veillance system shows that, in Italy, the consumption of 5 daily portions of fruits and/or vegetables has remained low and substantially unchanged since 2008 and 2012 in people between 18-69 years of age, while in people above 64 years of age (silver PASSI data) 45% consume only one or two daily portions and 42% between three and four portions.
The reduction of salt in the diet is one of the WHO and EU priorities within the scope of the strategies for the prevention of non-communicable chronic diseases. The data concerning the consumption of salt in the Italian adult population (35-79 years) by Regions, estimated through the collection of 24 hour urine specimen that was carried out between 2008 and 2012 for the projects NCDC, MINISAL-GIRCSI and *Meno-sale-più-salute* (Less salt - better health), shows consumption significantly above 5 g a day.
The awareness that proper diet and a healthy lifestyle, beginning in childhood, are predictive of better health in adults reinforces the importance of addressing the issues of nutritional education beginning in preschool and elementary grades, using also school lunch time as an educational tool. It is essential to also address some environmental, social and individual determinants of unhealthy diet and lack of exercise in order to implement sustainable actions through cooperation of various sectors at national, regional and local levels, as well as to reinforce the active advocacy role played by health professionals to ensure that the economic, agricultural, commercial, urban and educational policies are directed to promote and encourage the adoption of healthy choices by the population in general.
In Italy, the execution of Memorandum of Understanding between the Ministry of Health and the Associations of artisan and industrial bakers seeking to reduce the amount of salt in the different types of bread represents a first, but fundamental step, in the promotion of cooperation with the production sector. It is appropriate to promote healthy products for healthy choices by encouraging agri-food production, transformation and distribution, in compliance with the general objectives of public health, to reformulate some food items reducing the levels of total fats, saturated fat, sugar and added salt, as well as to implement initiatives for informing and raising the awareness of consumers regarding the development of healthy diet choices.

Keywords "*Guadagnare Salute*", "*OKkio alla SALUTE*", PASSI, proper diet, surveillance systems

4.4. Alcohol consumption

The per-capita alcohol consumption in Italy in the year 2010 (6.1 litres) was significantly below the WHO European average (10.9 litres) and was also the lowest among the EU countries. However, the data of the last ten years confirms the development, also in Italy, of new alcohol consumption behaviour patterns that are far removed from the traditional Mediterranean model. While the number of alcoholic beverages remains relatively stable, there is a decrease in the number of people, especially among young people and young adults, with daily and moderate consumption mostly of wine; at the same time, an increase is noted in the number of people who, in addition to wine and beer, also drink aperitifs, aromatic bitters and spirits, outside of the mealtime, with occasional frequency and often in excessive quantities. The risks deriving from these new consumption patterns must be added to the traditional patterns consisting of daily consumption, mostly by elderly males, of wine with meals, not always accompanied by the strict moderation recommended for that age group. To be noted also is the increase in alcoholic consumption by women, which although still below the amount of consumption by men, shows that gender differences are becoming progressively less significant among the younger generations. The new drinking habits expose the population to greater risks affecting not only health but also social safety, especially when the consumption of alcohol is associated with driving, working and entertainment at night. The planning for effective preventive interventions must take into account, today, the problems deriving from the traditional consumption patterns and those related to the more recently adopted patterns,

thus requiring a multi-phase and complex approach. This approach calls for the adoption of strategies and initiatives aimed not only to a universal prevention but also and mainly to a selective prevention based on age and gender, according to the respective areas of vulnerability.

Keywords Alcohol, binge drinking, risks in alcohol consumption

4.5. Use of narcotic drugs and psychotropic substances

The use of narcotic drugs, including alcohol, and the related lifestyles represent a public health problem affecting not only directly the consumers but also indirectly the population in general. A greater concentration and coordination of objectives are a priority for all central, regional and local, public and authorised private, institutions involved in order to maximise the efficacy of the policies for fighting drug abuse. As regards substance abuse (excluding alcohol), in 2012, the SerD (Drug addiction services) has treated 164,101 patients, with a service coverage above 90%. The most widely-used substance is heroin (74.4%), followed by cocaine (14.8%) and cannabinoids (8.7%). The estimated average lapse of time between the first use and the request for treatment is 6.1 years. Infective diseases affecting most patients under treatment are HIV infections (8.3%), infections from hepatitis B (33.4%) and C (54.0%). The general trend is not to test for HIV, HCV and HBV the users who seek treatment for drug addictions. In 2012, the drug-related deaths numbered 390 (Ministry of the Interior). As for alcohol, in 2012, 69,770 alcohol-dependent subjects were treated by SSN territorial alcohol facilities (54,431 males; 15,339 females), the highest number to date, with an average age of 45.5 years in males and 47.3 years in females. Young people below 30 years of age represent 9.1% of the total users, but the new users in this category are 13.7%.

In 2012, the hospital diagnoses for disorders fully attributable to alcohol were 75,445 of which 58,410 referred to males and 17,035 referred to females, with a national hospitalisation rate of 113.3 per 100,000 populations, a figure that confirms a descending trend at the national level since 2002. According to the ISS estimates, the year 2010 accounted for 3.96% of the total of male mortality and 1.68% of the female mortality.

Keywords Alcohol, narcotic drugs, SerD

4.6. Gambling addiction

Gambling addiction (GAP) is a pathology characterised by a compulsive gambling disorder which produces serious disabling effects on health. Gambling addiction is increasing even if there is no current data available since no systematic assessment of the patients being treated by the Addiction Services of the Italian Central Administration has been carried out. DSM-IV-TR has defined compulsive gambling addiction as a "persistent, recurrent and maladaptive gambling behaviour that compromises personal, family and work activities"; ICD-10 (*International Classification of Diseases*) of WHO has included it among "habits and impulses disorders". The Law of 8 November 2012, n. 189, which recommends the promotion of the country's development through a higher level of health protection (Official Gazette n. 263 of 10 November 2012 - Ordinary Supplement n. 201 to articles 5 and 7), provides for a set of regulations concerning gambling addiction and in particular for the update of LEA (Essential Levels of Care) for the prevention, treatment and rehabilitation of subjects with gambling addictions. It is difficult to estimate the magnitude of this phenomenon in Italy since, as mentioned above, to date there is no certified, complete and accurately representative data on this issue. 54% of Italians have gambled and won cash at least once in the last 12 months. However, the estimate of "problematic" gamblers (those who gamble frequently and invest quite a large amount of money and, although have not yet developed a real dependency, are at high risk) is within a range of 1.3% to 3.8% of the population in general while the estimate of "pathological" gamblers is between 0.5% and 2.2% (DPA, Ministry of Health, 2012). The number of subjects undergoing treatment for gambling

addiction in 2012 was 5,138 (83% males). Lombardy and Piedmont are the Regions with the highest number of treated subjects.

Keywords Behavioural addiction, gambling, gambling addiction

4.7. Use of cosmetic products: cosmetics surveillance

Cosmetics are beauty products, but are also products for personal hygiene and care which are used daily and consistently from birth and for the rest of one's life. Their widespread use exposes the consumer to a great quantity of chemical substances of both natural and synthetic origin.

Regulation (EC) n. 1223/2009, issued by the European Parliament and by the Council for Cosmetics, which is the applicable regulation in the EU, provides for all cosmetic products available on the market to be safe for human health if used under "normal and reasonably predictable conditions"; despite this, it is possible that undesirable effects occur following the use of a cosmetic product due to its specific formulation, the quality of the product itself, the particular level of sensitivity of the consumer or the incorrect use of the product.

For compliance with the new provisions on cosmetic surveillance set forth in the above mentioned regulation and in order to define a single procedure aimed at the collection of spontaneous reports from the final user, the Ministry of Health is organising a cosmetics surveillance system, at a national level, for the management of reports on undesirable effects and for an analysis of the collected data in order to define adequate corrective or preventive measures as regards the marketed cosmetics and to guarantee the protection of public health.

For the correct launch and adequate performance of the national cosmetics surveillance system, the Ministry of Health has promoted information and communication activities intended for health operators and final users that would raise awareness about the importance of correctly reporting undesirable effects and would provide information about the new procedures for reporting these effects to the Ministry of Health.

Keywords Consumers, cosmetics, cosmetics surveillance, reports

5. Inequalities in the health sector

Socio-economic determinants are the single most important decisive factor in the differences in health across a population. In fact, social disparities in health are a complex problem that arises from a network of generating mechanisms: social stratification dictated by the unequal distribution of resources (distal determinants) influences the distribution of the main risk factors for health (proximal determinants): environmental, psychosocial, unhealthy lifestyles and, in many cases, limited access to the appropriate treatments.

In Italy, in the last two years, awareness has increased about the political relevance of the problem of health inequalities due to the combined effects of the interventions of the European Commission, increased capacity in interpreting the analysis of causal factors and consequences, and greater knowledge about the effectiveness of actions to combat these.

In particular, a consensus is broadening about the need to adopt an approach that recognises the indispensability of involvement across all sectors in order to reach an agreed and consistent definition of policies and interventions that can tackle the social determinants of health.

This is one of the main conclusions reached in the White Book of health inequalities in Italy, adopted by the interregional group "Equity in health and healthcare" (EHH), charged by the Health Commission of the State-Regions Conference to update the scientific evidence available and to lay the foundations for the development of an initial national strategy to combat health inequalities.

Among the significant initiatives, the inclusion, between the project lines, of the CCM 2012 programme is highlighted as an item exclusively dedicated to the financing of projects whose objective is the reduction of health inequalities and the elimination of disadvantage (geographical, but also economic and social) in terms of the health of the most vulnerable populations.

In addition, 50 million euros were earmarked

in 2012 within the allocation of the National Healthcare Fund for the creation of regional projects to combat the impact of the financial crisis on the social determinants of health inequalities, such as the increase in unemployment, the impermanence of employed work and the erosion of spending power, the weakening of the net of family protection and the increase in social exclusion.
Finally, within the research financed and the participation in community projects, a major boost has come from Italian participation (through AgeNaS, the Piedmont Region and the Veneto Region) in *Equity Action*, joint action between the European Commission and 16 Member States, which has enabled partners to develop new capacities with the field of the assessment of the impact on health of policies, the promotion of regional policies to combat health inequalities, the use of the Structural Funds for financing interventions aimed at intervening in the distribution of the social determinants of health and, finally, on the recruitment of stakeholders.

Keywords Determinants, inequalities, equity

The responses of the National Health Service

1. National health protection plans and programmes

1.1. Implementation of the National Prevention Plan

The 2010-2013 NPP adopted by the State-Regions Understanding of 29 April 2010, and extended to 2013 by the State-Regions Understanding of 07 February 2013, has identified four macro areas of action: Predictive medicine, Universal prevention, Prevention in the population classed as "at-risk", Prevention of complications and recurring diseases. One or more general lines of action have been defined for each macro area, and these are entrusted to regional programming in the form of the Regional Prevention Plans (RPPs). In accordance with the governance model adopted by the Plan, the Ministry has been entrusted with the task of assisting regional development through providing a range of support functions (Priority central actions adopted by Ministerial Decree of 4 August 2011). Together with the LEA Committee, it is then also responsible for certifying achievement of the objectives laid down by the RPPs, for the purposes pursuant to the Understanding of 23 March 2005 (access to a restricted portion of the National Health Fund).

Overall, regional programming has mainly focused on promoting and monitoring healthy lifestyles, taking a life-course multifactor and transversal approach, as recommended in the fight against chronic disease. The aim is to influence both high risk (lowering it as far as possible) and low risk (cancelling it entirely or ensuring that it remains such throughout the whole life).

The plan's strengths include the sharing of a planning method based on the analysis of health profiles and, therefore, which is structured to suit the regional and local contexts. This has been seen as a good practice to be maintained in the future and indeed to be improved through a more integrated, system-related planning. Critical issues include the monitoring of interventions and assessment of results, and it is here that future efforts should be concentrated, with a more systematic use of current data and flows and greater synergy between the regional and local levels.

1.2. "Guadagnare Salute"

Reduced well-being amongst the population has economic effects that impact both individuals and families, as well as making for an increasingly heavy economic burden on the health sector and generalised loss of productivity for society as a whole.

The promotion of health and the prevention of non-communicable chronic pathologies require a strategy hinged on positively- or negatively-impacting determinants, covering both unmodifiable aspects (gender, age, genetics etc.) as well as social, economic and lifestyle-related factors, affected by political decisions of different sectors.

In Italy, the distribution of modifiable risk factors (smoking, alcohol abuse, being overweight/obesity, unhealthy diet, sedentary lifestyle, etc.) varies considerably amongst the population. The most demanding challenge is to ensure that health potential and requirements are met and fulfilled, not only through lifestyles and the supply of health services, but above all through the quality of the environments and living and working conditions. Only thus can the inequalities caused particularly by social factors, namely social-economic conditions in which certain groups of the population live, be overcome.

With the "*Guadagnare Salute: rendere facili le scelte salutari*" (Gaining Health: how to make healthy choices easy) programme (Prime Minister's Cabinet Decree of 4 May 2007), Italy has launched a global strategy outlining the need for new alliances by which to promote human development, sustainability and fairness, as well as improve health according to the principles of "Health in all policies".

The Ministry of Health plays a leadership role in strengthening the as yet weak "intersector" culture and supporting the Regions, also in view of the objectives of the new NPP currently being defined. One of the key ele-

ments in the implementation of inter-sector policies promoting health is, in fact, the active participation of the Regions, which, as the institutions of competence in health-related matters, are responsible for implementing national strategic guidelines in their own RPPs by involving the communities concerned. The driving, strategic role (advocacy) played by the central health institution with regards to other institutional or not institutional interlocutors has not enabled the launch and consolidation, through the stipulation of Memorandums of Understanding, of profitable collaborations with institutional and other stakeholders in the various different sectors (Department for Regional Affairs, Tourism and Sport, CONI, Sports associations, Food producers and distributions' associations, etc.), encouraging their implementation in certain regional contexts.

To bring about clear, permanent changes in the living environment of local citizens and thereby help towards "making healthy choices easy", experimental projects have been run in the various different Regions. These are promoted by NCDC and offer preventive interventions, taking a transversal approach to risk factors and the leadership of health structures. Communication initiatives have been developed in order to achieve both the objectives relating to knowledge, for the dissemination of information on health risk factors, and to behaviour, giving rise to empowerment processes, aimed at encouraging healthy behaviour in the individual and society as a whole. These initiatives take a participatory approach and have thus successfully reached both the general population and specific targets in a capillary fashion, as well as health and other operators, using target-specific communication tools in an integrated, closer manner.

On the strength of experience and the route embarked upon by the "*Guadagnare Salute*" programme, health is slowly and gradually moving away from a model based exclusively on the provision of services (including prevention services) and towards one able to proactively promote health throughout the territory, as a "value in all policies" and everyday life resource. It is important to now pursue this, with a view to consolidating the multi-stakeholder approach, under the scope of which the Regions, in particular, as institutions seen as being "close" to the citizens, will need to further develop the opportunity of a local participatory action to "make healthy choices easier", building permanent, innovative relations with the local community.

Keywords Advocacy, inter-sector, National Prevention Plan (NPP), NCDC, promotion of health, risk factors

1.3. Promotion and protection of oral health

In Italy, public dental services are supplied in accordance with the provisions of Prime Minister's Cabinet Decree of 29 November 2001; levels of cover and intensity vary however, depending on both local budgets and the strategies and priorities identified by the various different autonomous provinces and Regions. Over time, along with a non-timely development of specific dental health protection programmes, there has also been an increase in the demand for services not offered by the public dental practice, and a rise in the services provided by freelance professional dentists.

As part of its specific public health initiatives, the Ministry of Health has promoted the adoption of oral prevention measures, partly by means of the issue of behavioural recommendations based on an analytical evaluation of scientific evidence.

In making these recommendations and in support of the work of those involved in managing oral health, specific population targets were considered (children, the elderly and drug addicts).

Keywords Cavities, dental trauma, health and/or social vulnerability, Prime Minister's Cabinet Decree of 29 November 2001, tooth loss

1.4. Promotion and protection of ophthalmological health

Law n. 284/1997 on visual rehabilitation has led Italy to recognise the usefulness of prevention in ophthalmology, with a view to guaranteeing the development of regional centres of reference for the prevention of sight problems and visual rehabilitation. These centres

represent an essential step in the promotion and protection of ophthalmological health as multi-disciplinary services of reference for diagnostic/functional assessment and the preparation of the individual rehabilitation project. Rehabilitation aims to achieve the best possible physical, personal and social quality of life, aiming to develop potential in children as they grow, which would otherwise remain unexpressed; it also seeks to optimise the use of residual visual capacity, particularly during adulthood and senility. Every year, the Ministry of Health presents parliament with a report on visual rehabilitation policies, in implementation of Italian Law n. 284/1997 (giving a description of all activities carried out, each year, by the Regions, IAPB Italia Onlus and the Ministry of Health). Another operational tool used in the field of the prevention of blindness and short-sightedness is the National Commission for the Prevention of Short-Sightedness and Blindness; this is established under the Directorate General for Prevention and has specific objectives both in relation to epidemiology and prevention, with the drafting of national guidelines. Finally, intended as a tool by which to promote ophthalmological health, the NPP includes a section entirely dedicated to ophthalmology which provides for ophthalmologic screening at birth.

The activities carried out under the scope of ophthalmological prevention are published on the institutional portal at http://www.salute.gov.it/portale/temi/p2_4.jsp?lingua=italiano&tema=Prevenzione&area=prevenzione Ipovisione.

Keywords Law n. 284/1997, National commission for the prevention of blindness, National reference centres, ophthalmological guidelines, ophthalmological screening, report to Parliament, visual rehabilitation

1.5. Technical guidance for the reduction of the cancer burden

On 10 February 2011, an Understanding was stipulated between the Government, the Regions and the Autonomous Provinces of Trento and Bolzano on the "Technical guidance for the reduction of the cancer burden", referring to oncology planning commonly referred to as the National Oncology Plan (NOP).

The reasons for the NOP are:

- cancer burden: tumours are one of the country's health priorities;
- international commitments made by the EU Council, which invites Member States to prepare a Plan;
- need for the country system to improve NHS response and help reduce inequalities.

The main contents and characteristics are:

- to give clear indications on where the State and Regions need to focus their joint efforts in order to further improve the "total management" of the patient by the NHS;
- the structuring of contents divided up into a theoretical framework of reference, shared priorities and common objectives;
- the "cornerstones": fairness, quality, genesis of knowledge, information and communication;
- the subjects broached:
  - cancer in Italy (surveillance systems, the epidemiological framework, hospitalisations),
  - prevention,
  - the progression of the cancer patient,
  - the elderly cancer patient,
  - tumours in children,
  - rare tumours,
  - oncology-haematology,
  - the technological renewal of equipment,
  - innovation in oncology,
  - training,
  - communication.

Keywords Burden of disease, oncology plan, tumours

1.6. National Plan for the Elimination of Measles and Congenital Rubella Syndrome 2010-2015

The elimination of measles, rubella and congenital rubella is a public health priority for Europe and Italy. The European Regional Commission of the WHO, in 2010, postponed the date envisaged for reaching the objective of elimination until 2015. In Italy, the "National Plan for the Elimination of Measles and congenital Rubella (NPEMeRu) 2010-2015" was approved on 23 March 2011, which moved

the target date for the elimination of measles and the prevention of cases of congenital rubella to 2015 and introduced the objective of the elimination of rubella.
During 2013, important activities were conduct correlated to the NPEMeRu: Italy hosted a meeting of Mediterranean countries, organised with WHO-Europe and ECDC (European Centre for Disease Prevention and Control) to promote discussion on the major problems encountered in the path to the elimination, the exchange of experiences and possible solutions: the integrated surveillance of measles and rubella was launched at the national level; the indications for the surveillance and follow-up of cases of rubella during pregnancy and congenital rubella were updated; two indicators, among those monitored at the European level in the process of checking the elimination were introduced as performance indicators for the NPEMeRu, in fulfilment of U) "prevention" of the ELA (Essential Levels of Care).
The data regarding the period considered indicate that measles still has great impact on health and cases of congenital rubella continue to occur. Unfortunately, the vaccination coverages for MMR are not optimal, therefore pockets of people exist who are susceptible to measles, especially among adolescents and young adults. As regards congenital rubella, the data indicate that many opportunities are lost for pre-conception screening and for the vaccination of susceptible women of childbearing age. Therefore, it is a priority to bring into force, uniformly in all the Regions, the strategies proposed in the plan in order to reach the objectives set.

Keywords Measles, NPEMeRu, rubella

1.7. National Vaccination Plan

The National Plan for Prevention by Vaccination (NPPV) 2012-2014 is the document of reference that acknowledges, as a public health priority, the reduction or elimination of the burden of infectious diseases that can be prevented by vaccination through the identification of effective and uniform strategies to be implemented across the entire national territory.
Indeed, the general objective of the new plan is to harmonise the vaccination strategies underway in Italy in order to be able to overcome the inequalities in the prevention of diseases that can be avoided by vaccination and ensure equality of access to vaccination services for all citizens, ensuring the pro-active provision, free-of-charge, of priority vaccinations for the general population and the groups most at risk. Indeed, the new calender envisages pro-active provision, free-of-charge, of the mandatory and recommended vaccinations in childhood and subsequent boosters; of the anti-HPV vaccinations for girls during the 12th year of life; of the pneumococcal conjugate and meningococcal C vaccinations; of the varicella vaccinations for all newborns in 8 Regions, anticipating the introduction in the whole country in 2015; of influenza vaccinations for the over sixty fives.
In addition, in order to guarantee the general population a good state of health into an advanced age and to enable protection from serious infectious complications in chronic illness, the NPPV provides indications with regard to the vaccinations in question, at any age, for subjects belonging to groups at greatest risk of becoming ill, of having serious consequences in the event of illness, or of transmitting the illness to others.
The Plan rolls out eight specific objectives, among which it is possible to identify certain priorities with regard to international commitment or critical areas detected in Italy, such as the completion of the digitization of vaccination records and the National Plan for the Elimination of Measles and Rubella 2010-2015.

Keywords Infectious diseases, NPPV, vaccinations

1.8. Safety at work plans

The sectors at greatest risk of serious and fatal accidents at work are those of construction and agriculture; here the most frequently-seen determinant factors are falling from heights, risk of burial or crushing due to tractors upturning or the use of machines and equipment, or failure to apply correct procedures for use.
The 2012 INAIL report confirms the accident

reduction trend already seen in recent years, positively influenced by the implementation of the NPP, which, insofar as the prevention of accidents at work is concerned, has led to the adoption of two separate specific national plans aimed at preventing serious and fatal accidents in the sectors of agriculture and forestry and construction.
The implementation of the NPP in agriculture and forestry is based on the development of supervisory programmes aimed at preventing or reducing risk, with operator training and updating seen as key qualifying strategic elements. Another element has been to optimise the importance and role played by specific training, particularly in professional schools, and the importance of the involvement of sellers of agricultural machinery in information initiatives. This latter aspect enables action to be taken on the second-hand machinery market and thereby sensitise operators to the importance of bringing the machines up to standard and making them safe.
The NPP in construction features two operating guidelines: the first is to fix precise numerical objectives for controls to be carried out regionally and territorially, and the second is the start-up of collaboration between various entities and institutes to develop initiatives to promote the protection of health and safety.
The attainment of the limits established by LEA may be used to evaluate the results achieved in respect of the objectives set forth in the NPPs in agriculture and in construction. Standardised training initiatives can also be developed to ensure homogeneity of interventions throughout the nation in terms of prevention and supervision, and the development of surveillance systems based on surveys run by the operators of the local health service.

Keywords Accidents, agriculture, construction, prevention

1.9. Nutrition

Nutritional status reflects the health of an individual. As part of the promotion of a healthy diet and nutrition, the Ministry of Health is highly active on different fronts.
In the first line, with the promotion, protection and support of breast-feeding, because a mother's milk is the only substance truly fit to satisfy the nutritional demands of babies. Another important factor comes from the Donated Human Milk Banks, created to meet the needs of babies who, for specific reasons, cannot be breast-fed; the Ministry of Health has prepared guidelines on this. The aim is to guide regional initiatives for the establishment and organisation of a Donated Human Milk Bank, defining standardised criteria for a service focused on the patient and his/her health needs.
Various initiatives have also been taken focused on the problems relating to school canteens, hospital catering and welfare catering.
Nutritional iodine deficiency also remains a global public health problem today. The negative effects of nutritional iodine deficiency can involve all stages of life, although pregnancy, breast-feeding and childhood are those during which they can be at their most severe. In order to prevent endemic goitre and iodine deficiency pathologies, the Ministry of Health has for years been promoting the use of iodised salt in lieu of normal salt, and as from 2005, the sale of iodised salt has been compulsory in all sales outlets.
Last, but by no means least, the Ministry of Health is highly attentive to problems relating to food allergies and intolerance. Coeliac disease is today the world's most common food intolerance, and the sheer number of people suffering from it makes for a considerable burden on the NHS. The only way presently available to fight coeliac disease is to observe a strict, gluten-free diet. To help improve the quality of life of those suffering from coeliac disease, in addition to the free supply of gluten-free foods, the State has also established a law dictating that school, hospital and public canteens must, at request, be able to supply gluten-free meals and that staff working in the catering industry must be suitably trained to ensure a safe meal outside the home.

1.10. Special diets

During the two-year period 2012-2013, the Ministry of Health continued its direct verification and control of products for athletes, those for special medical purposes, gluten-

free items (pursuant to Directive 2009/39 and Regulation 41/2009), of low sodium salt options and reduced lactose foods; these foods come under the scope of Directive 2009/39 and are classified as foods intended for a special diet and "diet" foods. The Ministry has also continued to verify and control products constituting the exclusive source of nourishment for babies up to the age of 6 months (pursuant to Ministerial Decree n. 82/2009 incorporating Directive 141/2006).
It has also taken an active part on a European level in revising the legislation that has resulted in the publication and adoption of the new Regulation (EU) 609/2013 on foods for specific groups (FSG).
As from July 2016, this regulation will abrogate the sector of foods intended for specific diets and, therefore, the concept of diet foods, to include in its scope of application only the provisions relating to products for babies and weaning products, baby food, food for special medical purposes and foods intended to entirely replace the diet.
The Ministry has been involved in the works relating to the rules connected to the Regulation (EU) 609/2013 that began in 2013, and which draw to a conclusion late 2014 or early 2015.
2013 also saw the monthly publication of the three sections of the National Register of products for special diets available from the NHS in accordance with Ministerial Decree of 8 June 2001, which was initially updated once a quarter.
Under the scope of training delivered to staff in charge of the official controls, three courses have been organised on the legislation governing baby food.

Keywords Dietary foods, foods for babies, foods for special diets, food for special medical purposes, foods without gluten, low lactose content foods, low sodium salt products/ foods for athletes, weaning foods

1.11. Promotion of the health of migrant populations and the fight against the diseases of poverty

Every foreign citizen may use the public health services (Law n. 40/1998). Nevertheless, obstacles have often been identified in gaining access to health services. A summary is given of the main national initiatives for the promotion of the health of immigrant populations.
The Health Ministry takes part in the European project EQUI-Health, with the aim of promoting the health of vulnerable immigrant populations, those requiring asylum and illegal immigrants, the Romany population and ethnic minorities. It envisages the promotion of health and social integration for immigrants to Member States in the Mediterranean Region.
As part of the National Strategy for the inclusion of the Romany people, settled and nomadic, a national round table was established on the issue of "Health" with the aim of defining guidelines and actions on: access to health and social services; health prevention; diagnosis and treatment; the training of operators.
Various projects of the Health Ministry's National Centre for Disease Prevention and Control have the aim of improving access to services and the use of the service by the immigrant population.
The Interregional Immigrants Board, established in 2008, has drawn up the "Instructions for the correct application of the regulations for health care to the foreign population by the Regions and Autonomous Provinces".
Since 1997, the National Institute for Health (ISS) has coordinated the Italian National Focal Point Infectious Diseases and Migrants, a network made up of over 70 experts from public and non-governmental organisations in various Italian Regions, which is concerned with the health of immigrants with specific focus on infectious diseases.
As part of the European project PROMOVAX (Promote Vaccinations among Migrant Populations in Europe), the ISS-CNESPS, in collaboration with the Health Ministry, created an "Instrument for Health Professionals" in 2013 aimed, in particular, at general practitioners and freelance paediatricians who treat immigrants in order to promote the overcoming of obstacles in the access to vaccination services, providing information to health professionals directed at the vaccination needs of immigrant populations.

The INMP distributes health care to the disadvantaged immigrant population through its multi-specialist outpatient clinic, ensuring direct access to health services with the backing of a large staff of cross-cultural intermediaries. Since 2011, INMP has ensured the supply of free medical devices in various treatment settings to the weakest bands of the population through the Health Ministry's social medicine projects. The three-year development plan, approved in the State-Regions Conference, envisages the establishment of an epidemiological monitoring centre and the organisation of a national public health network to be created through the active participation of the Regions.

Keywords Health care, immigrants, infectious diseases, health promotion, vaccinations

1.12. Implementation of the document drawn up to guarantee the safe use of chemical products

The programmatic document of the Health Ministry 2012-2013, in the context of the European regulatory framework on chemical products (REACH and CLP), was mainly directed towards the coordination of the control activities, the risk assessment of chemical substances, including in the form of nanotechnology, and the promotion of the pro-active citizen. In the two years in question, two National Control Plans on chemical products have been issued and coordination with the Regions was reinforced, which led to the increase in the number of controls compared to 2011 and the launch of a national network of laboratories able to provide the appropriate analytical capacity to the control of documentation. The Health Ministry has coordinated Italian participation in the community assessment plan of certain chemical substances (Community Rolling Action Plan), activities carried out in parallel with those of arranging dossiers for uniform classification, those in support of the decisions of the ECHA with regard to the compliance of the substances registration dossiers, the valuation of the biocidal active principles. With regard to the risk assessment of the substances in nanometric form, the competent REACH authority in the two years in question has taken the role of national coordinator of the European project NANoREG, in the context of the 7th Framework Programme for research, the objective of which is the integration of the research activities in the risk assessment sector of the risk of nanomaterials with community actions for their regulation.

In the sphere of the activities to increase the awareness of the citizens, information initiatives in schools have continued and the promotion of the awareness of citizens' rights to be informed about the presence of extremely worrying substances in consumer products was launched.

Finally, the competent REACH authority undertook the activity of reinforcing the flow of information that draws on the National Information System for the Surveillance of Hazardous Exposures and Poisonings (NISSHEP) as a source of useful data for conducting in-depth, targeted surveillance of the hazardous nature of products, with particular reference to those newly introduced on the market.

Keywords Control activities, nanomaterials, hazards, chemical products, risk assessment

1.13. National Asbestos Plan

The risk of mesothelioma and asbestos-related diseases has affected and continues to affect workers and people in contaminated sites. During the second Government Asbestos Conference (Venice, 22-24 November 2012), all members involved compared notes with jurists, scientists and epidemiology and clinical experts from the university and NHS, in order to prepare a proposal for a National Plan inclusive of guidelines for actions to be taken against the various problems identified. The National Asbestos Plan gives a description of the objectives and main guidelines to be adopted over the coming years. Its management calls for political coordination on a government level, and technical coordination with the presence of representatives of the Ministries involved (Ministry for Development, Ministry for Economic Development, Ministry for Employment and Ministry for the Environment and the Protection

of the Territory and the Sea), the central technical institutes of the various administrations involved, representatives of the Autonomous Regions and Provinces, trade union organisations and associations of victims and those exposed to asbestos. The aims and objectives relate to three separate macro areas (protection of health, protection of the environment and aspects of safety at work and social security), which are considered as a single element comprising the Plan itself; thus they must be related and managed in a coordinated fashion.
Aspects relevant to the public health and individual risk assessment, therapeutic possibilities and early diagnosis must be investigated and require the networked organisation of the specialised centres.

Keywords Asbestos, mesothelioma, National Asbestos Plan

1.14. Diabetes Plan

The Diabetes Plan has been prepared by the National Diabetes Commission established by the Directorate General for Health Planning in order to pursue the implementation of Italian Law n. 115/1987 and the 1991 Understanding, following up on the European guidelines inviting Member States to prepare and implement their own National Plans for the fight against diabetes. Submitted for review by the diabetics' associations and designated regional representatives, it was approved in the State-Regions Conference on 6 December 2012. The document lays down ten general objectives aimed at reducing the impact of the disease on people with or at risk of diabetes, on the general population and on the NHS; for each, specific objectives are listed, along with strategic guidelines and priorities. The need is stressed for a progressive transition towards an integrated model aimed at optimising both the specialised diabetology network and all primary care players, with a view to guaranteeing quality of life, preventing and treating complications, optimising the use of resources and ensuring primary prevention and early diagnosis. The fundamental assets on which to consolidate a national strategy that is compliant with the organisational models and specificity of the individual Regions are discussed. Finally, the areas considered as priorities in improving diabetes assistance are indicated, for each identifying essential aspects and critical issues, proposing objectives strategic guidelines, possible interventions and monitoring. Special attention is paid to diabetes assistance in children, in the transition from childhood diabetes to adult diabetics, the appropriate use of technologies and new devices and the role played by diabetics' associations.

Keywords Diabetic assistance, diabetic disease, diabetology transition, early diagnosis, health planning, Health Technology Assessment (HTA), integrated management, Law n. 115/1987, primary care, primary prevention, specialised diabetology network

1.15. National rare disease plan

Italy has included rare diseases under sectors of priority interest in public health since 1998 and, the first of European States to do so, it has equipped itself with a specific legislation in this respect, Ministerial Decree n. 279 of 18 May 2001. The operating procedures for its application, including the activities of the national register, have been shared through Agreements in CSR and with implementing projects of the NHPs, specific finances have been allocated to regional projects.
However, the Recommendation 2009/C 151/02, whereby the European Council and Commission specify that Member States should adopt a national rare disease plan, provided the recent occasion to adopt a further planning tool with which to design a national strategy coherent with the initiatives already in place in Italy and ensure homogeneity of all actions.
The scheme of the NRDP, after a brief introduction, presents the European and national legislation and examines critical aspects of how assistance is organised, describing the national network of the tools and instruments used to coordinate regional activities. It discusses the national monitoring system (national register and regional registers), the problems of encoding rare diseases and data-

bases (pathology registers and biobanks), the diagnostic and assistance route and the tools for therapeutic innovation (including orphan drugs). A paragraph is given over to the associations, which play a role of stimulating specific policies, research and healthcare interventions.
The draft plan emphasises the value of information, not only with regards to health professionals, but also patients and their families. A chapter is reserved to prevention and early diagnosis, given that people suffering from rare diseases often encounter difficulties in obtaining a timely diagnosis and receiving appropriate treatment during the early stages of the disease, when, at times, its progress and quality of life can be improved.
The third part of the document presents the methods of implementation and tools for monitoring the plan, with specific reference to the sections treated. It also gives useful indications on how to approach the problem in an organic fashion. The critical issues to be broached include the training and the networked work of the structures, and the professional optimisation of healthcare professionals for a more effective service for patients.

1.16. The protection of health of prisoners, internees and children subject to restrictive measures by Legal Authorities

With the Prime Minister's Cabinet Decree of 1 April 2008, all health functions concerning penitential institutes and institutes and services of juvenile justice system have been transferred from the justice administration to the NHS.
In order to govern the transfer process and monitor the difficulties of application, each Region has established a permanent observatory on penitential health, with representatives of the Region, the penitential administration and children's justice, whilst, on a national level, a permanent round table has been established on penitential health, with the involvement of the same institutions.
National coordination led to the approval by the Unified Conference (UC), from 2009 to 2012, of a series of agreements aimed at providing more specific planned guidelines. More specifically, reference is made to: 1) Guidelines on healthcare structures under the scope of the penitentiary system; 2) Guidelines on health data, information flows and computerised medical records; 3) Guidelines for the assistance of children subject to provision by the legal authority; 4) Guidelines to reduce the risk of self-harm and suicide of inmates, internees and children subject to criminal provisions; 5) Guidelines on HIV and imprisonment.
In 2012, the approval of Italian Law n. 9 gave a new boost to the process by which to overcome forensic psychiatric hospitals (OPG), providing for the development of protected territorial structures (REMS) managed exclusively by the healthcare service and intended to host people currently assigned to OPGs and allocating specific finances. In 2013, the Regions prepared programmes for the development of structures, approved by the Ministry of Health, which authorised the assignment of the finances. The evaluation of programmes for the assignment of current loans is underway for the years 2012 and 2013.

Keywords Forensic psychiatric hospitals (OPG), inmates, internees, penitentiary health, permanent round table, protected territorial structures (REMS)

2. The network of prevention

2.1. Prevention Departments

The prevention work carried out within the NHS plays a strategic role, considering that the future sustainability of the health system in a population that continues to age depends greatly on the capacity to reduce the burden of the disease. In these terms, the organisation of services is crucial and the Prevention Departments are the structures that are institutionally most involved. The Prevention Departments actually come under the scope of the institutional structures (which derive from the reform of the NHS of the years 1992-1993, i.e. Italian Legislative Decree n. 502/1992 and Italian Legislative Decree n. 517/1993) and that of the planning acts (NPPs).

Most of the Regions have organised the Prevention Department, albeit autonomously, on the basis of the macro areas/structures described in the mentioned legislation. However, only part of the prevention activities is carried out directly (or at least coordinated) by the Prevention Department Services, whilst entire segments (e.g. secondary prevention interventions) are generally aggregated to clinical diagnosis and treatment services and, on the other hand, increasing operative responsibilities (consider the promotion of a healthy lifestyle) involve other organisational structures, such as Districts.

It is objectively difficult both to analytically verify prevention activities and to report these to the dedicated (human and economic) resources, as well as to consider to what extent they account for 5% of the health fund share, considered as standard by the so-called Agreement for national health for "prevention" assistance levels.

In line with the principles laid down by the Prevention Plans, prevention must be strengthened and extended, above all privileging an inter-sector approach that, coherently with the evidence available today, is associated with greater effectiveness in assuring prevention. This increasingly requires the involvement of different professionals and action taken not only in the form of the direct organisation of services and activities, but also with respect to the network of players and significant relations (governance) to assure the efficacy of the prevention.

In addition to maintaining the activities entrusted to them as institutions previously, the Prevention Departments are therefore also called to meet further challenges entailing an organisational and managerial change to be managed and monitored.

3. The territorial district networks

3.1. Primary care and continuity of care

The reorganisation of primary care, introduced by Italian Law n. 189/2012, provides for the compulsory establishment of aggregated single-professional and multi-professional forms (territorial functional aggregations, AFT; Complex Primary Care Units, UCCP), including GPs, in all their functions, Primary Care Paediatricians (PCPs), outpatient specialists and other healthcare professionals present in the territory, also in order to enable the active offer of provisions and services, the global, timely and unitary management of the patient, the continuity of assistance every day of the week and throughout the whole day. In order to effectively implement the law, new Collective National Agreements (CNAs) need to be signed and in 2013, works was done on preparing the Guidance for authorised medicine by the Committee of the Regions-Health Sector, in the meeting held on 12 February 2014, prior to their issue.

As concerns primary healthcare, with the State-Regions Agreement of 22 November 2012, the national planning established, for 2012, the identification of funds dedicated to the presentation of specific regional projects, in implementation of the planning guidelines of the NHP. Under this scope and as concerns primary healthcare, 43 projects have been prepared aimed at re-qualifying territorial assistance and prepared by 15 Regions. The programme deeds sent and the completion of LEA checks have shown that the following organisational models have been activated and/or are currently being activated:

- 123 Healthcare Residences in Tuscany (50), Liguria (3), Emilia Romagna (49), Umbria (2) Molise (4), Marche (14) and Lazio (1);
- 42 Territorial Healthcare Trusts (PTA), of which 35 in the Region of Sicily, 5 in Molise and 2 in Abruzzo;
- 34 Territorial Primary Healthcare Units (UTAP), of which 32 in the Region of Veneto and 2 in the Region of Abruzzo;
- 175 Functional Territorial Aggregations (AFT), of which 164 activated in the Region of Veneto and 11 in the Region of Basilicata, but for which further activation is envisaged over the whole of national territory.

Moreover, 6 out of 15 Regions, namely 40%, have envisaged the identification of organisational methods by which to guarantee healthcare in H24 and enable the reduction of improper use of emergency structures (Liguria,

Table. Continuous care activities (Year 2012)

Region	Appointed doctors (MCA)	Doctors per 100,000 inhabitants	Contacts per 100,000 inhabitants	Prescribed hospital admissions per 100,000 inhabitants	Total hours of activity
Piedmont	424	10	13,939	399	974,283
Valle d'Aosta	16	13	16,982	899	63,842
Lombardy	1,027	11	11,229	323	1,632,260
Aut. Prov. of Bolzano	24	5	3,409	0	24,553
Aut. Prov. of Trento	41	8	16,956	1,226	231,725
Veneto	635	13	13,056	246	1,067,496
Friuli Venezia Giulia	164	13	14,314	452	309,347
Liguria	252	16	8,154	482	326,729
Emilia Romagna	620	14	17,056	144	1,209,970
Tuscany	667	18	17,446	543	1,054,348
Umbria	221	25	20,931	407	373,916
Marche	382	25	22,507	253	564,571
Lazio	638	12	5,478	142	948,962
Abruzzo	404	31	20,848	268	605,002
Molise	158	50	35,704	626	293,855
Campania	990	17	21,336	237	1,839,528
Puglia	986	24	16,717	209	1,332,977
Basilicata	432	75	26,975	401	721,544
Calabria	880	45	45,170	14,878	1,706,967
Sicily	2,052	41	30,456	318	2,187,816
Sardinia	1,014	62	25,883	783	995,192
Total	**12,027**	**20**	**17,260**	**796**	**18,464,883**

Source: Health Ministry – National Health Digital Information System (survey form FIS21 Health Ministry Health Decree 5 December 2006); Istat – Residential population at 1 January 2012.

Emilia Romagna, Marche, Campania, Sicily and Abruzzo).

In 2012, general medicine was guaranteed throughout national territory by 45,429 GPs, with an average in the number of choices of 1,156 users per GP. In 2012, PCPs totalled 7,656, with an average number of patients per doctor of 879. The Continued Care Service involved 12,027 doctors, who provided a total of 17,260 contacts per 100,000 inhabitants.

Keywords Territorial functional aggregations (AFT), Healthcare residences, continued care, general practitioners (GPs), primary care paediatricians (PCP), Territorial Healthcare Trusts (PTA), Complex Primary Care Units (UCCP) and Territorial Primary Healthcare Units (UTAP).

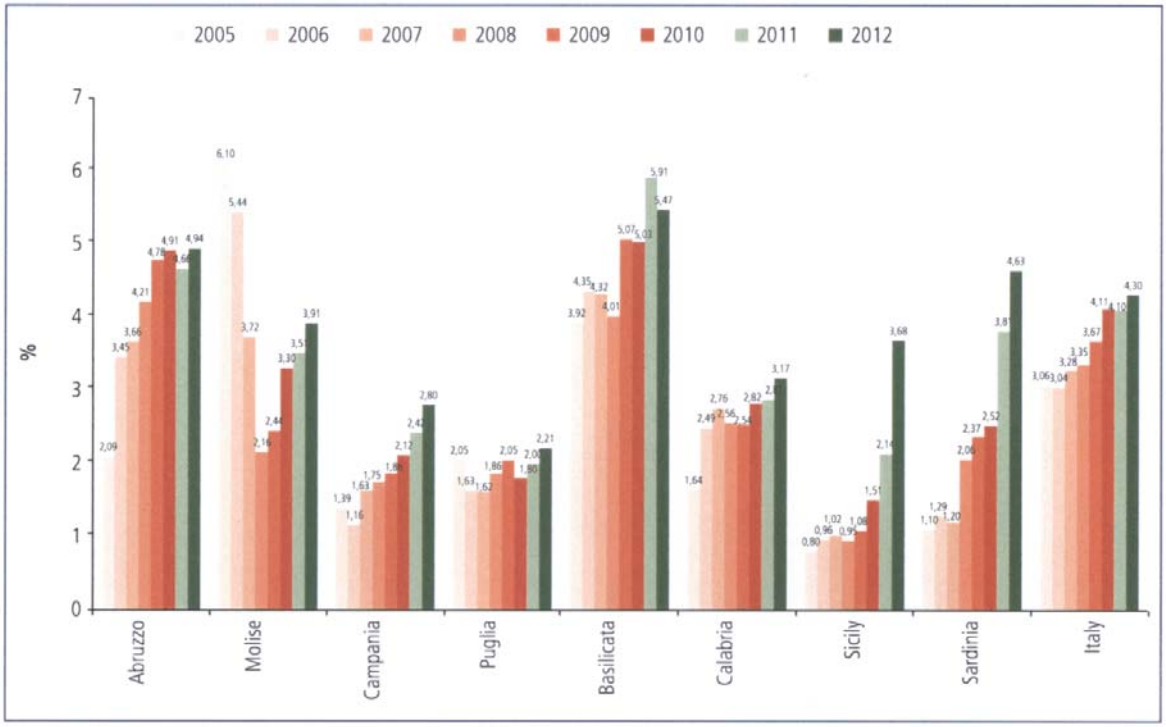
3.2. Care for the elderly and non-self-sufficient people

The demographic evolution, marked by a progressive reduction in birth rates and a greater survival rate, will, in the near future, go hand-in-hand with increased health and social-health needs connected with ageing and increased spending in this sector.

Faced with this evidence, the consolidation of territorial services coordinated by the district is a priority, and must be able to guarantee:

- unitary access to treatment, by means of the "Single Access Centres" (SACs) able to provide an effective, immediate response to the patient with simple treatment needs and ready to begin a structured route of management of patients with complex clinical and social-family problems;

Figure. Percentage of elderly people treated under Integrated Home Care (IHC) [Years 2005-2012].



- the multi-dimensional assessment of the patient by the multi-disciplinary team;
- the definition of the customised assistance plan and identification of the more appropriate care setting.

Assistance can be offered to non-self-sufficient patients in different settings, including at home (IHS), which is known to be the best option, as it enables the delivery of health and integrated social-health services, even if particularly complex and requiring intense assistance, in the home and familiar surroundings of the patient, thereby reducing the risk of inappropriate hospitalisation. However, if the patient's specific clinical problems, together with the lack of a suitable social-family network, should make home care inappropriate, the NHS guarantees residential and semi-residential assistance, of different levels of intensity, aimed at recovering and/or maintaining clinical conditions.

The need to start processes monitoring territorial, home and residential assistance, to evaluate the assistance provided and how appropriate it is, becomes concrete with the coming into force, in 2012, of two national information flows; these are respectively focused on home care (SIHS) and on residential and semi-residential care (FAR) to non-self-sufficient people, which enable a picture to be drawn of the social-health assistance with reference to the various stages of the care and the complexity and intensity of care required in the treatments provided.

The first data obtained from the two flows highlights some critical issues with respect to which intervention is necessary both through the strengthening of services and the reorganisation of care paths, integrating healthcare professionals and better connecting territorial services with other nodes of the healthcare network (primary care, hospital assistance and prevention).

3.3. The role played by the pharmacies

With the law n. 69/2009, new services of "great social and health value" are envisaged that can be distributed by public and private pharmacies within the scope of the SSN, aimed at ensuring that pharmacies can participate in the integrated home care service in support of the activities of the general practitioner, collaborating in health education programmes for the population, carrying out