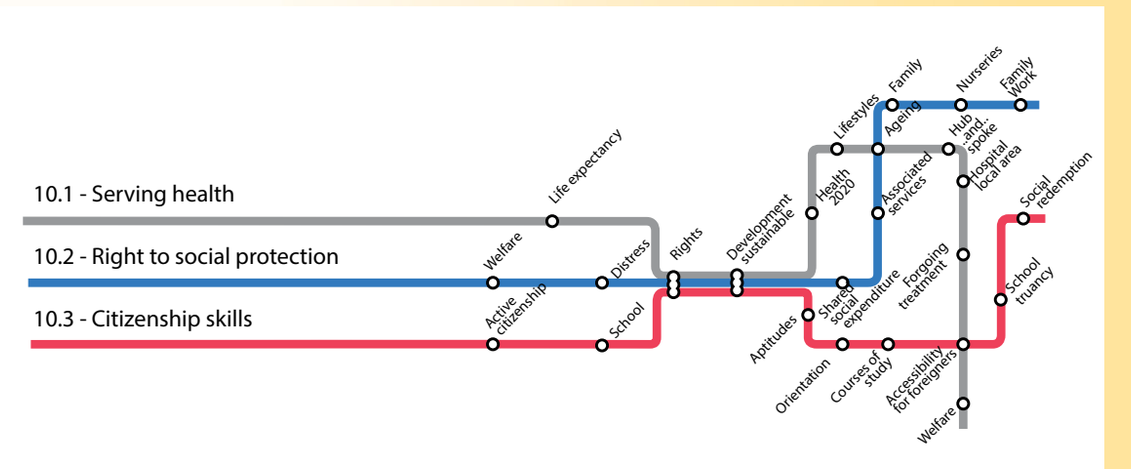
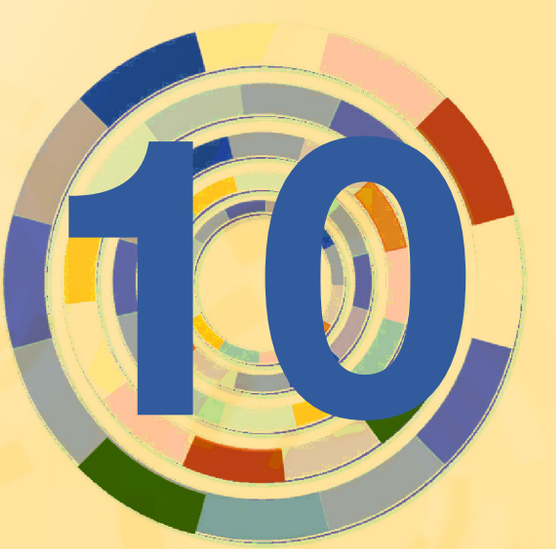
The path towards social inclusion of all citizens is a current matter of urgency for sustainable growth. Guaranteeing social inclusion means giving everyone the opportunity to enjoy basic standards, reducing the great social inequality which can also result from fragile family backgrounds, and giving everyone the chance to live in accordance with their own values and to improve their own conditions.

Social rights and governance are closely related and society as a whole has more opportunities to progress if its citizens are educated, healthy and active, rather than ignorant, sick and unemployed. For this reason, efforts to facilitate inclusion must be implemented through specific measures, as expressed in our Constitution, according to which "it is the duty of the Republic to remove those economic and social obstacles which effectively restrict the freedom and equality of citizens, prevent the full development of the human being and the effective participation of all workers in the political, economic and social organisation of the Country" (art. 3).

Investing in key individual rights, such as health, social welfare and education, reducing inequalities and access barriers, represents a road to the fair and sustainable development of society, which also has tangible repercussions on the economic progress of a local area. In certain cases, this investment involves public spending, sometimes to reorganise services, and at other times to review intervention priorities or to reduce obstacles to accessibility.



Social inclusion, a journey through rights and services



10. Social inclusion, a journey through rights and services

Sustainable growth requires mutually reinforcing economic and social policies that coalesce to ensure that the new opportunities are guaranteed for all, thus creating a sound and closely knit social fabric which in turn encourages further growth. This is what is meant by the expression "social inclusion" in the context of the EU: "substantive opportunity for individuals to live according to their values and choices and to overcome their circumstances", in a setting where "all persons and groups enjoy essential standards and disparities among persons and groups are socially acceptable, the process through which these results are achieved being participatory and fair"[1].Access to essential standards, or rather to services which are deemed essential for leading a dignified life, and the chance to improve one's own quality of life should not be for the few, but should be guaranteed for everyone with a view to removing social inequalities, opposing the lack of opportunities which may result from fragile social and ethnic backgrounds or from specific individual vulnerability. It means promoting a harmonious context and bridging any gaps within local areas, social groups and people.

Inclusion refers to citizenship rights: access to social rights (to improve one's own circumstances), such as education, work, health, housing, environment, security and income, the protection of which requires active government intervention, and access to political rights to participate actively in the process. The mutual conditioning of social and political rights should be highlighted: if political rights are the tool for asserting social rights, then it is just as true that bulking up the offer of public goods and services (take education, for example) also enables individuals to act, improves social capital and democratic involvement in decision-making.Citizenship rights are similarly expressed in Constitutions, universal Declarations (such as the Universal Declaration of Human Rights of 1948) and in many supranational Conventions. The notion that the State sees to the welfare of all of its citizens is not only acknowledgement of individual usefulness, but an assertion that society as a whole has more chance of progressing if its citizens are educated, healthy and active, rather than ignorant, sick and unemployed.

This is also clearly aspired to in our Constitution, according to which "it is the duty of the Republic to remove those economic and social obstacles which effectively restrict the freedom and equality of citizens, prevent the full development of the human being and the effective participation of all workers in the political, economic and social organisation of the Country" (art. 3).

With the intent to promote the economic and social progress of its members, the preamble to The European Social Charter of the Council of Europe[2], reaffirms "the indivisible nature of all human rights, be they civil, political, economic, social or cultural". Among the social rights, the Charter acknowledges the right to occupation freely entered upon, in safe conditions and with fair remuneration, the right to education and training, to social security, to the protection of health, the right to benefit from high quality social services, to access housing of an adequate standard and the right to protection from poverty and social exclusion. These rights go hand in hand with political and civil rights, such as the right to freedom of association and to collective bargaining to defend one's own economic and social interests.In other words, if every right is in itself necessary, then its realisation in the absence of other rights and certain conditions is not sufficient to attain social inclusion.

Understandably, the fabric of inclusion and citizenship is still being woven, introducing new rights along the way, like a healthy environment and provision of correct information, and involves new subjects, such as migrants. The unification of Europe, which is broadening the concept of citizenship, enhances that of inclusion: civil, political and social rights in force in each country are extended to the citizens of all Member States living in that country. At the same time however, this creates a new identity: a ***non-EU citizen*** is an individual who is not a citizen of a Member State and who only partly enjoys the political rights and has fewer social rights, which remain essentially linked to nationality.

[1] Guglielmo Wolleb, "*Le politiche di coesione dell'Unione Europea – obiettivo inclusione sociale*", 2009.
[2] Drafted in 1961 and revised in 1996.

The European Union recommends reducing citizenship deficits, even more so during this time of crisis, in which the risk of groups of people or local areas falling into the trap of social exclusion could increase. As we have seen, there is a wide-ranging and varied set of social rights. Further on in the chapter we would therefore like to take a closer look at some of these that are not covered in other parts of the publication: the right to health, to social services and to education. In the next chapter we will take a more in-depth look at the context in which freedoms and social rights are exercised: the law, justice and security.

10.1 Serving health

Healthcare is an essential social right which guarantees one of the most important rights of the individual: the right to health. It is a fundamental and inviolable right acknowledged by our Constitutional Charter, whereby citizens can assert their rights to the protection of physical and mental integrity of the human being, both in relation to the State and the public institutions and in relation to private parties or employers. The protection of health is also in the interest of the community: not only does guaranteeing treatment to all individuals satisfy the requirement of safeguarding the interests of individuals, but, at the same time, it also pursues the objective of protecting the health of the community. The universal nature of this right rules out the possibility of accepting inequalities in health and access to health

Health inequalities are a threat to the collective health

services: the World Health Organisation considers these inequalities "unfair and wholly avoidable" [3], within the countries and between the countries. In the Health 2020[4] document, the same Organisation provides a strategic action plan aimed at improving health and well-being within the European region. The common objective is to "significantly improve the health and well-being of the popultions, reduce health inequalities, strengthen public health and ensure people-centred health systems that are universal, equitable, sustainable and of high quality". Specifically, WHO urges the countries of the Union to pay more attention to the risk of an increase in health inequalities due to uncertain economies. It must be clear that investing in the health of people means investing in society.

A better state of health contributes to growth

What makes a society grow also has a positive effect on the health of the people, but the contrary is also true, or rather, that a good state of health, as well as being a value in itself, is also the foundation for social and economic development.

Health in fact contributes towards greater productivity, a more efficient workforce, healthier ageing, and more limited expenditure for health and social benefits.

Futhermore, we must not forget that health and healthcare are fully-fledged economic systems: not only does the healthcare sector affect the health and productivity of people, but it is also one of the most important sectors of the economy in many developed countries, as it employs many people, invests in production and consumes products and encourages research and innovation, thus creating ties with many other economic markets.

The current situation appears fragile, as the difficult economic and financial status of many countries poses complex challenges, risking to undermine progress already made and the ability to sustain healthcare costs, and thus failing to ensure adequate healthcare and social protection. For this reason, the health systems of the various European countries, at both national and local levels, are urged to improve their services by implementing those which are more suited to socio-demographic requirements and new disease patterns. Priority must be given first and foremost to prevention, through a lifetime approach, to favour healthy and "active" ageing. The healthcare systems must be reorganised, with integrated people-centred services, moving care as close as possible to the patient's home. Another important recommendation requests reinforcement of citizen participation: enhancing the fact-finding and intervention tools available to people, including in associations, enables them to monitor their own lifestyles, have a say in their

Active participation of citizens for the protection of their own health

own health, in disparities in quality and in the provision of healthcare.

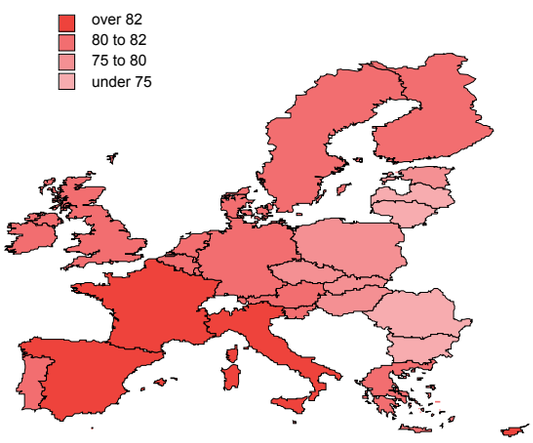
All this is in line with the provisions of the WHO Constitution: "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being".

[3] WHO, "*Rio Political Declaration on social determinants of health*", 2011.
[4] WHO, "*Health 2020: A European reference policy framework supporting action across government and society for health and well-being*", September 2012, www.salute.gov.it/imgs/C_17_pubblicazioni_1819_allegato.pdf

ATTENTIVE TO SOCIAL RIGHTS TO PROMOTE INCLUSION

DIFFERENT FROM AS EARLY ON AS BIRTH IN EUROPE

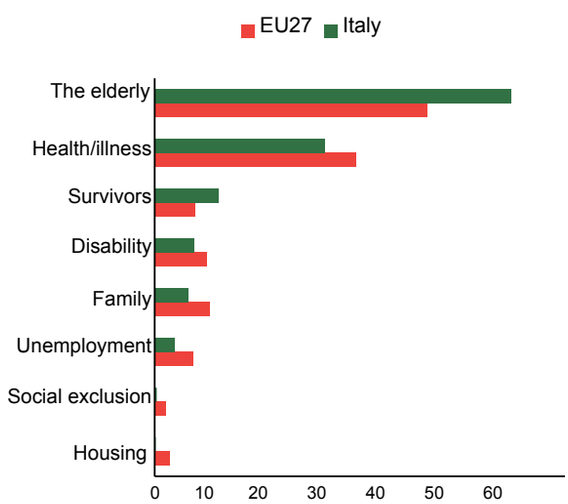
Life expectancy at birth (in years) Year 2011



	Males	Females
Veneto	79.8	85.0
Italy	79.4	84.5
EU27	77.4	83.2

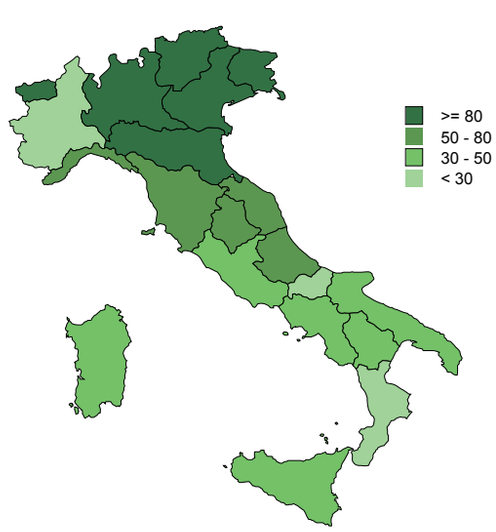
POORLY BALANCED WELFARE ACTIONS

% Social protection expenditure by category Year 2011



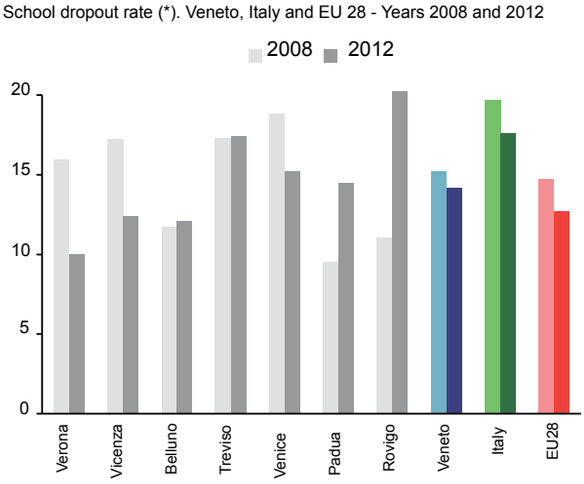
VENETO IS PUTTING ITS HOPES IN YOUNG CHILDREN…

% of municipalities which have implemented early childhood services Year 2011



AND IS STRIVING TO EDUCATE THE LITTLE ONES

School dropout rate (*). Veneto, Italy and EU 28 - Years 2008 and 2012



(*) Population aged 18-24 years with at most a middle school diploma, who are not attending training activities/Population 18-24 years x100

Source: Processing by Veneto Region - Regional Statistical System Section on Eurostat, WHO and ISTAT data

Fewer inequalities and a healthier population

There are some inequalities between European countries in terms of health, due to different economic statuses, different lifestyles and the level of efficiency and accessibility of health services.

Some of the longest living people in Europe right here in Veneto

Turning to life expectancy, a health indicator which can easily be compared between different countries, the gap between States currently amounts to as much as 9 years, thus confirming the presence of inequalities in this context, too.

Eastern European countries have a lower life expectancy, while Italy is among the most long-lived countries, with a life expectancy of 83 years. The age is slightly higher in Veneto and women can expect to live until as old as 85.

One of the common health objectives at an EU level is to increase the life expectancy of the population. But as well as considering how long people live, it is important to understand how long people live in good health and what makes quality of life optimal. In fact, a good health programme has to think about increasing life expectancy and ensuring a good state of health for the years gained, in line with the WHO slogan "add years to life, add life to years". Encouraging people to stay healthy throughout life causes life expectancy to rise, bringing with it important benefits at an economic and social level, too. Improving health must start from pregnancy and from early childhood development. Healthy children learn better, healthy adults are more productive and elderly people in good health can still actively contribute to society.

The gradual ageing of the population leads to a growing rise in the number of elderly people, with an increase in certain illnesses, especially chronic disease. The more they are guaranteed a healthy life, including through appropriate policies and prevention plans promoting healthy lifestyles, the lesser the impact will be on health expenditure to care for and assist this population group. 70-80% of health expenditure in Europe is estimated to be allocated for healthcare costs for chronic diseases, which account 87% of deaths. Hospitalisation of elderly people in Veneto, too, accounts for 45% of the total number of hospital discharges and 60% of days spent in hospital.

This is one of the points of the EU strategy, namely to foster good health in an ageing Europe, aspiring to increase the number of years lived in good health by 2020, to help citizens stay active and productive for as long as possible.

Socio-economic factors significantly influence state of health. Better educated people are generally more aware of the importance of adopting a healthy lifestyle, and those with adequate financial resources can access adequate healthcare more easily.

Lifestyles, income and education affect health

As the Director-General of WHO, Margaret Chan, said "We want to see better health and well-being for all, as an equal human right. Money does not buy better health. Good policies that promote equity have a better chance". Equal access to education, to an adequate income, a good job and adequate accommodation, and reduced disparity are key health-promoting factors.

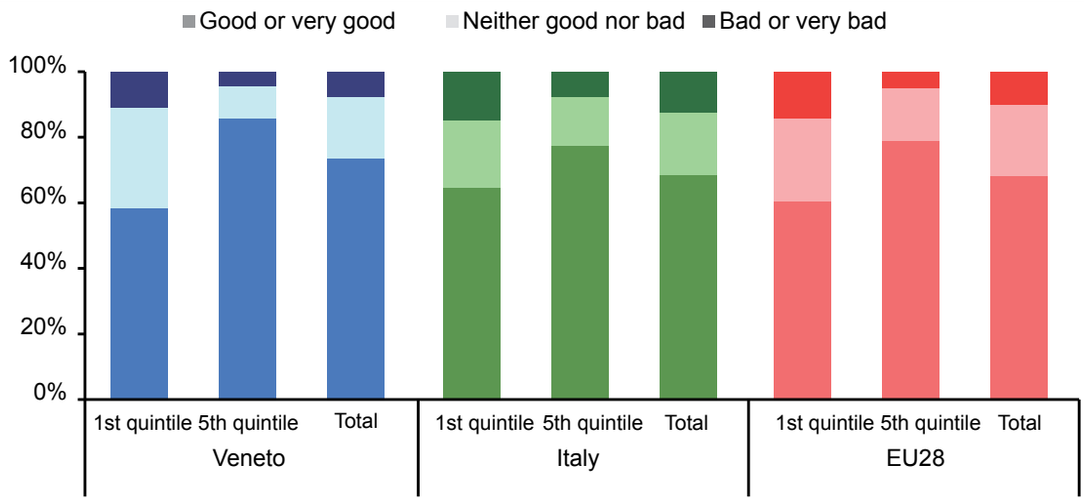
With regard to the family's disposable income, 86% of those in Veneto with high income state that they are in good or excellent health, compared to only 59% of those who, on the other hand, earn very little. There is certainly a substantial and, at first glance, even wider gap than that registered at a national level, but it decreases (falling from 95.8% to 89%) if the percentage of those who claim to be in neither good nor bad health, and therefore all in all in reasonable health, is added, which is especially high in Veneto among those in the lowest income bracket.

Table 10.1.1 - Percentage of people of at least 16 years of age who claim to suffer from chronic or long-term disease by income level. Veneto, Italy and EU28 - Year 2012 (*)

Income quintiles	Veneto	Italy	EU28
1st	27.6	23.9	35.1
2nd	21.4	26.3	36.4
3rd	24.0	26.5	32.3
4th	16.2	24.1	28.3
5th	14.9	21.6	24.9
Total	**20.0**	**24.5**	**31.4**

(*) Households shown in ascending order with respect to equivalent household income; the 1st quintile contains 20% of households, those with the lowest income, and the last quintile, the richest 20% of households
Source: Procressing by Veneto Region - Regional Statistical System Section on Eurostat and Istat data

Figure 10.1.1 - Percentage of people of at least 16 years of age by declared health status and income level. Veneto, Italy and EU28 - Year 2012 (*)



(*) Households shown in ascending order with respect to equivalent household income; the 1st quintile contains 20% of households (those with low income), and the last quintile contains the 20% of richest households.
Source: Processing by Veneto Region - Regional Statistical System Section on Eurostat and ISTAT data

Chronic disease and long-term health problems also have a greater incidence in the less well-off population groups (28% compared to 20% of the overall population and 15% in the highest income bracket).

Services close to the city

Changing healthcare needs and the emergence of new challenges produced mainly by the rise in life expectancy, along with the gradual ageing of the population and the increase in chronic and degenerative disease, often linked to disability, makes it necessary to rethink the service organisation model to ensure that the system is economically sustainable.

Regional Law no. 23 of 29/06/2012 "Regulations applicable to social and healthcare planning and approval of the 2012-2016 Regional Health and Social Plan" defines the reorganisation of the health and social system in Veneto to be implemented over the 2014-2015 two-year period, in order to adapt legal standards, to ensure that care is more appropriate and that resources are more fairly distributed and to adopt more efficient management models. The aim is to reduce the inappropriate burden carried by the hospital facilities that prevents effective and efficient allocation of resources. The hospital is reserved for treating patients in acute phases of illness or in the immediate post-acute phase, referring more markedly chronic long-term social care and prolonged rehabilitation to the local area, in accordance with network and cooperation logic, to ensure that full responsibility is taken for the person and to guarantee continuity of care. On the one hand, this requires relaunching the hospital function and on the other, strengthening the services of the local area, to provide a solution which is close to home for the chronically ill and which gives the acutely ill the guarantee of being able to go where they can receive the best treatment. The intention is therefore to provide care which is as close as possible to the patient, consistent with high quality, safety and effectiveness of the treatment required, with a positive impact on the relationship of people with the health system and in terms of access to services.

Investment in the local area aims to redesign the network of services in the context of a chain of care able to guarantee a system of graduated healthcare, with varying degrees of intensity that is close to the needs of the person. The strategic objectives are to renew the role of the social and healthcare district, reinforce home help, restructure residential care and develop intermediate non-hospital care facilities, to ensure an adequate transition from the hospital into the local area.

At the same time, the regional plan for health and social services (PSSR) aims to completely streamline

Network hospitals for timely and appropriate treatment

streamlining of the hospital network: hospitals are defined, conceived and connected to each other according to a network logic, in such a way as tomake it easier for citizens to access general services and streamline access to more complex and high tech specialist services. The hospital network is a hub and spoke model, which involves concentrating the most complex caseload in a restricted number of centres (hubs), which handle amounts of activity that enable provision of the the highest quality care and optimal use of the organisational resources available. The activity of these centres is closely integrated by means of functional connections with the activity of the peripheral centres (spokes), which ensure healthcare for the remaining caseload.

The hospital network in Veneto is therefore composed of two levels: provincial hub hospitals and network hospital units (spoke). Provincial hub hospitals are highly specialised for a more extensive area, as well as having general services and a medium level of specialisation, representing hub centres at a supra-hospital level. Highly specialised services and high tech equipment are allocated with reference to a catchment area of around 1,000,000 inhabitants, taking into consideration low housing density areas.

The network of hospital facilities must offer accident and emergency activities and low and medium level specialist services, and must ensure diagnostic and treatment services (laboratory, anatomical pathology, radiology, dialysis) to be guaranteed within the network including the aforesaid level, representing spoke centres. In addition to these two levels, supplementary acute care facilities which may also have an accident and emergency department, are provided in the network. These can also be single-speciality facilities and are called "network hub hospitals".

The hospitals of Vicenza, Treviso, Belluno, Rovigo and Mestre are provincial hub centres. As well as being hub centres for the respective provinces, the Azienda Ospedaliera di Padova and the Azienda Ospedaliera Integrata di Verona are regional hub centres for certain functions (e.g. for newborn emergency medicine, burns, transplants and cancer surgery), as well as being centres of excellence, including for research, and they are reference points at a national level. Bearing in mind that there are many different locations, there are 40 public network units and network hub hospitals, in addition to 27 private accredited facilities with services that are complementary and supplementary to the public system, sharing the principles of the latter, such as transparency and the optimisation of healthcare quality.

Cardiology services are an example of how the quality of treatment offered has been successfully improved as a result of the network is that of cardiology services.

The cardiology network: an excellent example of the "hub and spoke" model

Acute myocardial infarction (AMI) is one of the main causes of death and disability in the western world; it is one of the most frequent medical emergencies and requires highly efficient healthcare organisation to ensure the most effective treatment in a timely manner.

Hospital services specialising in haemodynamics have been organised according to the hub and spoke model since 2007 in Veneto: the spoke centres are able to ensure daytime cover, while the hub centres ensure cover 24 hours a day, 7 days a week and act as the fulcrum for the outlying centres. The level of specialisation in hub centres can go as high as an interventional cardiologist, accompanied also by the specialisation of all his/her team and the coexistence of third level services (heart surgery), which make it possible to work with the utmost effectiveness and clinical safety. It has long been recognised at an international level that the best clinical results are obtained in centres that are able to provide at least 400 coronary angioplasty procedures per year.

When the ambulance reaches a patient who has suffered a heart attack, diagnosis is confirmed by an electrocardiogram, an electronic copy of which is sent to the provincial centre. This means that it is already possible, during transportation in the ambulance, to identify the hospital to which the patient should be referred, thus minimising operation times. This organisation ensures more appropriate and timely treatment, to the extent that the proportion of cases undergoing coronary angioplasty (so-called "balloon") within 24 hours rose from 18.3% in 2006 to 28.7% in 2012.

Table 10.1.2 - Acute myocardial infarction: hospitalised cases and percentage of cases with angioplasty. Veneto Years 2006:2012

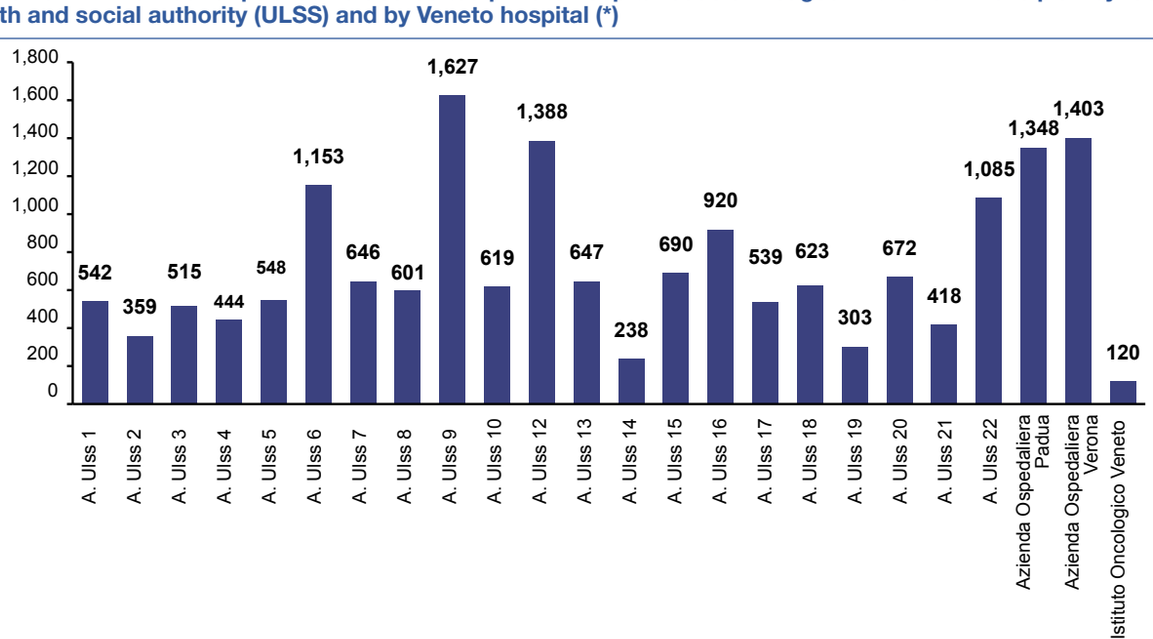
	Events hospitalised	% events with angioplasty	
		during the event	within 24 hours
2006	7,240	42.4	18.3
2007	7,037	43.4	19.6
2008	6,862	45.5	21.7
2009	6,738	48.2	22.8
2010	6,759	51.6	25.4
2011	6,607	54.5	26.9
2012	6,377	56.8	28.7

Source: Regional Epidemiological System processing on Veneto Region data

Completion of the rationalisation process of the hospital network also requires a reductionin the number of hospital beds. As the regional standard, the PSSR (Regional Plan for Health and Social Services) requires standard that the equivalent of 3.5 beds be provided for every one thousand inhabitants, of which 0.5 for rehabilitation, which is slightly below the national parameter of 3.7 (of which 0.7 for rehabilitation), recommended by law no. 135 of 7/08/2012 (the so-called "spending review"). The update involves reducing the number of beds provided in 2012 (18,667 hospital beds), by 1,219 hospital beds, dropping to a total of 17,448 beds in public units and private accredited hospital care facilities for patients living in Veneto by the end of 2015. The update also requires restructuring at a local level for a more just distribution among the local health and social services, as specified in Regional Council Resolution no. 2122 of 2013[5]. As well as accounting for the presence of provincial facilities, planning beds at the local health and social services level satisfies the various levels of health needs and the specific characteristics of the population of the local area.The saving made by reorganising the hospital network has allowed healthcare in the local area to be enhanced, by opening intermediate non-hospital care facilities able to take in patients for whom it is not possible to envisage a home help scheme or for whom it appears incorrect to resort to hospitalisation or institutionalisation. The reduction in beds in the hospital network (-1,219) goes hand in hand with the increase in beds in non-hospital facilities (+1,263). At the end of June 2011, there were 1,755 beds in intermediate care facilities (hospices, community hospitals, territorial rehabilitation units, rehabilitation institutions and centres, therapeutic

Better distribution of hospital beds throughout the local area

Figure 10.1.2 - Number of public and accredited private hospital beds envisaged in the 2014-2015 plan by local health and social authority (ULSS) and by Veneto hospital (*)



(*) Regional Council Decree no. 2122 of 19 November 2013
Source: Processing by Veneto Region - Regional Statistical System Section on Veneto Region data

[5] Regional Council Degree no. 2122 of 19 November 2013: "*Updating of the hospital endowment sheets of public and private accredited facilities, pursuant to regional law no. 39/1993, and definition of the territorial endowment sheets of the service organisation units and intermediate care facilities. PSSR 2012-2016. Resolution no. 68/CR of 18 June 2013*".

rehabilitation communities),and this should rise to 3,038 by the end of 2015, to reach the optimal overall standard established by PSSR (1.2 beds for every thousand inhabitants over the age of 42).

As a result of the changes made in recent years, our health and social system is one of the most efficient in Italy.

Trentino-Alto Adige and Veneto receive the best feedback on the healthcare system

This is also confirmed by feedback from the citizens who use it.

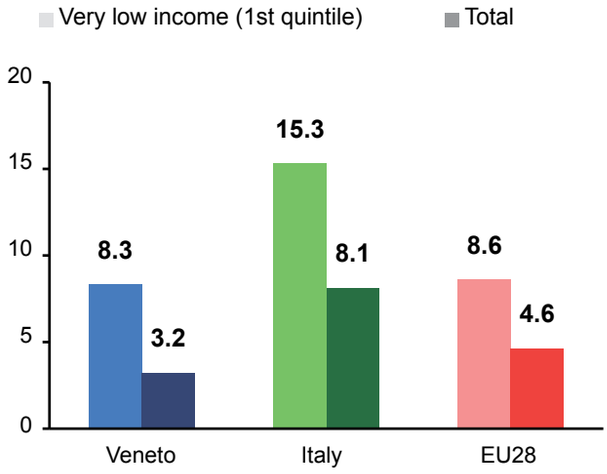
On a scale of 0 to 10, the average level of satisfaction expressed for the public health service is 7.4 points, up half a point on 2005 and above the national average (5.8). 57% feel very satisfied with the medical care received (42% in Italy); nursing care is also considered to be good (57%) and above the national average (41%).

Renounced rights

The recent economic crisis has affected the right to health in our country, too. According to Istat [National Statistics Institute] data, around 7 million Italians - equal to 11.2% of the population - claim that they forgo buying medicinal products or using health services, including medical visits, specialist check-ups and surgical operations, despite their needing them. The reasons for renouncing are mainly of a financial nature (6.2% of the population), but there are also reasons linked to the shortcomings of the offer (4%). The situation is more serious in the South, while forgoing treatment concerns 9.5% of the population in the regions of the North-East, 4.5% of which due to lack of economic funds.

Europe is not excluded from inequalities in access to care either. With the current economic crisis, specialist visits and, even more so, dental check-ups, have become a luxury for some or a privilege which they cannot allow themselves or tend to put off. For example, considering only dentistry services, which are often provided by private facilities and therefore which are payable in total by the patient, in Europe 4.6% of the population forgo check-ups or treatment and the percentage is almost double that among poorer families (8.6%). While the situation in Italy is less favourable, fewer people forgo in Veneto, although poverty-stricken people are still at a disadvantage: 8.3% are unable to pay, compared to 3.2% of the total population.

Figure 10.1.3 - People aged at least 16 who declare that they have had to forgo going to the dentist in the last 12 months for financial reasons by income level. Veneto, Italy and EU 28 - Year 2012 (*)



(*) Households put into ascending order with respect to equivalent household income; 20% of households are found in the 1st quintile (those with the lowest income), and the richest 20% of households are found in the last quintile
Source: Processing by Veneto Region - Regional Statistical system Section on Eurostat and Istat data

Recent cuts to the public health service risk lowering the quality of health services, creating unfairness among the population in terms of access to treatment.

Better-off people can afford private treatment and also fall back on supplementary health insurance, which benefits almost 9 million patients. 23% of people in Veneto declared that they had taken out health or accident insurance in 2012, that is more than one million people. However, the rise in private health expenditure to the detriment of public health expenditure could put those who are unable to pay at risk of receiving less healthcare and forgoing treatment.

Access by foreigners to health services

To address health inequalities, the WHO recommendations include express reference to "ethnic minorities, some migrant communities and groups such as Travellers and Roma", who may, more than others, risk being subjected to more discrimination in terms of the right to health, due to lower living conditions and lower accessibility to services. The universal healthcare mandate is a principle overriding ethnic origin and citizenship, as well asadministrative

regulations concerning residency, being based solely on the principle of solidarity, or rather unwillingness to accept the segregation of people, and with public health as its sole purpose. To this end, the Consolidation Act on immigration[6] states that even "foreign citizens in Italy who are not in compliance with the entrance and residency regulations, are guaranteed urgent, or in any case basic outpatient and hospital treatment, even on a continual basis, for disease and accidents, and they are also covered by preventive medicine programmes safeguarding the health of the individual and of the community". Younger on average than the population as a whole, foreigners residing in the North-East generally enjoy good health (88% ratetheir health positively) and therefore fall back on

Young and healthy: the profile of the foreign citizen in Italy

medical treatment less than Italians.

However, we should draw our attention to two effects: self-selection, whereby those making the choice to emigrate are generally healthy individuals, and the tendency of elderly or ill foreigners to return, where possible, to their country of origin to receive treatment, known in the literature as the "salmon effect". Attention should be given to this aspect, as it can be the sign of a shortfall in accessibility to health services: emotional and religious factors are undoubtedly among the reasons why people return, but other reasons may prevail in connection with the culture gap or economic distress.Access to health services by foreigners does in fact appear to be limited, due to socio-economic marginality, the cultural context in which they live, as well as poor knowledge of our health organisation and existing legislation - not always adequately imparted to foreigners - and also due to language obstacles (for 14%), bureaucratic difficulties (13%) or to avoid being subjected to discrimination (2.7%).

Foreigners undergo medical check-ups, especially if specialist in nature, and diagnostic tests less frequently (20% in the North-East compared to 55%) while they go more to the accident and emergency department,

Fewer routine visits, more emergencies

which is viewed as being easier to access and

thought to provide a more rapid solution.

The hospital is used differently, too: urgent admissions prevail (67% of foreigners admitted compared to 57% of Italians), while there has been a reduction in those choosing to go (e.g. for surgery), especially among men.

Table 10.1.3 - Use of health services by citizenship. Veneto - Year 2012

	Italians		foreigners	
Medical check-ups (a)	54.9		20.0	
Diagnostic tests (a)	26.6		13.2	
Accident and emergency department access rate per 1,000 residents	334.5		412.6	
% emergency admissions on total admissions	56.6		66.6	
Hospitalisation rate per 1,000 residents (b)	Italians		foreigners	
	M	F	M	F
total	74.3	101.4	60.5	141.4
medical	32.2	44.2	32.0	72.5
surgical	42.1	57.2	30.3	68.9

(a) Per 100 residents in the North-East; "Italians" refers to the overall population
*(b) Hospitalisation rate: (residents admitted aged 1-60 years old/population aged 1-60) *1,000*
Source: Procesing by the Regional Epidemiological System on Veneto Region data

Emergency hospitalisation may be a consequence of limited access to treatment, which can transform overlooked disease into situations of emergency. It must however be highlighted that emergencies may at times result from dangerous situations and lifestyles or dangerous working conditions, as shown by data on accidents in the workplace: in 2012, the accident rate of foreign employees in Veneto (6.1%) was way higher than that of Italian employees (3.9%).
Women experience hospitalisation more frequently than men, due to both medical (natural births) and surgical (Caesarians and elective abortions) childbirth admissions. The highest hospitalisation rates observed in foreign women (141 admissions in one thousand foreign residents, compared to 101 admissions in Italian women), are linked to the same reasons: the increase in the number of female immigrants, especially from the East, has led to an increase in births in our region and, consequently, a greater presence of female foreigners in the departments of obstetrics and gynaecology.

[6] Legislative Decree 286/1998 "*Consolidation Act on the provisions regulating immigration and regulations on the status of foreigners*".

Despite this, female foreigners are faced with more difficulties, including those of a financial nature, in using

Foreign women are faced with difficulties in benefiting from childhood services

the childbirth services and taking advantage of healtchare duringpregnancy andthe postnatal period. The cultural aspect and level of education can increase these difficulties, affecting the tendency towards prevention of women belonging to certain ethnic groups. Almost 0.9% of female foreigners in Veneto do not attend check-ups during pregnancy, with peaks of over 2% in Asian and Balkan women, compared to less than 0.1% of Italian women. On average, pregnant foreign women attend the first check-up later on (35% between the second and third trimesters of pregnancy, compared to 12% of Italian women) and have fewer ultrasounds and invasive prenatal diagnostic procedures. This means that the risk factors are not monitored as much, resulting in more frequent unsuccessful births among foreign women (1.2% of babies born to foreign mothers compared to 0.7% born to Italian mothers)[7] or the need to undergo a Caesarian birth.Data on Caesarian births in foreign mothers, which appears to be similar to that in Italian mothers, really ought to be calculated allowing for the younger age of foreign mothers (a 5-year difference in average age at childbirth, with a greater proportion of women under the age of 20), which would therefore lead us to expect far fewer Caesarian sections.

The higher rate of hospitalisation in the first year of life of babies born to foreign mothers highlights a critical issue in the mother and child health area.

Table 10.4.1 - Health indicators in newborns and use of services by citizenship. Veneto - Year 2013 (*)

	Italian women	Foreign women
% of women not attending check-ups during pregnancy	0.06	0.86
% Caesarian births	27.7	27.9
% unfavourable newborn outcomes	0.7	1.2
Hospitalisation rate before first birthday	329.1	397.2

(*) Provisional data
*Percentage of unfavourable newborn outcomes = (Weight at birth less than 1,000 g or born before 28 weeks of pregnancy or stillborn / Total births *100*
*Hospitalisation before 1st birthday = (admissions of residents aged 0-1 years, excluding healthy babies) / (population aged 0-1 years)*1,000*
Source: Processing by the Regional Observatory for Disease in Pediatrics on Veneto Region data

10.2 The right to social protection

While up until 2009 the governments have tried to meet the new needs by increasing social protection expenditure, austerity policies have prevailed since 2010, creating problems for the national welfare systems. Social protection expenditure in Europe went up from 26.1% of GDP in 2007 to 29.6% in 2009, before coming back down to 29% in 2011. It accounts for 29.7% in Italy, down three percentage points from 2007; it remains above the EU27 mean in any case, in a context which displays rather variable values: from a minimum of 15.1% of GDP in Latvia to a maximum of 34.3% in Denmark. This is 7,725 euros per capita a year, the eleventh highest value among the 27 European countries: Austria, France and the Northern European countries appropriate more than 10,000 euros per inhabitant and Germany more than 9,000 euros, while the European mean is 7,303 euros.

Our welfare system leans strongly towards the "old-age" function, which uses 52.1% of social protection

Poorly balanced welfare expenditure

expenditure[8], the second highest value among the European countries. However, we are last in place for efforts to contain social exclusion and housing difficulties.

The crisis has increased poverty and has brought with it new requirements, necessitating a change in treatment priorities, to which the systems struggle to adapt. These days, Italy sets aside a greater amount for the most critical problem of unemployment, 2.9% of expenditure for social protection services, almost 1 percentage point more with respect to 2008, although support offered to the unemployed is still limited. The effort to guarantee a minimum income level for those losing their jobs, including as protection against the risk of poverty, is in fact greater in other European countries (European average: 5.6%), even though their unemployment rates are lower than that in Italy. The resources dedicated to combating social exclusion and housing poverty are still derisory in relation to an increase of more than two million people at risk of poverty or social exclusion in the last three years: only 0.3% of the total expenditure, compared to a European average of 3.7%.

[7] Percentage of unfavourable newborn outcomes = (born with a weight of less than 1000 g or younger than 28 weeks or stillborn / total births)*100.

[8] Social protection services expenditure accounts for spending for social protection net of the administrative costs and other costs, which account for 4.3%.

Despite the focus on the family as the bedrock of the community and an active subject of social protection, investments in its favour are limited and the "family, maternity and childhood" function accounts for only 4.8% of expenditure, compared to almost double that in Europe. The share for old-age pensions is instead continuing to rise, despite recent reforms to slow down social security spending.

The weakness of the social protection system has repercussions on daily life, creates difficulties for families and fuels a lack of faith in citizens in the ability of the welfare system to guarantee adequate protection. According to a Censis survey[9], most Italians believe that the system is unable to offer appropriate measures for the various social risks (63%), does not succeed in bridging social inequalities (75%), has evident territorial imbalances (86%), is too costly and, above all, is unsustainable over time (79%). Families know that they have to put ever more trust in themselves rather than in the public welfare system for their own social protection, despite the current difficulties and prolonged overexposure to the effects of the crisis. This does nothing but intensify social inequalities: those with economic resources use private services, while the others, unable to foot the bill, risk staying without coverage.

Moreover, there is a danger that families, alarmed by the sense of social insecurity and with all their efforts and concentration focused on protecting themselves, may not feel able to take new risks and take on new challenges and put forward the emotional and economic energy required for growth. In this sense, too, not investing in welfare, in its ability to meet social security needs and reduce inequalities within the country, means underestimating an important stimulus for growth.

The important role of the Municipalities[10]

“The Republic guarantees an integrated system of actions and social services for people and families, promotes actions to ensure quality of life, equal opportunities, non-discrimination and citizenship rights, prevents, eliminates and reduces conditions of disability, individual and family needs and poverty, caused by inappropriate income, social difficulties and states of dependency, in compliance with articles 2, 3 and 38 of the Constitution". This is the purpose of framework law no. 328 of 2000[11], which assigns management of the interventions and social services to the Municipalities, the organisations closest to the needs of the citizen.

The same law, similarly to that already provided for concerning healthcare, introduces the concept of basic services levels relative to social and civil rights (LIVEAS), which must be consistently guaranteed throughout Italy. It is the exclusive legislative competence of the government to define LIVEAS (article 117 of the Constitution as revised in 2001), thus with a view to ensuring that the right to social welfare is consistent throughout Italy, in compliance with the principle

of equality. The Regions are responsible for planning, coordinating and guiding social interventions and can provide further levels of assistance.

However, to this day, more than ten years after the constitutional reform, the government legislator has still not defined the basic social and civil service levels; this prevents holders of a right from claiming the provision of services needed to ensure that he or she enjoys the right and voids the obligation of the public individual to provide the services. Over the years, certain regions have tried to fill in this void, by identifying, independently and not always in the same way, at least a part of the LIVEAS, nullifying however the intent of the constitution of universality and equality.

In this context, social care provided by the Municipalities represents an important part of the national welfare system. As they know the community and are close to the citizens, the Municipalities are the most suitable authorities to lay bare social need and define the most appropriate actions and measures. The Municipalities are called upon to implement measures which combat poverty and support income; support measures for the minors in conditions of poverty, for the complete integration of disabled or disadvantaged people, to help the elderly and disabled people continue living at home or to accommodate them in residential and daycare facilities; integrated socio-educational services to oppose addictions, through preventive and rehabilitative measures and social re-integration; measures to help balance time at work with caring for the family and support for women in difficulty; information and advice for people and families to help them benefit from the services and to promote self-help initiatives.

[9] Censis. *Gli scenari del welfare. Le nuove tutele oltre la crisi*. Franco Angeli, 2012.

[10] Municipality expenditure data has been deduced from the Istat survey on expenditure for social services and measures by individual or associated Municipalities, which observes spending in the relevant current account used for providing social services or implementing social measures; consumption data is not inferred from the same survey but from a regional administrative source, published in the recent report “*Le strade del Sociale in Veneto*” by the Veneto Region Social Services Department. The data updated to the last available year was preferred for the consumer data, even if Municipality expenditure refers to 2010.

[11] “Framework law for the realisation of the integrated social services and measures system”.

The spending capacity of Municipalities is sorely tried. As shown by the Istat survey on expenditure

Slowdown of social expenditure by Municipalities

of individual or associated Municipalities for social measures and services, social expenditure of the Municipalities of Veneto was almost 560 million euros in 2010, equal to 0.39% of the regional GDP. While expenditure has risen on 2003, there was a slow-down in growth in the last year (+0.2%), which can even be seen as a fall (-2%) if calculated at constant prices[12], i.e. is accounting for inflation. According to the initial provisional data for 2011, social expenditure by the Municipalities of Veneto was expected to fall to around 545 million euros, down 2.5% from 2010. This is also found at a national level. Furthermore, transfers to Municipalities to fund social expenditure have been greatly reduced, especially starting from 2009, mainly due to cuts to the National Fund for Social Policies. Given the reduction in revenue transfers to the Municipalities and the restrictions imposed by the Stability Pact, it is easy to envisage the difficulties faced by the Municipalities in broadening or just maintaining the range of social services offered.

Approximately 114 euros were spent per inhabitant in Veneto in 2010 (the provisional data for 2011 being 110 euros), which is in line with the national average (118 euros in 2010 and 116 in 2011), but lower on average than spending in the regions of the North-East (162 euros). However, this average summarises very different levels of expenditure depending on the consumer in question and the type of action: for example, as much as 3,797 euros per capita are spent in the disabled area (3,954 estimated for 2011).

Expenditure depends on the level of need, the availability of resources, but also on the degree of

A stratagem: forming associations

efficiency of the services. To optimise the ever more insufficient resources and ensure fairer distribution of the services provided to citizens, the policies tend to be more and more focused on associated service management. Expenditure managed in association is equal to a third of the total expenditure, which is higher than the national mean (24.5%) and almost all of this takes place through social mandates to the local health and social authorities (ULSS). On the other hand, Veneto Region has supported delegation of the management of social services by Municipalities to the health facilities from the very outset of the regional health and social system, not only to guarantee consistent healthcare throughout the local area, but also to ensure fully integrated social and health services, the defining characteristic of the Veneto system.

Along with the delegation to the local health and social authorities, the associated management of services through other groups of Municipalities is encouraged, a strategic objective reaffirmed also in the new 2012/2016 health and social plan.

Due to complexity or seriousness, situations often require various types of action, not only social but also health and social, which have to be planned and harmonised to take full and adequate responsibility of them. If the share of the National Health Fund financing health and social services[13], appropriated mainly for dependency and disability, is added to social expenditure, then expenditure rises to 1 billion and 325 million euros.

Considering social expenditure net of the health share, the main recipients of the services are families with minors, disabled people and the elderly, on who,

Families with minors, disabled people and the elderly are the main recipients of social expenditure

together, 80% of the resources (83% in Italy) are focused. Poverty-fighting policies account for 7%, while the amounts used for dependence and for immigrants remain residual, despite an increase in the presence of foreigners in the local area. Expenditure for the family and minors has increased over the years, while that for disabilities, the elderly and dependence has decreased. The actions fighting poverty and social disadvantage in adults require more resources, albeit to a limited extent; finally, the share for immigrants and integration measures is essentially stable. Although Italy is still behind many European countries, especially those in the North, with respect to work-life balance

Veneto is one of the top regions for early childhood services

policies, recent years have even seen a growing awareness from the public institutions in Italy concerning early childhood services, which are increasingly recognised as being of significant educational value and playing a crucial role in favouring employment of mothers.

[12] Valuation at constant prices is obtained by applying the deflator index, used to deflate costs of general services of the public administration and of the other sectors in which both the public administration and non-profit institutions serving households work.

[13] Purely health services are not taken into consideration.

Table 10.2.1 - Social expenditure by the Municipalities by consumer area. Veneto - Years 2003, 2009, 2010 and 2011

	2010		% of total expenditure			
	Total expenditure (in euros)	Per capita expenditure (in euros) (a)	2003	2009	2010	2011 (b)
Family and minors	171,189,156	98	25.0	31.0	30.6	32.2
The Elderly	145,123,526	148	31.1	23.2	26.0	22.1
Disabled people	140,095,570	3,797	27.7	25.3	25.1	26.9
Poverty, disadvantaged adults and homeless people	37,377,325	12	5.2	5.9	6.7	7.0
Immigrants and nomads	15,253,530	31	2.1	3.5	2.7	2.9
Dependency	6,523,182	2	3.0	1.5	1.2	0.9
Multi-users	43,606,489	9	5.8	9.7	7.8	7.9
Total	**559,168,778**	**114**	**100.0**	**100.0**	**100.0**	**100.0**

(a) Per capita values are the relation between expenditure and the reference population for each consumer area. Following the order given in the table, the reference populations are respectively: the number of people in families with at least one minor; the number of people aged 65 or over; an estimation of the number of disabled people under the age of 65; the population aged between 18 and 65; the number of foreign residents; the population over the age of 15; the resident population. (b) Provisional 2011 data
Source: Processing by Veneto Region - Regional Statistics System Section on Istat data

The Municipalities of Veneto spend almost 72 million euros to sustain early childhood services, which is equal to 13% of social expenditure overall: more than 80% of Municipalities manage public facilities directly or contribute financially to keep boarding costs at private facilities in their own area to a minimum (compared to 41% in 2004). Coverage is instead limited to 55% of Municipalities in Italy, which is up on 2004 even if the trend has appeared to slow down in the last two years. At a local level, there is a variety on offer with especially critical issues in the southern regions, while Veneto is one of the best regions for local coverage. In detail, in 2012 810 early childhood services were actually operating and could accommodate 24,551 children, which is 17% of children under the age of three.If the services authorised by the Region but not yet in operation are taken into consideration, the potential places become 28,053 and the coverage rises to around 20%, with points above the average in the provinces of Verona and Rovigo (around 22%) and Padua (21%).

This coverage places the Veneto region among the first at a national level in the field of childhood services, even if it has to be improved to approach the 33% aspired by the European authorities[14]. There was a decrease in the offer (27,528 authorised places) in 2013, due to many Bodies failing to complete the project already authorised by the Regions because of the difficulties created by the economic crisis.

The life-work balance as a company strategy

As part of the work-life balance initiatives, the Region strives to encourage a culture of balance between work and family commitments, which not only contributes to the well-being of the employees, but represents a fully-fledged strategy of organisational efficiency, with positive results in terms of productivity and prosperity. In 2011, the Veneto Region, first region in Italy after the independent province of Bolzano, obtained the licence to use the "Family and Work audit" European label, an internationally certified instrument to introduce a family-centred personnel management policy in businesses. Businesses which opt for certification offer flexible working hours, organise work with the needs of the family in mind, including through appropriate use of the potential offered by new technologies (telework), encourage their employees to be independent and take on responsibility, and guarantee care services for family members in need of them, such as children and elderly people.

Businesses wishing to receive the certificate are assisted by the Region for a three-year period in the process of introducing and improving balance-based measures, after which they are listed in the regional register of certified businesses and have the chance to benefit from the network made available by the Region

[14] Council of the European Union, Barcelona, 2002.

and from the specific refresher meetings in connection with this. 7 businesses received the certificate in 2013.

This audit is not simply a new certificate like any other, but a process with ambitious goals: to balance, to share and to embrace human, social, cultural and educational capital to bring about a real cultural turning point. For this reason, it is essential to ensure that the effects are monitored even some time after receipt of the certificate.

Support policies for elderly people envisage a social and health-and-social services system: residential facilities, mainly for dependent individuals, daycare centres, home care and help and financial support for the families who take responsibility for elderly persons. For some time now, the Veneto model has been

The option of home help and care for the welfare of elderly people

encouraging home help and care as a preferred and strategic choice in regional policies. There are various kinds of home care measures supporting the family, aimed at preventing, maintaining and regaining the potential which enables people to stay within their own life, physical, social and emotional context. The Municipalities allocate almost 63 million euros of social expenditure for this (11%), in addition to as much again from the health fund for integrated home care, which necessitates the presence of various types of health professions. More than 34 thousand people in 2011were assisted by a home help and care project (approximately 3.4% of elderly people), 48% of which in integrated home care.

While the purely social type of home help and care is down on the previous year (-7.7%), integrated home care has instead risen (+2.8%), requiring greater commitment of resources.

Around 27 thousand care allowances are appropriated for families for various reasons, such as carer grants or support for Alzheimer sufferers cared for at home. Where it is impossible to assist elderly people properly in their own homes, be it because they are alone or seriously ill, institutionalisation in residential facilities is preferred. The Municipalities contribute for more than 45 million euros (8% of social expenditure), but resources used rise notably when accounting for the health fund share (389 million euros). There are 20,735 authorised beds in residential facilities for dependent elderly persons, down 13% from 2007. With regard to disability, around 23 million euros are appropriated for home care and 88 million for care in residential facilities, both funded mainly by the National Health Fund, for 59% and 66% respectively. 4,169 disabled people were followed at home in 2011 with personalised projects, with the purpose of fostering personal independence and the ability to relate to others and participate in the social and working life. Alongside home help and care is the contribution offered by 286 day centres in the local area, attended by around 6,500 disabled people.

In Veneto, as in the North-East, expenditure is higher for disabilities

Table 10.2.2 - Municipality expenditure for certain significant social measures. Veneto - Year 2010

	Social expenditure		Expenditure funded by the National Health Fund (in euros)
	In euros	% of total expenditure	
Family			
Nurseries and other early childhood services (a)	71,809,091	12.8	189,676
The elderly			
Home help and care	62,583,252	11.2	61,304,523
Residential facilities	45,695,694	8.2	389,194,331
Disabled people			
Home help and care	9,551,621	1.7	13,638,586
Semi-residential facilities	38,217,258	6.8	67,799,480
Residential facilities	29,036,830	5.2	58,774,287
Socio-educational support at school	31,004,185	5.5	656,807
Job placement support	6,415,849	1.1	635,427

(a) The share of the National Health Fund for early childhood services concerns local health and social care authority nurseries only.
Source: Processing by Veneto Region - Regional Statistical System Section on Istat data

There has been an increase in temporary recourse to residential services by disabled people and their families for emergencies and for relief from the duty of care: there are 3,794 consumers staying in residential facilities or communities in Veneto.

The school inclusion and labour integration services are other specific actions of the regional planning. The former is dedicated to disabled children of pre-school and school age and aims to develop the potentiality of the disabled person in the education, schooling, learning and personal development processes: the Municipalities spend 31 million euros, given that there are 14,243 disabled pupils in state schools (2010-11 academic year), 2.4% of the total, up 64% compared to ten years earlier.

The inclusion, participation and active citizenship process also involves programmes for helping disabled people enter the world of work, although the resources for this purpose are still limited.

10.3 Citizenship skills

In order to fully exercise their citizenship rights, each person needs to be able to access adequate information and make the best use of it, to decide upon his or her own present and future. For this reason, the citizenship services provided by every State must include suitable education and training to ensure that each person is placed in a position to develop their own potential and personal talents and thus make a significant contribution to the development of the Country. The right to education and study, including as a precondition to being able to benefit from many other civil and social rights, has by now been established institutionally at all levels: from the 1948 universal Declaration of human rights by the United Nations (article 26) to the European Union Europe 2020 Strategy (2010).

The right to education assumes a universal nature in the Constitution of the Italian Republic, with an express statement in article 34: "the school is open to all". The Republic promises a minimum obligatory course of study free of charge, but it also has to make efforts so that "those who are capable and worthy of merit, even if they do not have the means" have "the right to reach the highest levels of studies".

But a quickly changing society like the one we live in today, with close connections worldwide, requires a surplus of abilities, flexibility and adjustment, or rather it needs specific skills in a wide range of areas, defined by

Key competencies are required for personal fulfilment, active citizenship, social cohesion and employability

the European Parliament as “the key competences necessary for personal fulfillment, active citizenship, social cohesion and employability in a knowledge society”: communication in the mother tongue and in foreign languages, mathematical competence and basic competences in science and technology, digital competence, learning to learn, social and civic competences, sense of initiative and entrepreneurship, cultural awareness and expression[15]. Our system has thus complied with the recommendations, first of all by extending compulsory education from 8 to 10 years and then by extending this to also include vocational training courses, implicating the Regions in this to establish vocational training centres.

What do I like learning at age fourteen?

There is now widespread awareness of the fact that to deny the right to education means denying people themselves. The best way to safeguard this right in a way that is acceptable for all citizens is still a matter of debate. Much progress has been made, but there is still a lot that can be done.

It is clear that a school system, which takes the expectations and potential of the children and transforms them into opportunities for human, social and labour development, is the main instrument for removing the economic and social obstacles of which our Constitution speaks. In this context the school's ability to help the children to recognise their own abilities and inclinations, to choose the most relevant study and work paths for their talents and to develop social consciousness to be able to make satisfying life choices takes on great importance.

At the end of an initial general study period, the teenagers attending the last year of the lower secondary school are asked to make a decision as to their education, which will qualify their subsequent course of study.

More and more people are choosing "liceo" upper secondary schools

[15] European Parliament Recommendation OJ L 394/2006

At such a young age they find themselves having to identify their own future specific competencies. Educational and professional guidance therefore takes on great importance, including to prevent course interruptions, partial or negative training career outcomes or any undesirable cases of people slipping through the system.

87.6% of young people chose to enrol at a second level secondary school in 2012, while more than 12% opted for a vocational training centre, an ever rising percentage which goes hand in hand with the growing number of opportunities available. The same applies to "liceo"upper secondary schools which, differentiated and enriched with new specialisations, are chosen by 37.5% of young people (not even 28% in 2008). Technical education (33%) is the next most popular, followed by vocational schools (17%).

The choices made during the initial general period of study are usually confirmed by the young people, who in fact enrol in the first year of the upper secondary school according to the expected distribution. The percentage of those undertaking a vocational path is lower in Italy than in our region, in favour of a greater preference for "liceo" secondary schools (47.4%). It is mainly in the first year that the greatest difficulties arise and young people risk being unsuccessful, either

Interruptions, failures and dropouts are symptoms of difficulty which occur especially in the first year

due to a careless choice in terms of specialisation of study, or due to a school which is not very centred on the talents of the young people or not really organised to accommodate them and offer gradual and personalised stimulation with new learning courses.

In Veneto, as in the rest of Italy, in all types of schools, the most evident issues are concentrated in the first year: the percentage of those not passing the year is amost double that of the following years and dropout rates are also observed: 8 out of 100 young people (11 in Italy), who are strongly demotivated or unable to handle difficulties, decide to drop out of the education system. Although dropouts may only be on a temporary basis, they are in any case a sign that the system has been unsuccessful. Of the various study courses, "liceo" secondary school studies safeguard the most against these hitches; this secondary school path is the one most aimed at continuing studies at university and is chosen mainly by young people who do not urgently need to find work, by the most knowledgeable who are more often from medium and upper class families, from which they can draw on a more solid cultural background compared to that of their peers.

Table 10.3.1 - Percentage of upper secondary school pupils who drop out (*) and do not pass the year (**) per course year. Veneto and Italy - academic year 2011/2012

	Failures		Drop outs	
	Veneto	Italy	Veneto	Italy
I	14.3	15.0	8.3	11.4
II	8.2	9.2	0.6	2.5
III	8.4	8.3	-	-
IV	6.4	7.4	-	-
Total	**8.7**	**10.3**		

(*) Pupils who drop out of school and do not enrol in the subsequent academic year.
(**) Not admitted to the subsequent academic year at the June exams.
Source: Procressing by Veneto Region - Regional Statistical System Section
on Veneto regional academic Office, Miur and Istat data

Dropping out and failing in the first year are experiences which leave a lasting mark on the educational life of young people, because it damages their self-esteem, provoking a sense of inadequacy for the adult world which may be reflected in their future choices; effective guidance is therefore managed by these indicators, too.

This is why early dropout from school is also monitored by the European Union, which has set itself the goal of reducing this to below 10% in its Europe 2020 agenda.

School drop-outs are decreasing but require close monitoring

At a European level, 12.6% of young people aged 18-24 are shown to leave school early, or rather gain a middle school diploma at most and do not engage in any training activities.

Although the percentage has been decreasing in recent years, it is higher in Italy (17.6%) and still a long way from the objective. On average Veneto is an excellent region, with a lower drop-out rate (14.2%) than that of Italy, but there is still great territorial inconsistency: there are still major problems especially in the provinces of Rovigo and Treviso, while the situation in Veneto, Vicenza and Belluno is better, with drop-out rates below the regional average.

While the school appears to perform well in Veneto, succeeding in granting diplomas to 74.7% of young people enrolling in the first year (2009 data; 70.3% in Italy), but still with variability according to the type of school, the margin of difference with Italy narrows in the transition to university: around 57% enrol at some faculty or other, which is in line with the Italian average (58%).

Foreign pupils are doubly disadvantaged

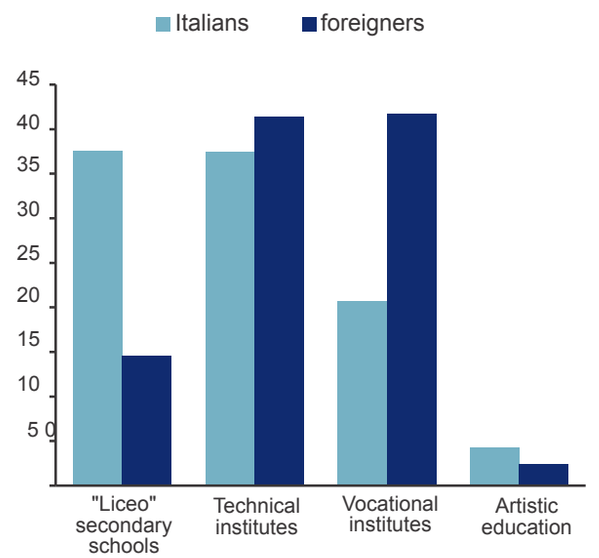
As an institutional service, the school represents one of the most important settings for integration. It is a meeting place for young people brought up in different cultural environments, where they can get to know each other, compare ideas and grow and learn together. Immigration brings the Constitution of a Republic able to “remove economic and social obstacles separating citizens” into the limelight. This is a strong though necessary mandate for a cohesive and inclusive society which the school still struggles to fulfil.

In Italy, but even more so in Veneto, foreign teenagers almost always choose professional and technical study courses (more than 80% as opposed to 58% of Italian young people), which demonstrates a greater inclination to enter employment sooner compared to their Italian peers, by gaining a qualification which can be used immediately on the labour market. Although a slight recovery in the choice of "liceo" secondary schools has been observed in recent years (around 15% compared with 13.3% in 2008), this is not enough to compensate for the imbalance with Italian peers, who attend secondary schools in more than 35% of cases.

The influence of the socio-economic status of families of origin on the educational choices of teenagers is thus plain to see and represents a perpetuating social condition which sees foreigners more inclined to undertake strictly technical or manual work, with a certain difficulty in raising one's own social status. If we then consider the outcomes of study courses, we see how foreign students also suffer the cultural gap of their families, who cannot be sources of complementary knowledge.

Socio-economic differences between families result in foreigners being less successful at school

Figure 10.3.1 - Percentage of pupils by type of school and citizenship. Veneto - academic year 2011/2012



Source: Processing by Veneto Region - Regional Statistical System Section on Miur data

In all types of school, they repeat years, drop out and move onto work training paths more often than their Italian peers. Out of 100 enrolled in all school years, 12 receive a diploma (17 Italians do), 60 pass the year (compared to 70), and 9 drop out (compared to 2 Italians). The dropout risk rises to as high as 15% in vocational institutes.

It is important to underline that it is not so much a matter of subjective inability as a sign of inadequacy, as highlighted in the Unar Report[16], if not of discrimination, of both the educational system and society, which are still not doing enough to handle the differences in origin of the boys and girls and to ensure the same training opportunities.

The ability of the educational institution to keep its pupils, to appreciate and valorise differences and at the same time communalities between the young people, goes hand in hand with the ability to broaden their knowledge and competencies, which are fundamental for growth and work. The results achieved by the fifteen year olds in the PISA surveys, promoted by the OECD with a view to testing the key skills mentioned earlier, confirm the picture which has emerged up to now. Most students from Veneto go well over the "adequate" rating in all three specific skills - reading, mathematics and science - with a mean

[16] Unar, Idos, “*Immigrazione - dossier statistico 2013*”, Rome, 2013.

Table 10.3.2 - Pupils by educational outcome(*) type of school and citizenship. Veneto - academic year 2011/2012								
	"Lieco" secondary schools		Vocational institutes		Technical institutes		Total	
	Italians	Foreigners	Italians	Foreigners	Italians	Foreigners	Italians	Foreigners
% Holders of a diploma	18.1	13.0	15.7	10.3	16.5	13.9	17.0	12.3
% Passing the year	74.1	66.8	66.6	58.1	69.2	60.8	70.8	61.1
% Repeating the year	6.0	14.9	9.6	13.6	10.9	16.2	8.5	15.0
% Moving onto vocational training	0.3	1.2	1.7	2.6	1.1	3.0	0.8	2.5
% Dropping out	1.5	4.1	6.4	15.4	2.4	6.1	2.8	9.2

(*) Pupils enrolled in the 2012/13 academic year by status the following year. The percentages refer to all academic years
Source: Processing by the Veneto Region Immigration Watchdog on Arof data

Table 10-3-3 - Average scores achieved by fifteen year old pupils by nationality and type of skills. Veneto - Year 2009			
	Reading	Mathematics	Sciences
Italians (Veneto)	512	514	526
Foreigners (Veneto)	426	442	427
Foreigners (North east)	416	430	424
Foreigners (North west)	424	429	420
Foreigners (Italy)	418	420	427

Source: Procressing by Veneto Region - Regional Statistical System Section n Veneto regional educational office data - OECD PISA 2009

total score of 510.5, enough to exceed the OECD mean (499) and Italy as a whole (485.9). The results obtained by foreign pupils are however significantly lower than those of their Italian peers. But it must be said that at the same time, their scores surpass the mean scores of young foreigners in the whole of North Italy, something which is not always the case if we look at native Veneto people.

There's still a long way to go

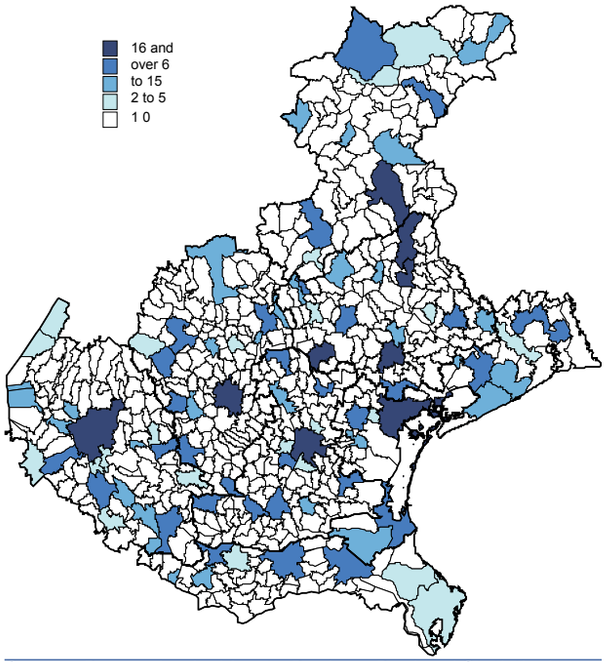
The school's ability to attract and keep the pupils until the very end of the path of study is the result of many factors. Territorial access is one of these factors, which understandably has a direct influence on costs, including "energy" costs, borne by the pupils and by their families to ensure course attendance. From this viewpoint, territorial access plays a key role in bringing to light the abilities of the local area to plan facilities and means of transport which are suitable in order to meet educational and mobility requirements.

With 477 upper secondary school institutes, or on average one every 39 km2, Veneto guarantees good accessibility if compared to the Italian average

Educational territorial accessibility is good, but there are still local critical issues in Belluno and Rovigo

(44 km^2). There is however great inconsistency within the area: if Padua and

Figure 10.3.1 - Municipalities containing upper secondary schools. Veneto - academic year 2008/09



Source: Processing by Veneto Region - Regional Statistical System Section on Veneto Region data

Treviso offer one institute for about every 25km^2, one in every 80-90km^2 is offered at Rovigo and Belluno.

In reading this data, the size of the population and the area of its finding must be taken into account: in some zones it is also possible to use a bicycle daily for journeys of a few kilometres, whereas in other areas it is not possible and public transport is necessary, bothdue to traffic and the type of roads to travel along and due to the mountainous and inaccessible nature of the landscape. Taking a look at the map by municipality, schools of engineering are mainly located in the municipal seats and are less concentrated on the other hand in the bordering areas.

Why should a local area continue investing in health and welfare?

Access to treatment and social services are inviolable rights in every civil society. Guaranteeing these rights offers the possibility of improving people's quality of life and, as well as being a value in itself, is also the cornerstone of social and economic development of the Country. The current situation seems fragile, as the difficult economic condition poses complex challenges and may heighten previously existing inequalities, risking undermining progress already made and to not ensure adequate care and social protection. The urgent nature of new needs requires a rethinking of the priorities and organisation of the health and social services. The new 2012-2016 Veneto health and social plan provides for the re-launch of the hospital function and, at the same time, the development of services in the local area, in accordance with network and cooperation logic, in order to ensure that full responsibility is taken for the person and to guarantee continuity of care.Continuing to invest in these key sectors, by promoting healthy lifestyles and appropriate treatment that is accessible for all, is a lever for equal and sustainable development of society.

What progress has the educational system made to support social inclusion?

Key skills, both knowledge-based and in terms of self-awareness and social and civic abilities, are required for personal fulfilment, active citizenship, social cohesion and employability. The school's ability to help children and teenagers to recognise their talents, choose courses of study and work that are most suited to their abilities and to develop social consciousness for making satisfying life choices therefore becomes a core value. An important role is played by educational guidance, the diversification of programmes offered, including vocational training, customisation of courses and measures to keep truancy to a minimum.74.7% of young people enrolled in the 1st year complete their education, which is more than at the national level; some do however stop early: the school dropout rate is 14.2%, which is falling and below the national rate but not yet in line with the 10% target required by the Europe 2020 scheme. Special attention is given to foreigners for whom, with an already disadvantaged socio-economic background, the school is not always able to bridge the gap between skills and initial training required for improving their social conditions.

Citizens rate the Veneto health system 7.4 out of 10, second only to Trentino-Alto Adige

9.5% of the population in the North East forgo treatment, 4.5% of which for financial reasons

The Municipalities in Veneto spent 545 million euros in 2011 on social services, especially for under eighteens, disabled people and the elderly

More than 80% of Municipalities in Veneto provide a state nursery service or help the family with accommodation costs

Bolzano and Veneto were the first to obtain the "family and work audit" European trademark to present certificates to companies that are considerate of the work-life balance

58% of fifteen year olds in Veneto choose a technical or vocational college, 83% of foreign young people