be carried out, without anticipating areas of specific intervention, both in the healthcare and social care fields. With the DL 248/07, also called "Milleproroghe", psychology becomes a healthcare profession. In fact, the Article 24- sexies provides that the National Association of Psychologists is supervised by the Ministry of Health, while, before, it was under the supervision of the Ministry of Justice.

Social professions

The Formez report of 2009 on "The work in the social service sector and in social professions", commissioned by the Ministry of Labour, Health and Social Policies, makes it clear that, in the absence of a regulatory framework at national level regarding social professions, the regional welfare systems have felt the need to qualify services and social interventions ensuring operating, functional and professional standards capable of guaranteeing uniform levels of performance.

In the field of professional training, competition between state and regional sources is mandatory with the Regions being entrusted with the task of programming and adjusting the principles dictated by the State to the territory.

Hereinafter, we are going to describe those professions that are recognized at the national level: educator, social worker and social health operator.

Even if it is not dealt with, we emphasize the emergence of new social professions in some regions, such as the network agent, the mediator, the entertainer, the coordinator in the field.

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The professional educator

The professional educator operates in cultural and local services, in agencies for voluntary work, in contexts of social marginalization, multiculturalism and/or multiethnic society, with the objective of promoting and protecting people and diversity through targeted and effective initiatives for the formation of personality, as well as for the prevention and/or the reduction of the discomfort and disadvantage, for the care of people in protected psychiatric areas. The scope of his professional practice is represented by public and private structures having the function of educational and social activities, such as: social and educational centres and structures, social services, protected psychiatric clinics and community homes, senior centres, centres for immigrants, communities for people in conditions of social and cultural hardships, prison systems, but also streets, districts, cities, museums, libraries, video stores, etc. We define as "Professional Educators" those who have a bachelor's degree in Educational Sciences at the Faculty of Education or at the University Course on Professional Educator provided by MD 520/98, or those who have a bachelor's degree for professional educators (Faculty of Medicine and Surgery) provided by the Interministerial Decree of April 2, 2001, or any other qualification thereto equivalent or equivalent within the meaning of the Law 42/99, or within the meaning of the Healthcare MD 29 /03/1984, or by other regional or provincial regulations.

According to the Healthcare Ministerial Decree of October 8, 1998, no. 520 "[…] the professional educator is the health and social care worker who, in the possession of the qualifying university diploma, implements specific educational and rehabilitative projects, in the context of a therapeutic project developed by a multidisciplinary team, aimed at a balanced development of one's personality with educational/relational objectives in a context of participation in and return to everyday life; he also takes care of the positive psycho-social integration or reintegration of people with difficulties.

The professional educator:

a. programmes, manages, and verifies educational interventions targeted at the recovery and development of potential in people with difficulties to achieve increasingly advanced levels of autonomy;

b. contributes to promote and organize social and healthcare structures and resources, in order to achieve the integrated educational project;

c. programmes, organizes, manages, and verifies his own professional activities within health and social care services and social-healthcare-rehabilitative and socio-educational facilities, in a coordinated and integrated way with other professional figures present in those facilities, with the direct involvement of stakeholders and/or their families, of groups and of the general public;

d. operates on families and the social context of his patients, in order to promote their reintegration in the community;

e. participates in study, research and documentation activities targeted at the purposes listed above.

The professional educator contributes to the training of students and support staff, contributes directly to the updating of his professional profile and to health education. The professional educator performs his professional activity, within the scope of his competencies, in facilities and social healthcare and socio-educational services, both public and private, in the territory, in residential and semi residential facilities as part of the staff or as a free professional […]".

The social worker

The profile of the social worker obtained a formal legal recognition already in 1987, the year in which the Presidential Decree of January 15, 1987, no.14 attributed qualifying value to the diploma in social worker issued by schools for social workers. At the level of national legislation, the profile has been the object of several other acts that have regulated his training paths, his powers, his functions and area of expertise in an organic and defined manner. Among the most prominent ones, it is woth mentioning L. no. 84/1993 establishing the association and the professional register of social workers and the Presidential Decree 328/2001 amending and integrating the discipline of the system and of the professional register following the setting up of the degree course in Social Services and postgraduate degree in Planning and Management of Social Policies and Services (Class 57/S).

"Acting in accordance with the principles, the knowledge and the specific methods of the profession, the social worker carries out his activities within the scope of the organized system of the resources made available by the community, in favour of individuals, groups and families, to prevent and resolve emergency situations, by helping users in the personal and social use of such resources, by organizing and promoting performance and services in order to make them more responsive to emergency situations and to the need for autonomy and responsibility of people and by enhancing community resources with this aim."

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The health and social care worker

The professional figure of the health and social care worker (OSS) was recognized and regulated in 2001 at national level through an Agreement between State, Autonomous Regions and Provinces. The Agreement of February 22, 2001 establishes the profile of the Health and Social Care Worker (OSS) defining competencies and area of expertise and regulating the educational system of training courses. From the professional point of view, the understandings reached in the Conference between State, Autonomous Regions and Provinces relating to the identification of this professional figure allow the realization of the health and social care integration which has been made necessary by the impossibility of separating care interventions from interventions regarding prevention, rehabilitation and social recovery of the person.

1.2 Italian National Home Health System.

1.2.1 Health and social care integration (extract from the White Paper on the National Home Health Service)

Health and social care integration is regulated as a method of coordination of social performance, regarded as all the activities which are aimed to meet, through integrated care paths, the health needs of people requiring both healthcare and actions of social protection that can ensure healthcare and rehabilitation support even in the long term.

In the context of health and social care activities, it is worth mentioning: a) healthcare activities of social significance, i.e. those activities aimed at the promotion of health, prevention, detection, removal and containment of degenerative or invalidating outcomes of congenital and acquired pathologies; b) social activities of health care significance, i.e. all the activities carried out by the social system that have the aim of supporting people in need, with problems of disability or social exclusion that affect their health; c) health and social care activities implying high healthcare integration, characterized by particular therapeutic importance and presence of the healthcare components that relate mainly to the areas of mother and child, the elderly, disabilities, psychiatric disorders and drug addiction, alcohol and drugs, pathologies due to HIV infections and diseases in a terminal phase, incapacity or disability resulting from chronic-degenerative conditions.

Such a partition tries to shed light on one of the central points of the discipline in the field of nursing, the one of competence in the management field, at the planning level and with reference to the financial burden, since such functions are of common interests for both the Regional Healthcare Service, as for those aspects directly linked to healthcare, and Municipalities, as for the profiles that are more closely related to social assistance.

Each category, indeed, is attributed to a specific institutional level: the first and the third ones are managed by Local Health Authorities and included in the essential levels of health care according to the procedures identified by the relevant laws and by national and regional plans, as well as by the national and regional target-projects, while the performance relating to the second category is under the responsibility of the Municipalities that shall ensure their funding in the areas covered by regional law.

The identification of activities to be traced back to the three above-mentioned categories depending on the kind of need, the complexity and intensity of the healthcare intervention and the period of time it lasts, as well as the clarification of the criteria for their funding, as for what is up to Local Health Authorities and Municipalities, with clear and timely allocation of the related responsibilities to the former or the latter, took place through the enactment of the D.P.C.M. 14/02/2001, a framework law in this regard.

Furthermore, in this law it is stated that health and social care assistance is given to people who are in health need and require healthcare and social protection, also in the long period, on the basis of custom projects drawn up according to multidimensional evaluations and basic standards in the planning and organization of activities are provided for.

However, as a result of the reform of Title V of the Constitution, as we have seen above, the function of framework law is no longer compatible with the new constitutional framework and the state framework laws, that were issued prior to the entry into force of the constitutional reform of 2001, as the above mentioned D.P.C.M, like the principle of continuity, exert their effectiveness until the individual Regions have not exercised their competencies on the point.

As a result of the entry into force of the new Title V of the Constitution, a further issue to deal with relates to the topic of the connection of each activity to the concurrent field of "health protection", i.e. the field of "social assistance", since, as the latter falls within the residual competence of the Regions, it allows differentiated disciplines on a regional basis without being submitted to the filter of "fundamental principles". In any case, whatever the reconstructive solution in the field of social activities is, the State preserves the exclusive legislative competence having as its subject the determination of the essential levels of performance concerning the civil and

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social rights that must be guaranteed all over the national territory, which has to be regarded as a competence cutting across all the others and therefore able to derogate from the regional legislative power.

In the face of the traditional predominance of the attractive power of healthcare competence with respect to the social one, the legislative decree 229/99 and the framework law establishing the integrated system of social services have introduced provisions to clarify the areas of the different activities and related skills, in an attempt to overcome the fragmented nature of the welfare path within the healthcare and social system.

The task of ensuring healthcare and social integration is attributed to the District, an organizational branch of the Local Health Unit, through the organization and delivery of primary care services related to healthcare and social activities, as well as through the provision of healthcare services of a social relevance, characterized by specific and high integration, and of the social activities of healthcare significance in such cases in which they are delegated by Municipalities.

Among the numerous unfailing activities of the District listed by law, the following ones appear to integrate the typology of health and social care performance: activities or services for the prevention and cure of drug addiction; activities or services for disabled and elderly people; activities or services of integrated homecare assistance (essential instrument to achieve continuity between hospital and territory); personal services linked to the department of mental health and the department of prevention.

The Regions are entrusted with the concrete discipline of the criteria and the procedures by which Municipalities and healthcare organizations ensure the integration, on the basis of districts, of the health and social care activities under their competence, by identifying the tools and instruments to ensure the integrated management of care processes in the healthcare and social fields.

Among the different ways to promote health and social care integration, there are both the coincidence of the best community areas, from the social point of view, with the sanitary districts and the integrated planning, promoted through different instruments: the agreement on social and healthcare activities of the Community Activities Program (PAT) that determines the resources for health and social care integration, as well as the location of the facilities in the territory of competence; the participation of the Conference of Mayors in checking the attainment of the objectives in the health sector; the program agreements between Local Health Units/Municipalities and/or the agreements that incorporate the health contents of the PAT and the Zoning Map.

In particular, the Law 328/2000 has set itself the problem of the connection between health district and social area, imposing, as for the organizational part, the creation of appropriate fora, through the coordination or coincidence of the two community branches, so as to facilitate a real health and social care integration; as for the planning part, the coordination between zonal and district planning, since the Municipalities with regard to the health district shall provide the Zoning Map in accordance with the Local Health Unit.

Among the recurring contents of health and social care planning, there is the provision for health and social care integrated paths able to ensure continuity of care within the framework of a capillary network of services characterized by the health-care "management" of the patient.

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2. Main National Trends

In the last decade the ratio between need/demand for health care and the provision for services has changed in a relevant way, because of a variety of factors, such as: the progressive aging of population (about 20% of Italy's population is more than 65 years old); change in the structure of families; increase in chronic-degenerative conditions; strengthening of medicine and technology.

Forecasts show an increase in life expectancy which results in the problem of the quality of the life years people have gained. The level of disability is settling and starting to affect classes made up of older people, but the issue of Not Self-sufficiency arises as a real emergency for the future.

The provision of health and social care services has changed, with major decrease in hospital beds and, at the same time, a slow and uneven growth in the development of local services, where there is still much uncertainty about references.

Reference models have entered into a period of crisis (crisis in the hospital sector: the treatment of the disease is no longer the only indicator of medical intervention; crisis in the social model: the treatment of the disease is an integral part of the "ability to live" for the person in need, it involves the affective dimension as well as the social relation), with the need to redefine the priorities of the National Home Health Service.

2.1 Features of the Not Self-sufficiency system and the development of home care

The features of an equitable, effective and efficient system for Not Self-sufficiency are listed below:

- it is a system that recognizes the patient and his family as the main resource and promotes subjectivity
- it is a unitary system characterized by a strong health and social care integration, so as to make indistinguishable for the user the different types of interventions (health or social interventions), capable of combining multi axial and multi sectional interventions, far beyond those interventions certainly linked to health, health care, social care, including, for example, those regarding house and transport sectors;
- it is a system that invests very much in terms of accessibility and acts intensively to guarantee a low access threshold and a warm and friendly welcome;
- it is a system endowed with a strong capacity to orientate and help those in need, with technical mediation in the assessment of need, and it is capable of monitoring the quality and outcomes of interventions;
- it is a heavily shared system, with a considerable presence of informal networks, primarily centred on the family, on voluntary work, on the third sector. Above all, this system is very attentive to recognize, prevent and combat isolation and loneliness of people and families who live and deal with highly complex problems.

The third sector will be involved in a more reasonable way. Instead of being improperly called on to fill the gap left by public welfare, in the first place it should be considered as a stimulus for innovation and flexibility of services, horizontal subsidiarity and solidarity, and even more as a driving force for diffusion of the principle of reciprocity (which postulates proportionality, while the principle of exchange postulates equivalence).

If the purpose of a system of protection of people with a strong disadvantage, as in the Not Self-sufficiency case, is "not to leave or mortify anybody", we must ask ourselves not only the question of how much of the need/demand must be covered by public intervention (ultimately, it will be covered only partially anyway), but also how and to what extent the institutions of the welfare state (both in the healthcare and social field) can really be reliable actors of diffusion and reinforcement of this principle of reciprocity, which binds to the development of the local community, to solidarity and horizontal subsidiarity in its correct interpretation.

The central point i still that of understanding if and how the public system will be able not only to encourage the growth of the economic and financial capital, but also of the social one. Even if this objective (the increase of economic capital) is sensible and shareable, it is inherently limited, if we consider the long term (for progression of the demand) and if we evaluate its viability (e.g., the recovery through higher tax burden appears unlikely) or its timeliness (the increase in the managerial efficiency of delivery organizations is difficult to achieve).

There is need for additional resources, which, first of all, should arise from their own reconversion (e.g., from hospital or residential resources toward domiciliary resources), but we cannot avoid the central topic: how to bridge the gap between a demand that appears to be growing relentlessly, both in its quantitative and qualitative aspects, with respect to resources - public but often also private resources - that are not going to increase accordingly, even in the long term.

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We do not glimpse a different solution from that of the conscious and coherent involvement of the community as a whole, with the assumption of responsibilities as citizens, with a stronger cooperation between public and private sectors and local community.

In this case, healthcare authorities and social services constitute the fundamental pillars of the public system; with its high degree of integration, the health and social care district seems to be able to represent the institutional agent that is more likely to carry out the integration process.

In the context of long-term treatment, with greater determination, the public system must set itself the objective of:

- increasing its efficiency
- refining the technical mediation of the assessment of needs, a practice which is expensive but essential for the customization of interventions
- overcoming the performance logic in services and reinforcing the culture and practice of an integrated “management” of the patient
- integrating with the other areas of Sociality to "act as a system", thus achieving intersectional interventions
- creating organizations "free" from red tape and overspecialization, spreading skills and knowledge till the lowest levels of the organizations, focusing on the recovery of security and confidence of citizens and operators, thus making both more conscious of the importance of their decisions. Citizens/users who are more informed, competent, used to a more mature demand, able to use services in a more appropriate manner can contribute greatly to bridge the gap between supply and demand and to create complex organizations that will be able to really "give more to those who have less".

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3. National Bodies in charge of the home health service

Taking as a reference what has already been made by the different regions, the local welfare network may use the following instruments:

- activation of beds at local level managed by GPs and by nursing staff;
- management of the acute phase at home through an integrated homecare assistance provided by multidisciplinary teams that can offer immediate consultation, arrange the structured “management” of the patient on the basis of an individual therapeutic plan and supplement the services offered on the territory;
- availability of beds in intermediate facilities in hospitals whose coordination is in the hands of nursing teams, with the doctor performing functions of advice in the face of specific needs for assistance and monitoring;
- programs of assisted or scheduled discharge from hospital upon identification of the path to follow after the discharge;
- programs of protected discharge of the patient who is still weak from hospital upon identification of the way to carry out the “management” of the patient;
- health hotel, a service completely managed by nurses within appropriate outpatient units at low-welfare intensity, aimed at patients discharged from hospital and at patients who are waiting for a scheduled hospital stay
- programs of home hospitalisation;
- intermediate facilities for rehabilitation after an acute phase;
- community centres/specialty clinics in which there are medical specialists, GPs and nurses;
- community nursing teams that go to houses of patients who are often chronic, terminally ill or in need for rehabilitation by offering different healthcare services.

With regard to home care, such a welfare level is ensured by the DPCM 29.11.2001 "Essential Levels of Welfare", which introduces home care performed by GPs and by Paediatricians in the district level, with the support of nursing and rehabilitative services and of the nursing aid (home care service) to be performed in an integrated manner with Municipalities by sharing even social costs (50%) with them. Home-care service has developed into integrated homecare assistance (ADI). In almost all the Regions in Italy, home care services are considered part of primary care and the elective community field in which they are located is the District, which represents also the best place to carry out integrated activities in the social field because of its community dimension.

In complex cases, in order to prepare a plan of individualized assistance we start with the “Multidimensional Assessment”, the identification of a case manager who is the manager/supervisor of the project of assistance and we complete the process by checking the results, to evaluate the program of assistance adopted under the profile of quality and appropriateness.

Home care has undergone a process of progressive articulation and structuring to meet the increasing complexity of the needs and pathologies of the recipients: from chronic diseases, to complex disabilities (ALS, etc.), to oncological and terminal pathologies.

Current technologies and devices applied to home care service help people, even those who have severe disabilities and/or are not self-sufficient, deal with a process of gradual change in their quality of life through "Home" care systems.

In this perspective, particularly in case of chronic diseases, home care appears to be an alternative to inappropriate hospital admissions and a better form of care because of the benefits it implies in terms of the patient’s quality of life, to which we must add the economic benefits as well with respect to other forms of admission different from hospitalization.

On the level of clinical governance, a correct setting of home care satisfies the following conditions:

- “management” of the patient based on eligibility criteria for patients to be cared of;
- continuity of care with the coordinated management of the care plans of the different services included in primary, specialist and hospital care (scheduled discharge, nursing care, rehabilitative care, pharmaceutical benefits and appropriate prosthetic);

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- management integrated with home care services offered by local authorities;
- professional collaboration between different professional figures;
- evaluation of interventions carried out and relative expenditure.

It is also essential to provide the proper functioning of the information system for home care, for the management of patients and a systematic analysis of the intensity and complexity of the interventions delivered, as well as to check activities, results and costs.

The GP and other possible medical specialists on the basis of the patient's characteristics, the professional nurse, the rehabilitation therapist and the social services staff, including the one dedicated to family home care, are the components of the multidisciplinary team performing home care.

Despite the varied regional realities, as for home care, we can draw some profiles ranging from forms of home care of a performance type to more complicated levels characterized by different forms of care such as:

- pperformance home care consisting of health care benefits which are occasional or scheduled and are carried out under the guidance of the GP;
- integrated home care, with multiple levels of complexity depending on the different pathological conditions to which they must respond. They are characterized by a multi-professional "management" of the patient and by the formulation of an "Individual Care Plan", drawn up on the basis of an overall assessment of the person;
- palliative home care for both terminally ill cancer patients and patients who do not have cancer, they are also characterized by a multi-professional "management" of the patient and by the formulation of an "Individual Care Plan", but the service offered is more intensive as it is linked to highly complex needs, the care team is provided with specific skills.

In addition to community beds managed by the GP and the nursing staff, the integrated network between community and hospital, consisting of a multiple services and facilities aimed at ensuring continuity of care, includes various types of residential facilities aimed at responding to different healthcare needs according to a gradient of differentiated care intensity. In the context of these structures for not self-sufficient patients, we can distinguish:

- specialised teams (Intensive Residential Care Units) for the "management" of not self-sufficient patients who require intensive treatments, including conditions of minimal responsiveness and serious neurological disorders, characterized by complexity, clinical instability and/or serious disability, who require support to vital functions and continuity of care with ready medical availability and presence of nurses;
- specialised teams (Extensive Residential Care Units) for the "management" of not self-sufficient patients in great need for health care: daily medical and nursing care, treatments of functional recovery, administration of therapies intravenously, enteral nutrition, serious bedsores etc.;
- specialised teams (Alzheimer Disease Teams) for the "management" of patients with senile dementia in the phases in which the mnestic disorder is associated with disorders regarding the behavioural and/or the emotional spheres that require extensive rehabilitative treatments, reorientation and personal protection in a "prosthetic" environment, with residential or semi residential services;
- Residential Care Unit for Maintenance: they provide long-term healthcare and maintenance services, as well as rehabilitative services with residential or semi residential services.

As a rule, the residential services from these facilities are defined as healthcare in the long term for not self-sufficient patients in chronic conditions and/or in relative steady clinical conditions, thus distinguishing itself from the provision of "therapy after the most acute phases" carried out in hospital arrangements, as a general rule. These services require periodic assessments to check how the kind of need changes in time, but also to see if the conditions of home care can be restored, in particular for residential services after hospitalization, for scheduled periods and in the context of hospital discharge programs.

The services provided by these structures are highly characterized and conditioned by the general organization and resources put into the field by the supplying structure and are linked to:

- the technical, organizational and professional characteristics of the "team" (or more generally of the residential structure within which it is located), characteristics that define the activity carried out;

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- the patient's characteristics, in order to identify the "case which is being dealt with" through the identification data of the user of the service and some indicators of the need for care that allow to define how appropriate the treatment delivered is.

In the field of the disability, we can identify structures that differ depending on the kind of service delivery:

- structures/teams that provide diagnostic, therapeutic, rehabilitative and socio-rehabilitative services in residential structures for people with disabilities who need intensive or extensive rehabilitation, as well as treatments for the maintenance of people with problems that require highly intensive care, including minimally responsive patients;
- structures/ teams that provide diagnostic, therapeutic, rehabilitative and socio-rehabilitative services in residential structures for children suffering from behavioural disorders or diseases related to neuropsychiatry;
- structures/teams that provide therapeutic, rehabilitative and socio-rehabilitative services for the maintenance of patients' standards, in residential structures together with particular care for severely disabled patients;
- structures/teams that provide therapeutic, rehabilitative and socio-rehabilitative services for the maintenance of patients' standards, in residential structures together with particular care for disabled patients without family support.

The allocation of community beds also includes residential psychiatric facilities referred to in mental health hospitals and hospices.

At the territorial level, a peculiar role is played by about the eighteen thousand pharmacies that are present in Italy, both public and private ones, which will help to increase the size and the complete accessibility of possible health reference points, also to support the activities of monitoring of physiological parameters or ongoing therapies, with the final aim of integrating hospital and community structures. In fact, the reform on pharmacies introduced with the Legislative Decree 153/09 will be an important step in the reform of the health service, by deeply influencing its functioning in general, once the enforcing ministerial decrees are made.

The decrees on the point of being issued concern, indeed, the possibility of reserving health services and collecting reports, the possibility of carrying out analytical and instrumental activities aimed at self-control, the possibility of taking advantage of physiotherapy and nursing activities, the support for home care through the provision of social-health operators, also to improve the overall accessibility of health services currently provided by the Health Service, which people in need may particularly benefit from.

The legislature also provides that, until Regions have adopted specific rules, the proper implementation of decrees will be subjected to evaluation and monitoring by Local Health Authorities, in the context of the parameters that will be determined by regional conventions, which will be defined subsequently, and the corresponding reductions in the services that are currently provided in other structures.

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4. National policies implemented to promote and improve home health service.

4.1 Continuity of care and integration between hospital and community (extract from the National Health Plan)

One of the main objectives of the NHS is to ensure continuity of care:

- between the different intra- and extra-hospital professionals, so that the fragmentation originated in the development of overspecialized skills integrates in a single framework (team work, development and implementation of shared therapeutic pathways, etc.);
- between the different levels of assistance, especially in the delicate boundary between hospital and community, the period after discharge that the patient is sometimes still forced to deal with alone, outside a known and shared path;
- of therapeutic treatment when necessary.
- The welfare model oriented to the continuity of care provides for the design of suitable paths and a "management" of the patient performed in a continuous way by a team characterized by social and health skills, as well as the monitoring of the phases of transition between the various welfare structures by means of appropriate tools for the assessment of appropriateness, taking into account what is made available through the Health Card System.

An organizational method aimed at facilitating a unified access to health, public health and social services is the "Single Point of Access" (PUA), which operates through the collection of signalling, orientation and management of the demand, activation of services for simple needs, as well as start-up of the multidimensional assessment for complex needs, thus improving collaboration and coordination between the different public and not public, health care and social components, engaged in the clinical path, in order to ensure its unitariness.

Patients who are most in need of continuity of care are:

- patients who were acute cases and were discharged from hospital and run high risks of returning to hospital, if they are not properly assisted. They need clinical and nursing skills under the supervision of a case manager, in a dedicated structure or at home;
- chronic patients, stabilized in the territory, who are in great need for care and run the risk of inappropriate hospitalization, if they are not properly nursed. The clinical path requires a strong integration between multidisciplinary health care teams (doctor, nurse and social worker), with the place of care being the patient's home or a protected structure;
- chronic patients overall in good health who have as their objective the monitoring of their health, reside at home and have the characteristics necessary to be educated to self-diagnosing and self-empowerment (diabetes, asthma).
- For the patients who are discharged from hospital and are being treated in the local area, the continuity of care must be guaranteed, already during the hospital stay, through an activity of multidimensional assessment that takes into consideration both the clinical conditions and the healthcare and social situation of the patient to define the care path that is more suitable and compatible with the existing network of social and district services, in agreement with the GP and during the hospital stay.

Also in the integrated management of chronicity, the GP is the primary reference point and responsible for the "management" and the diagnostic therapeutic path that is more appropriate for the patient. The management of chronicity can require a local organization including the possibility to have community beds/residential services managed by the GP and the nursing staff, within proper structures of intermediate care, and at the same time dedicated paths for hospitalization.

Management of chronicity and continuity of care rely heavily on the contribution of innovative technologies, including telemedicine, remote support, and, more generally, information and communication technologies (ICT) in particular to ensure the realization of an operative network method, which integrates the various institutional and non-institutional actors whose task is the "management" of chronic cases (LHAs, Hospitals, districts, primary care, health residences, municipalities, but also families, associations, profit and non-profit institutions; in other words, the rich social capital that characterizes many local realities in Italy).

During a three year period, the aim is to implement the assistance network by defining the main points and functional interrelations in a managerial and relational system among professionals, that, even though it is based

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on team work, can clearly identify responsibilities and procedures for the definition and making of the care path and the transition, if necessary, between different structures and areas of care. This complex system of integration/continuity must be characterized by the flexibility allowed by the mixture of heterogeneous services in relation to the level of integration between health care and social components of the professional skills involved, by easy access and by appropriate services to satisfy patients. The coordination and integration of all healthcare and social activities at local level are guaranteed by the District which is also responsible for researching, promoting and implementing appropriate synergies between all the systems of local offer and for serving as an instrument of coordination for the system of primary care (GP and other professionals operating within the National Health Service).

In addition, the District represents the interlocutor of Local Authorities and exercises this function in a coordinated way with corporate policies.

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5. Description of Training Courses for Professional Health Carers on the Issue.

5.1 Training for health promotion

In paragraph concerning Italy included in the Review of the literature referred to in Chapter 1, in relation to training for health promotion, it is written that "[…] In Italy, the first training course in health promotion was activated by the University of Perugia in 1990.

DoRS (the Regional Centre for Health Promotion Documentation) is an organization funded by Piemonte at regional level and was founded in 1998. […] It is involved in the training of professionals and policy makers in order to develop the skills and knowledge necessary for the practice of health promotion. They also provide assistance for the planning, implementation and evaluation of interventions, projects and policies for health.

In collaboration with DORS, the Department of Public Health at the University of Torino has worked on the students' skills by developing a Master's degree in health promotion, prevention, and food education (Piemonte Region, 2005) […].

In recent years, the courses of the faculty of medicine have undergone a reorganisation process throughout Italy to meet the current and future needs of the healthcare industry. Health promotion is considered as a key component within the new curriculum and this shows that there is growing awareness that the promotion of health is essential for the preparation and training of doctors.

Among the other courses offered in Italy, there is the Master's degree in design, coordination and evaluation of integrated interventions of health education and promotion at the University of Perugia. Other courses in health promotion are offered in Siena, Torino, Cagliari, Milano e Roma."

Starting from what is written in the paragraph above, we have tried to study what type of training in health promotion exists in Italy, who offers it and who it is aimed at.

In 1990, Modolo and Briziarelli wrote that health education in Italy had become part of University exclusively in the health sector and only recently. Several years ago, education was included into the Postgraduate School in Hygiene and Preventive Medicine of Perugia, but it was not until 1988 that it became an important part of the curriculum. Then, it was included in the curriculum of the Faculty of Medicine, as a discipline of the integrated course of Hygiene and Public Health. As regards other degree courses, until then there had been no positive approach, not even in teachers training. For the latter, the usual disciplinary training did not deal much with issues concerning infancy and adolescence and much less with issues relating to health. In the courses for professional nurses, whether academic or not, quite a large room was dedicated to health and health education.

Twenty years later, the situation does not seem to be changed very much; in fact, according to Briziarelli, despite general acknowledgment and acceptance of health promotion, little has been done to introduce it in the basic training of the operators who must put it into practice.

He emphasizes that, both at basic and specialized level, the areas of specific training remained very vague and, as what happened to prevention and healthcare education, the contents of the promotion of health practically have not entered the Faculty of Medicine. It has not only happened in Italy but everywhere in the world, with the exception of few realities in which they have made a breach, such as in some locations in Great Britain and Holland. Various attempts have been made in Italy in the disciplinary sector of MED/42 (general and applied hygiene) but, in any case, they have not been made in all locations. A glimmer was to be found in specialization courses for teachers, thanks to the introduction of health education, which, however, accounts only for a small part of health promotion.

As many other common paradoxes in Italy, the MED/42 sector has undergone an interesting development, as regards health promotion and health education, in Degree Courses for health professions, especially first-class Degree Courses (nursing and midwifery) and fourth-class Degree Courses (health care and prevention technicians) and, above all, this has been possible thanks to the hygienists who have had the opportunity of chairing the Boards of these Courses all over Italy.

Although to a lesser amount, the same phenomenon has characterized other Courses, such as pietistic discipline, professional education, speech therapy. In all Degree Courses for health professions, all humanistic disciplines (anthropology, psychology, pedagogy…) have also developed considerably. As for these disciplines, some attempts have been made also in Degree Courses in Medicine, including the Degree Course in Perugia that was among the first courses in Italy to deal with the discipline of Medical Anthropology. In specialization schools, these aspects have basically concerned only the School in Perugia. Health promotion and the disciplines associated with it have been taught and practised more intensely in some locations than in others. However, as Briziarelli

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concludes, we can now say that a very strong impulse has come from young teachers in different Universities which have learned from the experience in Perugia and are pursuing it.

As regards the training of psychologists, health promotion/community psychology is among the areas of teaching of the specialization school in health psychology, which has the purpose of training specialists to carry out the following interventions in organizations, communities, groups and people's houses:

- promotion and maintenance of health;
- prevention and treatment of illness;
- analysis and improvement of systems for the protection of health and the working-out of health policies;

using the competencies and techniques which characterize the profession of the psychologist.
According to a generally accepted definition, "Psychology of health corresponds to all the specific contributions - scientific, professional, and training ones – of psychological discipline to the promotion and maintenance of health, the prevention and treatment of illness, the identification of etiological and diagnostic correlates of health, disease and associated disorders, and to the analysis and improvement of the system of health care and working-out of health policies".

In Italy, there are 3 specialization schools in health psychology, in Torino, Roma and Bologna.

Within the framework of nursing, health promotion and health education are mostly linked to the nursing of family and community within the framework of public health nursing. In many documents, WHO urges member states to implement health care reforms aimed at prioritizing basic health care focused on family and community (community care), above all, with the final purpose of carrying out activities of self care, prevention, health promotion in the perspective of strengthening individual resources as well as community's resources (empowerment). In this context, in virtue of the nurse's specific profile and training, he is the professional responsible for the overall assistance because he can understand the needs of the community and assist the "management" of the patient better than other professional figures.

5.1.1 CSESi

The Experimental Centre for Health Education was founded in 1954 in Perugia, first as a voluntary body, under the aegis of the World Health Organization, then as a University Centre in 1963 and as an Inter-university Centre, with the University of Naples, in 1991. The Centre is an example of collaboration between disciplines and professionals who contribute to the development of the issues and methodologies of health education and health promotion. In order to develop the principles and methodologies of Health Education, the Centre has always drawn inspiration from the WHO principles, supporting the correctness of its policies, which are still considered to be very significant for Europe and for the world, despite contrary tendencies. It supports the defence of the Welfare European Model, particularly as regards the right of citizens to care and health promotion.

Over the years, the experts of the Centre have worked with many WHO working groups, starting with the groups for the renewal of the training of doctors and health care professionals, issues on which the Centre has organized conferences together with WHO since the sixties.

Other issues developed were "health promotion in the world of work", "documentation", "communication", "health education and promotion in schools", "participation in the drafting of a Thesaurus for the promotion of health", to help build a common language among the various European languages.

The Centre has collaborated with various European countries, especially since it hosted the European Office of the International Union for Health Promotion and Education (1986-1991), making up the first European Conference (in Madrid), the second one (in Warsaw) and the sixth one (in Perugia). The collaboration has also been extended to countries in Latin America, Ecuador, Nicaragua and Africa.

Over these years, CSES has performed a wide training activity directed to professionals in health service, local authorities, schools; this function has been empowered by the results of numerous research projects that have focused on the development of innovative training patterns as well as the design and evaluation of interventions in health promotion and health education. The upgrading initiatives on modern techniques of teaching/learning promoted by the Centre have also had impacts on educational and experimental innovations of the teaching of Hygiene and Public Health in university courses. Especially in past decades, the Centre was broadly considered a fundamental point of reference because of its cultural elaboration and methodological approaches and its commitment to training.

The Centre works on the doctorate in health education which is based at the Department of Medical Surgical Specialization and Public Health of the University of Perugia. It also carries out an editorial activity to maintain contacts with operators and to spread principles and methods. In particular, two magazines must be mentioned:

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"Health Education and Health Promotion" (already Health Education and Preventive Medicine, founded as Health Education in 1956) and "Human Health", founded in collaboration with the Institute of Social Medicine in 1972.

In Italy, the first training course in health promotion was activated by the University of Perugia in 1990 through the Experimental Centre for Health Education. As a structure that promotes, builds and supports research and training on issues related to the protection and promotion of health, since 1958 CSESi has organized a Summer Course (there have been up to 25 editions of the course); in 1979 it opened a One-year Course, which was subsequently transformed into the two-year "Master's degree in health education", articulated in the first year of "Graduate Course in Health Education " and in a second year consisting of "Workshops on Health Education"; if you attend at least 4 workshops and discuss a thesis, you will be awarded with a diploma of "Master in Health Education ". The courses organized by CSESi have been attended by many doctors and health workers.

Today, the Master of the University of Perugia lasts 1 year and has changed its name: "Master in Design, Coordination and Evaluation of integrated interventions in health promotion and health education". This Master offers a curriculum that fits in the reference frame established by the strategic articulation represented by the Ottawa Charter and that finds its closest expression in Healthy 21, the health objectives for the 21st century set by the World Health Organization. The strategy of Health Promotion, of which Health Education represents the central operational instrument, is a key element of health policies in Italy; it is demonstrated by all the latest national and regional health planning. It constitutes the central mechanism and process to achieve the objectives set for the new public health system. Since it is firmly connected to the determinants of social health and is based on the perspective of social sciences, it requires a clear commitment to the empowerment, participation and development of the community. The inclusion in this strategic and operational vision requires operators involved in actions for health promotion to have better knowledge and capacity, but, above all, to reconsider the role they play within healthcare services.

Access to the master is reserved to those who are in possession of a Degree of first or second level or of the old sort achieved in Italy, to professionals in possession of a degree, graduates from universities which are not located in Italy, according to current legislation.

The purpose of the course is to provide specific professional competencies in the field of interventions for health promotion and health education, to:

- develop an up-to-date vision of the scientific basis and cultural references relative to the models of health and health promotion, with particular emphasis given to the European context and the "Health in all policies" approach
- acquire the ability to manage processes of transfer/translation of the results of scientific research into the operational context
- know and apply methods for the design of interventions for health promotion and education at the individual level, in small groups, and in communities
- know and apply actions of qualitative and quantitative research for the analysis of health needs and the evaluation of interventions
- know the fundamental methods of educational communication that can be used in/with different contexts and targets
- know and manage processes for the assessment of impacts on health
- know how to manage working groups involving different professions and disciplines
- know how to coordinate integrated programs of health promotion and health education
- activate and support processes of continuous improvement of the quality of the services involved in actions of health promotion and health education projects
- coordinate and support multidisciplinary projects of research for the analysis and evaluation of health needs and demands to support planning in health promotion and health education.

The University of Perugia participates in Eu.Ma.H.P Consortium: it offers to the participants in the Master the possibility to acquire the necessary credits also for the European title by attending a training course at one of the European universities that are members of the network. The European Master in Health Promotion - project of the European Commission - DG Sanco - was established to create a post-graduate training program which was common, shared, modular, and of a high quality for specialists in the field in Europe and ensure a benchmarking procedure designed to guarantee high quality services in health promotion. It is promoted by a network of European universities and enjoys the recognition and support of the European Union.

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No other post-graduate university course (master or postgraduate courses) has had the same success and continuity as the course offered by the University of Perugia. As an example, hereinafter we list some courses related to health promotion and health education that are not currently being held:

- the University of Firenze - Department of Public Health held several courses: "Management of educational and training activities for health promotion" in the academic year 2002-03, "Health education of teenagers" in the academic year 2003-04, "The determinants of health" in the academic year 2006-07
- the University of Siena held a postgraduate (completion) course in "Health education and promotion: strategies, methods and tools" and a Master's degree in "Health promotion, prevention, and food education"
- the Department of Infancy and Adolescence of the University of Parma held the university Master in "Health protection and promotion and food education in Infancy and Adolescence"
- the University of Bologna offers a Master's degree in "Nutrition and health education" and a 2nd level Master's degree in "Development of physical activity and health promotion" for the training of Equity in Health Manager.

In the Hp-source.net database, Masanotti G., who has introduced the information relating to health promotion in Italy, points out three Universities among the main bodies involved in the development of knowledge in the context of health promotion: the University of Perugia (Prof. Pocetta, Department of Surgical and Medical Specialities and Public Health), of Siena (Prof. Giacchi, Institute of Hygiene) and of Cagliari (Prof. Contu, Department of Hygiene).

As for the way in which the Departments of Hygiene of Universities are called in Italy, two of them have names that make us think of a paradigm shift (at least in their title). Among the 34 Schools of specialisation in hygiene and preventive medicine, under the Faculty of Medicine and Surgery:

- at the University of Genova, the Department of Health Sciences - Sect. of Hygiene and Preventive Medicine was established
- at the University of Palermo, the "G. D'Alessandro" Department of Sciences for Health Promotion was established. The "G. D'Alessandro" Department of Sciences for Health Promotion, with which the lecturers of the Institute of Infectious Disease and Virology and of Occupational Medicine are connected, has the aim of "promoting research in the field of complex interactions between human beings and environment in relation to different epidemiological realities, such as infectious and chronic, degenerative realities, in order to promote the physical and psychological wellbeing of people".

5.1.2 Training outside university

Apart from the training in health promotion offered in universities, training is also offered mainly to operators in service who are already dealing with health promotion (nurses, doctors and other LHA workers; teachers of different levels) by LHAs, instrumental and institutional bodies (DORS, ISS, CCM…).

In this regard, in spite of the limits in the basic training of the various operators, Modolo tells us that the issue of training has grown in importance in the policies both of the health-care system and of schools. In fact, thanks to the economic resources made available by the NHS and to the guidelines set by the two systems, they have stepped up their efforts for the training of operators in service, in which various training agencies, including the University, have been involved.

According to Briziarelli, in Italy "the reality has gone beyond the activity of formal institutions and interventions for training in health promotion and especially in health education have been made over time and in almost all regions in Italy. This type of training has taken place thanks to the commitment of several subjects: scientific institutes and training agencies, including private ones, local and regional health services, schools, and it has targeted health and social professionals, teachers, and other people working in schools."

It is a discontinuous and fragmentary training which we are not going to describe in detail in this report. However, we can certainly say that in some regions there has been a greater offer. An emblematic example is Piemonte where DORS was established. It is a service funded by Regione Piemonte - Department for Health protection, targeted at LHAs and Hospitals, at people working in schools, on research projects and in associations as well as those who work in the field of Prevention and Health Promotion for various reasons. Among its objectives, there is precisely that of training operators (professionals and policy makers) to develop skills and capacity to intervene in order to promote people's health. DORS' field of action, which was initially restricted to Piemonte, has been then extended throughout Italy.

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One of the most recent initiatives at national level is the training plan of the PinC project of the Higher Health Institute (ISS). One of the activities of the program is the design of a communicative and training strategy for health professionals (GPs, paediatricians, operators of the National Agricultural Information System (SIAN), Protective Devices (DP), Drug Addiction Services (SERT), health-care workers of local services, etc.), healthcare and social operators, school operators (Regional Health Units, School Management, Teachers), pharmacists, associations of citizens, staff of municipal administrations, decision-makers, Police Force or the "key figures", whether medical or not, whose contribution is fundamental to reach the primary target (adults, adolescents, children, women, elderly people, families) of health promotion. It is interesting that the target of this training is the result of a survey. PinC provides for the realization of a package of activities and communication and training tools to support the objectives of the program called “Guadagnare salute” (“Being more healthy”).

Participation in these training courses has been facilitated in some way also by the obligation for healthcare professionals to acquire CME credits (CME stands for Continuing Medical Education).

5.1.3 Associations and Other Bodies

Associations for Health Education and Health Promotion

In the Report on the Health Profile of the Country in 1990, it is stated that "the aggregation of those working for health education in organized and structured forms does not represent a new phenomenon in the Italian scenario and, indeed, because of its dimension, it can also be considered one of the most substantial aggregations of all scientific associations. There are two major organizations active in the field: the Italian Association for Health Education and the Italian Committee for health promotion and health education (already Italian Committee for Health Education).

The professional associations in this sector present some well identifiable characteristics. With respect to the traditional scientific professional associations, AIES (the Italian Association for Health Education) and CIPES (the Italian Confederation for Health Promotion and Health Education) have always favoured, respectively, effectiveness, being AIES a voluntary body, and political and organizational action in order to support decision-makers at a higher institutional level (Ministry and Regions).

Hereinafter we introduce the two abovementioned organizations and other bodies that are believed to have given/give important contributions to the development of health education and health promotion in Italy.

However, let us not forget that there are other associations, for instance, those interested in self-help and self-care in various sectors, or in the defence of the rights of the sick, that are trying to further involve the population in health education, by shortening the gap that often separates citizens from institutions, and to create interesting opportunities for participation. In addition, even if it is not strictly linked to education and health promotion, a role in raising awareness is also played by voluntary associations, naturalistic associations, groups for the defence of the environment, that contribute to the success of a preliminary framework.

CIPES

Founded in 1954 as the Italian Committee for Health Education, the Italian Confederation for Health Promotion and Health Education is a non-institutional national organization that aims to foster the development of Health Promotion and Health Education in Italy; to ensure the technical and organizational collaboration to voluntary structures that worked in the area of health; to connect Institutions, Associations and Companies that operate in the fields of health care, education, care and welfare systems; to facilitate the exchange of information and the comparison of experiences in the theoretical and applicative field of health education; to encourage research and experimental studies on the most effective methods in health education; to contribute to the formation of a public opinion that is correctly sensitive to problems of physical and mental health. CIPES collaborates with the International Union for Health Promotion and Health Education (IUHPE), of which it is a constituent member. CIPES has its headquarters in Perugia at the interuniversity Experimental Centre for Health Education - CSESi at the University of Perugia.

The Confederation periodically organizes the Italian Conference on Health Education, promotes and coordinates conferences and inter-regional and regional seminars, constitutes committees or working groups on topics or specific areas, disseminates publications, and establishes scholarships. Members of CIPES can be Agencies, Associations and National Societies in the health, educational, welfare and social security fields that operate in the field of health education or are interested in its development; LHU regional and provincial federations, local Centres and Associations for health education; individuals, Institutions, Foundations, Companies, which intend to assist the Confederation in the achievement of statutory purposes. Members participate in the Assembly and elect the Board of Directors; receive the bulletin, now called Newsletter; receive the documents of the Executive Board; may participate in the study groups and commissions; translate international searches in Italian; may request the assistance of study groups or of the members of the Executive Board for information on programs, publications, audio-visual materials coming from Italian Regions or foreign countries; have the possibility to buy the

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publications directly edited or available for this at a reduced price, as well as to support programs of research or staff training, seminars and conferences of a national or regional kind together with CIPES.

CIPES collaborates with the Ministry of Health and maintains relations with other international organizations working in the field of Health Promotion and Education. The last National Conference was held jointly with AIES at the Lido of Venice in October 2010, in the context of the National Congress of Hygienists Sltl in Italy.

AIES

The Italian Association for Health Education (AIES) was formed in 1966 to create points of connection between all those who have an interest and are engaged in activities relating to health education. AIES is a way to bind various experiences, a way to reflect on how to address problems of health education, a way to participate in promotional actions. It intends to contribute to the development of an idea of health education based on community, which starts from its needs, which allows to understand health problems, which stimulates participation and collaboration between service operators and population.

It is composed of healthcare and social professionals, teachers at university and at secondary, primary and nursery schools, and citizens concerned with the development of health education. The Association has its headquarters in Perugia at the interuniversity Experimental Centre for Health Education (CSESi) at the University of Perugia.

It is divided into Local Sections with administrative and organizational autonomy, within the framework of the general programs established by the Association each year. Individuals (individual members) who, for any reason, participate in or collaborate to health education activities can become members of the Association. To become members you must submit your application to the Chairperson of the appropriate Regional Section. The following Local Sections have been established: Abruzzo, Calabria, Friuli Venezia Giulia, Lazio, Liguria, Ortonovo Committee, Lombardia, the Province of Perugia, the Province of Piacenza, Roma, Sardegna, Sicilia, Toscana, Veneto.

Angelo Celli Foundation

Angelo Celli Foundation in favour of Health Culture, with headquarters in Perugia, was established on July 10, 1987. It was promoted by Alessandro Seppilli, who provided it with its initial assets and had been its President until 1993. He wanted to name the Foundation after Angelo Celli (1857-1914), defined by the Italian Encyclopaedia as the most famous hygienist in the Nineteenth Century, placing him as a model for those who are involved in public health since he managed to combine a long and passionate teaching mastery, vast and fruitful research activities on the most serious diseases of the time, and a solid and constant commitment, even in Parliament, with the aim of a rapid and widespread social translation of the achievements of scientific medicine that was thriving at that time, together with a strong attention to the living conditions of the weakest segments of the population, and a firm basic belief in a health strategy firstly targeted at prevention and secondly at the treatment of diseases that are self-evident by now.

The purpose of the Foundation is the construction and the widest possible expansion of forms of culture – and, therefore, of knowledge, values, behavioural patterns and life styles – that are functional to the promotion of individual and public health, regarded as an egalitarian right and an indivisible good. By focusing its activities toward this goal, the Foundation works on the problems associated with nutrition patterns and practices, with life styles and in general with the socio-cultural structures which are at the basis of the individual and collective well-being and the necessary conditions for a constructive civil coexistence, a conscious realization of the rights/duties of citizenship, and an openness free from preconceptions against "diversity" and intercultural relations. In all these directions, on its own or in collaboration with other bodies, it promotes and implements studies and research, debates and conferences, advisory activities, editorial initiatives, training courses at various levels and more differentiated communication types.

In Italy and other countries, the Foundation has widely investigated and worked on the social factors that play a role in the health/disease processes, on collective representations concerning the body, the diet, the somatic and psychological pathologies and the figures and institutions, whether conventional or not, that appear to be responsible for health protection, on communication and social habits that are related to health in various ways, on moments of "domestic health management" and on the possible subsequent "therapeutic itineraries", on the images relating to drugs and diagnostic-therapeutic procedures, on relationships and the mutual expectations between doctor and patient, and in general between health services and their users, even in the face of increasingly intense and extended flows of immigrants, with the objective to contribute to a more effective socio-cultural development of health strategies and to foster an increasingly extended culture of health, among operators and in the population, regarded as the awareness of objective and subjective processes connected to health and as the origin of an active and increasingly necessary behavioural participation of everybody in its protection. The Foundation publishes three magazines: "Health Education and Health Promotion"/"Human Health. Bimonthly Journal on Health Promotion and Education".

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SItI

SItI stands for Italian Society of Hygiene, Preventive Medicine and Public Health (ONLUS). The Society brings together all the qualified individuals who are interested in collaborating to the achievement of the following purposes:

- to promote scientific and cultural progress in the field of Hygiene, Epidemiology, Public Health, Preventive Medicine and of Community, Planning, Organization, Management and Health Economy, as well as in all its other possible functional branches;
- to implement the cooperation between Hygienists, Health Administration and National and International, Medical and Scientific Institutions pursuing the same aims;
- to facilitate the cultural and professional evolution and development of prevention activities and the role and qualifications of its promoters and operators at central and peripheral level;
- to give momentum to health education activities aimed at raising the level of the population's hygiene and health;
- to promote the activities of professional updating and lifelong learning with regards to members, also through programs of continuing education in order to raise professionalism and managerial, scientific and technical skills;
- to promote and, through the activities of members and through collaboration with other companies and scientific organizations, participate in scientific studies and research in the context of the disciplines referred to in subparagraph (a) with the working out of manuals, guidelines, operating protocols and multicentre studies.

5.2 Settings for health promotion

In the community context: the Italian Network of Healthy Cities

The aim of the WHO project called Healthy Cities is to involve Local Administrations in the development of policies in which health is one of the main reference values.

Italy took part in the project in 1987 with the cities of Milano and Padova joining in. In 1995, the Italian Network of Healthy Cities was formally constituted and it currently consists of more than 70 Municipalities in 17 Regions. In 2001 it became a non-profit making association. The Network promotes the role and commitment of Italian Municipalities in health promotion policies at the local level. It spreads and develops the Healthy Cities movement at the national level: the associated Municipalities aim at building a shared path of collection, analysis and dissemination of the best and replicable elements of good practices in health promotion, for example, in relation to cities pollution, cancer prevention, transplants, and healthcare resources. In addition, the Network is constantly engaged in the key issues of the WHO project "Healthy Cities": urban planning for health, health impact assessment, aging in health.

In the health context: Health Promoting Hospitals

The Health Promoting Hospitals project was born at the end of the Eighties with the competition of the WHO European Office with the aim of connecting and supporting the hospitals that undertake initiatives of transformation and reorientation based on the setting approach. In the period 1993-97, the European Pilot Hospitals Project was initiated and developed involving 20 European hospitals to develop, each, 5 health promotion projects. In 1995, the idea was launched to set up the National Networks to incorporate the specificity of health promotion in the organization, in the hospital principles and culture. The goal was to improve the quality of health care, the working conditions, the satisfaction of operators and users. Each Hospital committed itself to provide at least 3 projects. In Italy the first two Hospitals participating in the movement were the Hospital of Padova and the Buzzi Hospital in Milano. Within the framework of the reorganisation of the National Health Service and in particular in the context of the business logic, the proposed underlying philosophy is absolute quality with a central role given to the customer's interests and satisfaction. The preparation work for the constitution of the Regional Network in Veneto began in 1995 and it was then designated as the Coordinating Centre of the Italian Network of Health Promoting Hospitals by WHO and the Ministry of Health and its organization was designated as the methodological and organizational reference point for the other Regional Networks in Italy. The initiative in Veneto was followed by the formal constitution of the Network in Piemonte in 1997 and the First National Conference of Health Promoting Hospitals was held in January of the same year. Finally, the Second National Conference was held in March, 1998 during which a program agreement was set between the two networks towards the constitution of the National Network. Thus, the Italian Network of Health

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Promoting Hospitals is a "network of regional networks", which are fully independent in the management of their activities and in the direct relations with local hospitals, with their respective regional authorities and with the WHO European Office. As of today, 12 regional networks have been established.

The HEPPY project fits in the HPH Network of the Region of Piemonte, within two specific projects: the "Continuity of care between Hospital and Territory" Project (Coordinator: Dr. Maria Grazie De Rosa) and the "Hospital and territory without pain" Project (Dr. Carla Bena).

In the school context: Promoting Health Schools

In Europe, thanks to WHO, and other international organizations, a concerted action has been taken to extend the health education activities that had already been carried out in schools. Apart from health education, all aspects of school life had to be taken into consideration: the development of the holistic sense of health, from the environment to the organization of the activities, from activities related to catering and so on, thus passing from the prevention of possible childhood diseases to the transformation of school time into a fundamental moment for the harmonious growth of the student. Basically, all European countries have joined the initiative, creating a very wide network of subjects who have adopted this strategy and are still pursuing it. In Italy the initiative was implemented by the Ministry of Education, which selected a group of sample schools in some regions to give the project the go-ahead in an experimental manner and is followed by the Ministry of Health, which is the official referent of the project for WHO.

The Regions for Health Network (RHN) was established in 1992 to strengthen the focus on health improvement in the regions, with a view to increase their role in Europe. This Network supports the development of policies and strategies for health improvement carried out at national level and promotes equity in health, broad participation in decision-making processes and balance between health promotion, social-environmental context and health services. Some regions in Italy (Veneto, Calabria) are or have been part of it, but there is no coordination among them in Italy.

5.3 Centres for documentation and databases on health promotion

In the Report on the Health Profile of the Country, it is repeatedly highlighted how difficult it is to briefly give account of what happens in Italy with regard to health promotion and health education because of the extreme heterogeneity of the documents and the dispersion of information sources, also due to the absence of a National Observatory. It is also said that, while waiting for a rational and efficient Observatory for health promotion and education to be fully operational in Italy, the data provided by SEDES and the Experimental Centre for Health Education have been used. Then, the possibility of creating this possible observatory has not been mentioned any more.

Over the years, in Italy many partial examples (from a thematic, geographic or documentary point of view) of databases have been put in place, but these experiences were often interrupted because the mandate had ceased to exist or because of different reasons related to sustainability. To overcome these problems and to provide a national and regional database of projects, interventions and good practices of prevention and health promotion, the PinC project (the National Information and Communication Program in support of the objectives of “Guadagnare Salute”) has promoted a collaboration with Dors, the Regional Documentation Centre for health promotion in Piemonte with consolidated experience in the construction of databases. The working group also includes Toscana (the Ars database), Veneto, and Emilia-Romagna, as well as Zadig, a news agency specialized in science. Other regions, such as Umbria, have declared their interest in joining in and, more generally speaking, the participation in the working group is open to local realities willing to engage in the project. PinC is scientifically co-ordinated by the National Centre for Epidemiology, Surveillance and Health Promotion (CNESPS) of the Higher Institute of Health (ISS).

Since 2000, in collaboration with operators from Piemonte, Dors has built a database of health promotion projects ("Pro.Sa. projects"), originally addressed to regional experiences. The collaboration of Dors with Documentation Centres in different Regions was started in 2007 thanks to two successive Ccm projects entrusted to Dors within the framework of the program “Guadagnare Salute”. These two projects are: "Research activities on the projects and interventions related to prevention and health promotion in adolescents at the regional level in Italy" and "Development and consolidation of the network of documentation centres for prevention and health promotion". For these projects, DoRS got in touch with the study and documentation centres working in the various Regions. In the Regions where study or documentation centres were not present, it sought the cooperation of Regional Authorities, Regional Health Agencies and University Departments with a vocation and an experience in research and documentation in the sector of childhood or adolescence or, more generally, in issues relating to Health Promotion and Health Education.

This has allowed the experimentation of the use of the Pro.Sa database in a supra-regional context with convincing results. As a whole, they collected more than 2000 projects in 16 Regions, then they catalogued and

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placed them in a database. Then, the projects were subjected to a selection in order to identify potential good practices. At this point, access to the database was characterized in a national sense, through a dedicated site "Italian Network of Documentation Centres for prevention and health promotion" (www.retepromozionesalute.it) whose management and development are carried out by Dors. Although the possibility of further growth and improvement must be taken into account, this is one of the most complete, organized, and accessible information base that is available today on prevention and health promotion in Italy. Although the project was formally ended in 2008, then the database was still used by 7 Regions, without dedicated funding.

Starting from this cultural baggage provided by Dors, the collaborative project with PinC provides for the development of the information system and the national and regional database (revision and adaptation of the site www.retepromozionesalute.it); the structuring of a path for the selection of good practices within the database; the participation (in the phases of design, delivery, preparation of educational materials) in training initiatives promoted by the National Centre for Epidemiology, Surveillance and Health Promotion (Cnesps) of the Higher Institute of Health.

DORS

DoRS (Regional Documentation Centre for Health Promotion) is an organization funded by Piemonte at regional level. It has its headquarters in Torino, Italy, and was founded in 1998 through the Decision of the Regional Government of Piemonte no. 90-23098/97. It provides documents and materials taken from the literature, the experiences and the "products" made by those who are working to improve health for LHAs, caregivers, researchers, unions, teachers, community organizations and decision makers at the local, provincial and regional levels. It informs on the evidence produced, and disseminates the evidence of how effective the interventions in the health field are. In addition to the spread of literature, it is involved in the training of professionals and policy makers in order to develop the skills and knowledge needed to promote health in the population. They also provide assistance for the planning, implementation and evaluation of interventions, projects and policies for health. DORS is actively working to develop networks at local, regional, national and international levels and, especially, it actively cooperates in the project for the development of a National Information Network.

SEDES

It is the internet site of the Agency for health promotion and education, documentation, information and cultural promotion in the healthcare and social field, with headquarters in Perugia; the Agency carries out function of support and advice, information and cultural promotion in the context of prevention, health promotion and health education.

CTDS

The Documentation Centre for Health in the Province of Trento consists of archives, library, newspaper library, media library, and on-line database. In its various sectors, it collects a large amount of documents concerning a wide range of topics that relate to the concepts of health promotion and education, improvement of the quality of life, health and social care.

CEDES

The Documentation Centre for Health Education is part of the documentation system of the Region of Toscana and has the purpose of providing for the dissemination of scientific information and health culture.

ISS - The WHO Documentation Centre in Italy

The Higher Institute of Health (ISS) has been the WHO Documentation Centre for Italy - Regional Office for Europe since 1991. The Centre supports WHO activities by promoting the dissemination of the documents produced by the offices of WHO-Headquarters and WHO-Europe. With this aim, it collects and catalogues this material, recovers bibliographic information and provides primary documents. It also promotes the translation into Italian of WHO/EURO documents regarding topics of particular relevance and deals with the review of publications of a specific and topical interest.

5.4 The European context

Among the 47 European countries, 27 are members of the European Union with a total population of about 500 million people. Three other European countries are candidates for accession and other countries, including Iceland, have applied or are planning to apply to become members. EU citizens have never lived so long and life expectancy is still growing. However, the health of the EU population is far from being as good as it could be and there are still significant levels of preventable diseases leading to early mortality. The underlying social and

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economic conditions and the living and working conditions associated with them are identified as the most important determinants of health in Europe.

During the last decade, there has been a rapid and unprecedented growth of the power and influence of the EU in the development of public policies for health in Europe. From its initial indirect responsibility for the factors that affect health, such as the common standards relating to medicine, medical insurance, and workers' health, through the various European treaties the EU has become the driving force that facilitates the actions in favour of health protection and improvement in Europe and beyond Europe (Davies 2003). This has an important impact on the need for and the attention to the core competencies necessary for health promotion in Europe.

The European health strategy "Together for health: a EU strategic approach for the period 2008-2013" includes actions to promote good health by addressing the major determinants of poor health associated with morbidity and premature mortality. The EU member states have the greatest responsibility for policies regarding health and health services for European citizens. A cooperation is needed at the community level and the cooperation and coordination between European countries and international organizations enhances the effectiveness of prevention policies. The EU supports the exchange of information and the guidelines including good practices that contribute to improve health protection in the Community.

To effectively implement this strategy, the workforce must be skilled and qualified for health promotion throughout member states. Professionals must share a common vision of the basic principles and knowledge of health promotion based on the evidence of effectiveness, as well as the ability to translate strategic objectives into practice. Building and enhancing skills to effectively promote health is crucial to improve health and reduce health inequalities in Europe and member states would benefit from a system that facilitates structured exchange, collaboration and consistency between the different national structures within the framework of development of competencies for the workforce in the field of health promotion (Santa-María Morales et al., 2000).

Efforts to increase the capacity to meet the needs of the population require a work force with sufficient expertise to face challenges. The identification of the core competencies for health promotion in Europe offers a way to develop a shared vision of what constitutes the specific knowledge and skills required for an effective practice of health promotion in the European context (Battel-Kirk et al., 2009). Given the different stages of the development of health promotion in Europe, it is reasonable to say that there is a need for a coherent framework that, starting from the advances made at national and international levels, leads to a global and flexible system for workforce development and quality assurance (Santa-María Morales et al., 2009).

In Europe, there is a variety of social, economic, cultural and political contexts that have an impact on the current developments of the skills necessary for health promotion in the different member states. In EU policies and strategies, however, the quality standards are central to an ethical use of resources and to an effective action on health. The staff training based on well-defined standards and the implementation of quality control standards are seen as important mechanisms to obtain a quality service. In the last twenty years, the EU has developed a series of directives and decisions (Recognition of the Professional Qualifications, 2005/36/EC, Setting up a Group of Coordinators for the Recognition of Professional Qualifications, 2007/172EC) to establish more flexible systems for the recognition of professional qualifications and to ensure quality and access to health services, promoting the principle of free movement between member states. The cross-border recognition of professional qualifications gives impulse to the development of common standards and quality criteria in training and education of health professionals and, from the perspective of health promotion, of all professionals with the goal of improving health (Santa-María Morales et al., 2009). These strategies and treaties thus provide a powerful context for development of competencies in health promotion at the European level.

The Treaty of Maastricht (Title XII, Education, Vocational Training, Youth and Sport Article 165 - ex Article 149 TEC) establishes that the European Community should contribute to the development of a quality education by encouraging cooperation between member states, supporting and integrating this action when necessary. Maastricht also provides that member states should encourage the mobility of students and teachers while encouraging the academic recognition of diplomas and periods of studies, encouraging cooperation between educational systems and developing exchanges of information and experiences on topics shared by the educational systems of all member states. Of course, this has a direct relevance to the development of skills that will form the basis of education and training in health promotion in Europe.

The main objective of the Bologna process was to create a European Higher Education Area based on international cooperation and academic exchanges that attracts students and staff both from Europe and from other parts of the world. The process takes its name from the Bologna Declaration, signed by 29 countries in June 1999. The signatories promised to reform the higher education systems in a convergent manner so as to make European higher education more compatible and comparable, more competitive and more attractive for the Europeans and for students and scholars from other continents.

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Specifically, one of the objectives of the Declaration was to work to create a system of comparable qualifications, common cycles related to the systems of first and second level, a system of credits (ETCS) based on the quantity of study, to encourage the mobility of students and staff in Europe, to promote cooperation in the development of common criteria/quality assurance at the European level and to encourage the European dimension in higher education as the development of curricula, inter-institutional cooperation, mobility patterns, integrated studies programs, internships and research (Davies, 2003).

Today, the Process unites 46 countries. An important feature of the Bologna Process and the key to its success is that it also involves the European Commission, the Council of Europe and UNESCO-CEPTES as well as representatives of higher education institutions, students, staff, employers and quality control agencies.

On the bases of the Bologna Declaration, the European Association for Quality Assurance in Higher Education in Europe (2005) has developed a series of standards and guidelines for the European system of higher education and has tried to find ways to ensure a proper system of peer review for quality control and/or agencies accreditation. All these developments provide a clear reason for the development of a European mechanism directed to ensure the quality of professional training and the qualification of those who work in the field of health promotion in EU member states (Santa-María Morales et al., 2009).

5.4.1 Collaboration on the development of competencies for Health Promotion in Europe

Through its public health program, the European Commission has supported many significant initiatives in this area, among which there are the development of competencies for second level training in health promotion of the EUMAHP project (European Master in HP) and other collaborative initiatives as the projects for developing competencies at the European level organized by PHETICE (Public Health Education in the context of an Enlarging Europe) and ASPHER (The Association of Schools of Public Health in the European Region).

European Masters in Health Promotion (EUMAHP)

EUMAHP is one of the initiatives funded by the European Commission, developed in relation to health promotion in Europe (Meresman, 2004). A group of experts involved in training for health promotion from all member states and Norway gathered in 1997. The development of the EUMAHP program began in 1998 with the aim of improving the quality of health promotion through the vocational training of health promoters in Europe and to benefit from the added value of the European dimension. The project also sought to "further develop and strengthen the European conceptualization of health promotion after the Ottawa Charter" (Colomer et al., 2002).

The development of competencies was central to the initial work of the EUMAHP project (Davies et al., 2000). The objectives of the EUMAHP project were:

- the improvement of educational standards in the context of health promotion within the academic institutions
- the certification or accreditation of professionals and operators in health promotion
- the professionalization of the field of health promotion and its recognition.

The development of the curriculum for training in health promotion was one of the main areas of the group work, and included a particular focus on the quality control of the relevant educational programs. The development of a curriculum and core competencies at European level was central to the project (Davies et al., 2000). The EUMAHP working group for professional and academic standards defined the skills necessary for health promotion as "the knowledge, skills and attitudes necessary to implement specific actions for health promotion within specific areas of practice based on specific standards" (Meresman et al., 2006). As part of the tasks of this working group, they gave a questionnaire relating to both health promotion in general and activities carried out in specific environments and with particular groups of people. It was drawn up by 33 experts in health promotion from all over Europe. Participants were asked to map the skills that they considered to be more essential, desirable or irrelevant. 27 skills were identified and they were divided into 5 areas:

1. analytical skills; e.g. understanding of the social, cultural and subjective determinants of health
2. skills for social management; e.g. sensitivity toward the dynamics of the group and institutions. Ability to manage these situations
3. skills for policy-making; e.g. understanding of sectors, policies and public services
4. communication skills; e.g. ability to talk, to actively listen with care, empathy, and sympathy
5. operational skills; e.g. management abilities: leadership, decision making, ability to mobilize resources, and to organize tasks.

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The EUMAHP framework for skills, including the 5 dimensions referred to above, has laid the foundations for the development of a core curriculum for the training programs of second level published by the group (Colomer et al., 2002). This initial work has provided important foundations for the collaborative development of a consistent basic curriculum for second level training in health promotion in Europe.

Public Health Training in the Context of an Enlarging Europe (PHETICE)

Another project funded by the European Commission that relies on expertise as a basis for the development of the curriculum is the PHETICE project (Public Health Training in the Context of an Enlarging Europe) that has developed a diagram to guide the multidisciplinary training of public health operators and has included experts for health promotion in its governing board.

The PHETICE project was launched in 2005, with the idea that the public health developments in the European Union demanded a unified approach for the workforce development through specializations in public health. It was believed that the introduction of a common EU dimension of public health was required to obtain these developments and to use the framework prepared by the European Commission.

The project was begun through 5 programs of European Master financed by the European Commission in the area of public health in the broadest sense, nutrition, gerontology, epidemiology and health promotion. The work carried out within the PHETICE project includes a mapping of the current situation of training in public health and a collection of important documents and information on how the common European system of health monitoring can be supported by training and how the systems of competencies and quality control are developed in Europe.

The PHETICE project was divided into 7 work packages and distributed among five partners. Within the PHETICE program, they carried out a mapping of the current situation of training in the context of public health in order to provide the project with context information, and a collection of important documents and information on higher education in public health in Europe. They have also collected information on educational and pedagogical strategies suitable for public health but also optimized to be in line with the Bologna Process. A survey was carried out among public health universities and schools in the enlarged Europe, using a common list of ASPHER courses (the Association of schools of Public Health) and European master's programs already existing. Answers came from 86 Universities (PHETICE, 2008).

A model was developed to analyze the competencies for public health and health promotion. This model, which was developed from already existing international models of public health and health promotion, is designed to be flexible so as to allow the widest possible use so that it can be connected to other areas and its use can be expanded at European, national and local level. This model has been revised to allow the inclusion of specific disciplines and core competencies. The model is dynamic and is divided into 3 areas connected to each other. In terms of result, the model is intended to improve the development of public health and contains examples of reference key groups (from populations to individuals). It also allows the user to define the health model within which he works (from ICD to EUPHID).

To improve the public health of the reference group, the public health process is deeply based on key values of "Health for all" (e.g., social justice and equity) that define the context in which skills are used and put into practice. Core competencies are divided into the following categories:

- assessment and analysis
- policies and planning
- implementation and evaluation
- communication
- information processing
- group work
- leadership.

The cyclic process interacts with the existing structure of institutions and professionals and of the key components that constitute them (for example, missions, values, skills of the institutions and values, skills and performance of individuals).

The PHETICE project establishes links with the work done by ASPHER and recommends that connection with other European network should be maintained (Davies et al., 2008).

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Association of the School of Public Health in the European Region (ASPHER)

ASPHER was established in 1966 to represent public health schools, other types of second level education in public health and other programs. These schools and other programs prepare students for careers in services or in the field of academic public health by obtaining diplomas in public health at all levels (bachelor, master and doctorate). ASPHER is currently developing standards based on skills for education of professionals in public health, including those who work in health promotion.

The attention of the ASPHER European Public Health Core Competencies Program (EPHCC) is directed to the development of a list of core competencies that Public Health Schools consider to be necessary to train their students to develop, organize, manage, and foresee public health problems (ASPHER, Phase 1 report). These competencies are needed to address the challenges posed by people's health and health systems, that a part of public health professionals could expect to face, and, of course, the systems of disease prevention and health promotion are an important component of this portfolio of competencies (Birt and Foldspang, 2009).

It was more likely that competencies would have been seen as appropriate and valid if they had been developed with a bottom-up method, with a close involvement of public health professionals who must demonstrate every day to have public health competencies in their job. The first phase of the project was a collection step. All the public health schools were invited to send a list of competencies that were important for them (Birt and Foldspang, 2009). Competencies were classified into six thematic areas:

1. Methods (epidemiology, biostatistics, qualitative methods)
2. social environment and health
3. physical, chemical, and biological environment and health
4. policies, organization, management and economy for health
5. health promotion and prevention
6. interdisciplinary research, including strategy, ethics and other topics.

These areas were largely in agreement with the ASPH areas (Association of Schools of Public Health) in the United States. Each area has its own working group and the chairman of the working group may suggest subdivisions. To optimize the inclusivity of the process, if a group member suggested a competence, this was inserted in the list. The aim was to produce a sound framework of applied competencies in public health training in Europe. There was not a maximum limit of competencies (ASPHER, 2007).

Within these areas, competencies were divided into two groups: practical (which require skills) and intellectual (which require knowledge and understanding) and each group contained a list of competencies for each of the following areas:

- determinants of health, risk factors
- theories and principles of health promotion and prevention
- strategy, development, management and evaluation of programs
- communication.

Some of the competencies included in the group's draft of the practical competencies necessary for health promotion required students to demonstrate the ability to describe and evaluate the determinants of health, describe and identify the biological, physical, chemical, social and psycho-social principles and elements involved in prevention and health promotion, carry out investigations on lifestyles, analyze data and know how to use methods of qualitative research. The draft of intellectual competencies required students to know and understand a wide range of social, psychological and economic areas, including basic philosophy, social sciences, impact of social environment on health, understanding of the social, cultural and economic origin of the determinants of health.

The provisional list of the core competencies for public health phase 1 was published in October 2007. This list was made from lists of competencies received from each president. Some competencies were reviewed or slightly modified by the presidents to avoid too much repetition and overlapping, which inevitably occurs when a series of independent candidates are put together (ASPHER, 2007).

During phase 2, contacts were established with public health stakeholders. Two conferences were held in 2008 (Arhaus, Denmark and Paris, France) and some workshops took place in Slovenia and Scotland. The result of these consultations was that the list of competencies created by the six initial working groups was changed and in October 2008 the provisional list of core competencies in public health phase 2 was published (ASPHER, 2008).

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According to Birt and Foldspang (2009), the challenges to people's health and health systems vary in time and in different European regions. Therefore, it is hoped that this process should be continued and strengthened in phase 3, and that it should lead to shared lists at a general and regional level of core competencies for education in public health in the various levels of education. Ultimately, the competencies for public health must be defined to appropriately adapt to the different levels of education and training in public health and also to the different possible levels of employment in public health (in order to facilitate the ability to compare job offers, and a real free movement of professionals in public health in Europe). Competencies can be monitored at an individual level and the lists of competencies also provide a new potential for the development of diplomas in public health at the European level (Birt and Foldspang, 2009).

Phase 3 is currently in progress, and it includes plans for public health schools and interactions among public health stakeholders through conferences, local and regional workshops, classifications of competencies based on the level of training, continuous revisions and continuous publications of lists of reviewed competencies.

In its planning for 2015 ASPHER is pursuing a series of Delphi surveys in order to consolidate the list of priorities. Both Delphi surveys have shown a very strong support for the project on competencies.

5.4.2 IUHPE/European initiatives

In 2005, the IUHPE European Regional Committee created a sub-committee with the purpose to develop recommendations on the development of training, accreditation and professional standards for health promotion in the European Union. An exploratory study on the developments of health promotion in Europe was carried forward by Santa-María Morales and Barry (2007) in the name of the sub-committee. The objectives of the study were:

- to examine the level of specialized training in health promotion in European regions
- to determine the current situation as regards accreditation and professional registration of health promotion operators in European countries
- to have a bird's eye view of the current activities at national/regional level as regards competencies and professional standards
- to determine the existence and the current situation of career paths in health promotion in the various countries

Data came from 33 countries and the study found that training in health promotion is going through a process of development in Europe, although there are different levels of development from one country to another. Only a small number of countries have reported active developments in competencies for health promotion and different levels of development have been reported. The study proves that at least 7 countries are developing competencies for health promotion and 4 of them are developing professional standards. Despite the small number of existing systems, the study's conclusions show that there are examples that can be used to develop competencies and professional standards at the European level (Santa-María Morales and Barry, 2007).

On the basis of the information collected through the exploratory study, the IUHPE/EURO sub-committee activated a pilot project with participants from seven countries to verify the feasibility of an accreditation system based on competencies at the European level. The project carried out by Battel-Kirk and Barry (2009) identifies the level of interest in and the progress toward this development within the participating countries and explores the barriers and incentives to an accreditation based on competencies. Overall, the project has confirmed their support to a European system and recommended that this system should take into account the differences between European countries in terms of health systems, infrastructure and development of health promotion. With eight other partners, the participants in this project went on with the development of a proposal to obtain funds from the Executive Agency for the Public Health Programme of the European Commission (now Executive Agency for Health and Consumers). The proposal was successful and has now turned into the CompHP project. The partners of the project have also worked on the development of the Galway Consensus Statement on the areas of core competencies for HP (Allegrante et al. , 2009), which was seen as the supporter of a reference framework that may be useful for European developments.

5.4.3 The Galway Consensus Conference Statement

On the basis of international developments, the 2008 Galway Consensus Conference was conceived as a first step toward an international agreement on core competencies necessary for the professional training of specialists in health promotion and education. This conference sought to promote the exchange and greater collaboration on the development of core competencies for health promotion and the strengthening of common approaches to the development of competencies and workforce. In collaboration with SOHPE (Society for Public Health), the United States' CDC (Centre for Disease Prevention and Control) and other partners, IUHPE met at

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the National University of Ireland in Galway from June 16th to June 18th, 2008 for the Galway Consensus Conference that culminated in the publication of the Galway Consensus Statement on the areas of core competencies for health promotion and health education (Allegrante et al., 2009; Barry et al., 2009). Conference participants came from institutions of higher education and key governmental bodies, NGOs, professional societies at the national and global level. The conference sought the participation of leaders and stakeholders throughout the world; however, among the approximately 35 experts who were invited to participate, only 26 experts, for the most coming from Europe and from North America, accepted the invitation and participated in the conference. Different regions in the world, including sub-Saharan Africa, Asian-Pacific region and Latin America, were not represented or were under-represented due to the lack of financial resources to cover travel expenses.

The reports prepared by the secretariat of the conference to stimulate reflections contained the most up-to-date review of the literature relating to the accreditation in health promotion and health education, which included professional preparation and assessment based on skills, standards, and approaches directed to quality control.

The participants in the Galway conference reached an agreement on values and key principles, a common definition and eight areas of core competencies necessary for an effective practice of health promotion. The Consensus Statement drawn up by the organizers does not refer to specific competencies, instead it focuses on the areas of core competencies that are fundamental to achieve improvements in health. The eight areas of core competencies are defined as follows:

1. Catalyzing change – to allow change and enable individuals and communities to improve their health
2. Leadership - to provide strategic direction and opportunities for participation in the development of public policies for health, by mobilizing and managing resources for health promotion and development of competencies
3. Assessment – to assess the needs and resources present in communities and in systems that can lead to the identification and analysis of behavioural, cultural, social, environmental and organizational determinants that promote and endanger health
4. Planning - to develop measurable objectives in response to the evaluation of needs and resources and to identify strategies based on knowledge derived from theory, evidence and practice
5. Implementation – to bring forward effective and efficient, culturally-sensitive and ethical strategies to ensure the greatest possible improvements to health, including the management of human resources and materials
6. Evaluation - to determine the scope, effectiveness and impact of programs and policies for health promotion. This includes the use of appropriate assessment and research methods to support improvements, sustainability and dissemination of the program
7. Advocacy – to promote with and on behalf of individuals and communities the improvement of their health and their wellbeing and to build their competencies so that they can take actions that can improve health while strengthening the community's resources
8. Partnership – to work in a collaborative way with other disciplines, sectors and partners to increase the impact and sustainability of programs and policies for health promotion.

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6. References

1. Piano sanitario nazionale 2011-2013, Ministero della Salute
2. Libro bianco su principi fondamentali del Servizio Sanitario Nazionale, Ministero della salute
3. Le indicazioni programmatorie nazionali sul sistema dell'assistenza domiciliare nel Servizio Sanitario Nazionale, AGENAS
4. Patto della salute 2010-2012
5. Modolo M.A., Briziarelli L., Educazione sanitaria e promozione della salute: sviluppo sociale e culturale, in Educazione sanitaria e promozione della salute, Vol. 13, n. 3, settembre 1990
6. Briziarelli L., Necessità formative per la promozione della salute e la salute globale, in Educazione sanitaria e Promozione della salute, vol. 33, n. 2, 2010
7. Briziarelli L., La promozione della salute, indicazioni per la formazione dei medici, in ESPS, volume 33, n.1, 2010
8. Relazione dello stato sanitario del paese, 1999
9. Modolo M.A., Briziarelli L., Educazione sanitaria e promozione della salute: sviluppo sociale e culturale, in Educazione sanitaria e promozione della salute, Vol. 13, n. 3, settembre 1990
10. Resegotti L., Promozione Salute n. 4, CIPES Piemonte, Torino, 2010
11. http://www.dors.it
12. www.unipg.it/csesi
13. www.asnas.it
14. www.societaitalianaigiene.org/cms/index.php?option=com_content&view=article&id=47&Itemid=86
15. http://www.epicentro.iss.it/focus/guadagnare_salute/PincInformatiCompetenti.asp
16. http://www.unipg.it/csesi/ita/cipes.htm
17. http://www.antropologiamedica.it/fondazione.html
18. http://www.ccm-network.it/prg_area4_centri_doc_Asl3TO
19. http://www.retepromozionesalute.it/allegati/REPORT_progettoAdolescenti.pdf
20. http://www.guadagnaresalute.it/site/la-banca-dati
21. http://www.agenas.it/norm_naz_assist_dom_ssn.htm

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