# The Italian Recovery and Resilience Plan (RRP) 2021-2026, the Women, and Their Health[1]

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*For women, the Italian Recovery and Resilience Plan 2021-2026 has meant the strengthening of important policies for work and maternity. For women's health, this Plan with the National Health Equity Program 2021-2027 have meant addressing the shortcomings of territorial and gender medicine, the regional gaps in the provision of the Essential Levels of Care of the National Health Service and strengthening the screenings for female cancers. The paper highlights how after the conclusion of these plans, the Italian National Health Service will have to identify a long-term strategy to ensure uniformity of services for women's health in all Italian regions.*

*Keywords: Italian Recovery and Resilience Plan 2021–2026, National Health Equity Program 2021–2027, women, health, Italian National Health Service*

## INTRODUCTION

In debates, the European Union is often presented as a complex institution that interferes, by bureaucratizing it, in the social and economic life of the member countries.

For Italy, this has often not been the case. Since the post-war period, Italy has struggled to implement important policies in favor of gender equality by supporting female employment and entrepreneurship, the implementing of various enabling interventions, starting with social services such as nursery schools, and appropriate policies to ensure a proper balance between professional and personal life, as it has not had, for example, autonomous and articulated green policies and struggles to achieve the modernization of the economy (Council of the Ministers of the Italian Republic, 2021).

On the other hand, compared to European countries such as Germany and France, since 1978 Italy has moved in the field of protection of the health of individuals from a Bismarkian-type social health insurance system to a system of public protection of the health of universalistic type, taking as a reference the National Health Service of Great Britain created by William Beveridge in the 1940s (but not adopting the complete social security system that Beveridge had designed together with the National Health Service). A universalistic model of protecting the health of individuals that allows a more efficient use of resources to achieve health objectives compared to other health models based on social insurance or private insurance.

## THE NEXT GENERATION EU

The European Next Generation EU (NGEU) plan or European Recovery and Resilience Fund is a fund worth 750 billion euros approved in July 2020 by the European Council in order to support Member States

affected by the COVID-19 pandemic. The NGEU fund covers the years 2021-2026 and is accompanied by the EU budget 2021-2027, with a total value of €1824.3 billion.

In Italy, at least, it was presented as an emergency intervention designed immediately to respond to the pandemic's economic and social consequences and strengthen health systems. If the timing actually has the characteristics of an emergency intervention, the areas of intervention:

- Boost the green transition through the promotion of renewable energies, sustainable mobility and more;
- Accelerate digital transformation through greater digitization of public services and the wider economy;
- Reinforce social infrastructure and services while reducing territorial disparities;
- Enhancing access to advanced education and training in skills relevant to the future economy;
- Support inclusive growth, research and development, and innovation for all;
- Ensure modern, efficient, and accessible healthcare service;

base their origins and settings from much further away. See the "target set" by the Barcelona European Council of 2002[2] on achieving a minimum offer of 33 percent for early childhood services by 2026, which for Italy is a goal to be achieved and which is at the center of the political debate in recent months, or the intention for Italy, through the Recovery and Resilience Plan's reforms and investments, to accelerate the achievement of the 17 Sustainable Development Goals (SDGs) endorsed by the UN 2030 Agenda (Council of the Ministers of the Italian Republic, 2021 ) (ASviS, 2023). Therefore for Italy the Next Generation EU with its National Recovery and Resilience Plan (NRRP) constitutes once again not only a stimulus intervention to restart the economy, limit social imbalances, but once again a powerful means to introduce highly innovative policies (at least for Italy) in the fields: green transition; digital transformation; smart, sustainable, and inclusive growth and jobs; social and territorial cohesion; health and resilience; and policies for the next generation, including enhancing education and skills.

## The National Recovery and Resilience Plan (NRRP) (and the National Health Equity Program (PNES)) for the Health

At the opposite, in the field of protecting the health of individuals, where Italy has created a model of high health and social value for decades, the intervention of the Next Generation EU, together with the action of the European Social Fund Plus - ESF+[3] and the European Regional Development Fund – ERDF[4], which constituted the new National Health Equity Program (Programma Nazionale Equità nella Salute) for Italy for the period 2021-2027 for the 7 regions of the South (Basilicata, Calabria, Campania, Molise, Puglia, Sardinia and Sicily), represents a highlight of weaknesses which, given the characteristics of the universalistic model adopted, should not have occurred.

The intervention of the Next Generation EU, together with the action of the European Social Fund Plus - ESF+ and the European Regional Development Fund - ERDF with the National Health Equity Program, "sanctions" the Italian National Health Service as incapable of controlling and bridging the differences between the various regional health services that compose it in terms of the quality of the structures and in terms of territorial and social homogeneity in the provision of services. In particular, the Next Generation EU intervenes on the Italian National Health Service for that unrealized link with the territory established by the much criticized Decree 70 of 2015 "Regulation defining the qualitative, structural, technological and quantitative standards relating to hospital care" (which defined the hospital standard at 3.7 beds per 1000 inhabitants, beds which in times of pandemic were lacking, especially with regards to beds in intensive care units). Decree 70/2015 underlined that "the reorganization of the hospital network for which this provision is aimed will be insufficient concerning the need to guarantee full coverage of the care needs that require hospital treatment, if, in a logic of care continuity, the theme of strengthening local structures is not addressed, the lack of which, or the lack of organization in a network, has strong repercussions on the appropriate use of the hospital." Only with the advent of the Next Generation EU and the related Italian National Recovery and Resilience Plan was it possible to review the organization of local assistance and

the prevention system based on new standards, in consistency with the investments envisaged by Mission 6 Component 1 of the National Recovery and Resilience Plan.

**NRRP-Mission Health**

The intervention of the Next Generation EU in Italy in its Mission Health has as general objectives:

- Strengthen the hospital system and, in particular, the territorial assistance network, to ensure homogeneity in the ability to provide integrated responses (health and social health issues), as well as equal access to care;
- Strengthen the resilience and timeliness of the health system's response to emerging infectious diseases characterized by high morbidity and mortality, as well as other health emergencies;
- Boost digital health care, design digital solutions for multidisciplinary and multi-professional care and assistance processes, as well as for proximity and communication with people;
- Promote and strengthen the field of scientific research, increasing resources for biomedical and health research, including via the promotion of equity funds and developing skills that can facilitate technology transfer;
- Provide safe, technologically advanced, digital, and sustainable hospitals, also by revamping existing facilities with particular reference to high-tech equipment and digitization;
- Strengthen the country's capacity, effectiveness, resilience, and equity in the face of current and future health impacts associated with environmental and climate risks;
- Enhance the technical-professional, digital and managerial skills of professionals in the National Health Service (NHS) and resolve shortages within the ranks of specialists and general practitioners.

About the interventions Mission Health consists of two components:

- Territorial healthcare assistance and telemedicine;
- Innovation, research and digitization of healthcare.

The resources deployed in the Mission for:

- Territorial healthcare assistance and telemedicine are EUR 7.5 billion plus EUR 400 million from REACT-EU;
- •Innovation, research and digitization of healthcare are EUR 10.51 billion plus EUR 1.31 billion from REACT-EU.

The Total Health Mission resources are EUR 18.01 billion plus REACT-EU resources worth EUR 1.71 billion, for a total of EUR 19.72 billion.

In the first intervention: Territorial Assistance and Telemedicine the Objectives of the component are:

- Strengthening and refocusing the NHS towards a model focused on territories and social and health assistance networks;
- Overcoming the fragmentation and structural gap between the different regional health systems by ensuring homogeneity in access to care and the provision of Essential Care Levels – "LEA";
- Enhance prevention and territorial care by improving the capacity to integrate hospital services, local health services and social services, to ensure continuity of care, multi-professional and multidisciplinary approaches, integrated hospital-domicile pathways for the whole population;
- Strengthening the country's capacity, effectiveness, resilience and equity in the face of current and future health impacts associated with environmental and climate risks, in a "One—Health" vision and in the evolution of "Planetary Health."

In all the actions of the first intervention, strong attention to gender issues is underlined.

**ESF+ E ERDF and the National Health Equity Program 2021–2027**

Within the actions of the European ESF+ and ERDF funds, the National Health Equity Program 2021-2027 for the 7 regions of the South (Basilicata, Calabria, Campania, Molise, Puglia, Sardinia and Sicily) has four priority areas of intervention:

- the fight against health poverty, by reducing barriers to access health and social services for vulnerable people (migrants, those without income, and the homeless);
- investments in mental health care where the number of local psychiatric facilities is low (Molise, Campania, Puglia, Basilicata, Sardinia) and the ability to quickly identify and take charge of the patient is low;
- gender health through the strengthening of counseling centers (in many regions of the South there is one center for every 40-65 thousand inhabitants);
- strengthening of oncological screening programs, which in the South cannot reach a satisfactory number of users.

The financial allocation of the National Health Equity Program 2021-2027 is lower than the funding of the Mission Health - Territorial healthcare assistance and telemedicine of the Italian NRRP and is divided as follows:

Euro 185,921,025 for the National Institute for the Promotion of the health of migrant populations and the fight against diseases of poverty (INMP) as the intermediate body designated for the implementation of interventions relating to the area "Countering health poverty", of which 112,126,100.00 euros supported by the European Social Fund Plus (ESF+) and 73,794,925.00 euros supported by the European Regional Development Fund (ERDF).

Euro 405,707,405.00, divided among the 7 recipient Regions (Basilicata, Calabria, Campania, Molise, Puglia, Sardinia and Sicily) according to the distribution method based on the access quota to the 2022 National Health Fund (Repertory of Acts no. 278/ CSR of 21 December 2022), as intermediate bodies identified by the Program about the interventions envisaged in the areas:

- Take care of your mental health;
- Gender at the center of care;
- Greater coverage of cancer screening;

of which 242,744,900.00 euros are supported by the European Social Fund Plus (ESF+) and 162,962,505.00 euros are supported by the European Regional Development Fund (ERDF).

The participation of the European Social Fund Plus (ESF+) in the National Health Equity Program 2021-2027 falls within the objective "to help vulnerable groups access healthcare'. The old European Social Fund (ESF) in the 2014-2020 funding period had as its themes: Active and healthy ageing. The new ESF+ for the 2021-2027 financing period has as its specific objective: Enhancing equal and timely access to quality, sustainable and affordable services, including services that promote access to housing and person-centered care, including healthcare; modernizing social protection systems, including promoting access to social protection, with a particular focus on children and disadvantaged groups; improving accessibility including for persons with disabilities, effectiveness and resilience of healthcare systems and long-term care services, and for the themes, those related to Health are: Digitalisation in health care; Active and healthy ageing; Accessibility, effectiveness, and resilience of health systems; Access to Long Term Care (excl. Infrastructures).

The participation of the European Regional Development Fund (ERDF) in the National Health Equity Program 2021-2027 is part of the ERDF's objective to improve regional health infrastructure. For 2014-2020 in its program, there was only one theme related to healthcare: Health Infrastructures. For 2021-2027 there are 7 themes related to healthcare: e-Health services and applications; Health infrastructures, Health equipment; Health mobile assets; Digitalisation in Health Care; Accessibility, effectiveness, and resilience of health systems (excluding infrastructure); Access to long term care (exc. infrastructures).

**What the Italian National Health Service Has Done Since 2001**

But the Italian National Health Service itself has at its foundation the protection of equity and equality in access to the services guaranteed by the National Health Service, first and foremost at the territorial level, and therefore between all the Italian Regions, to achieve equality in health. Law 833 of 1978 establishing the Italian National Health Service in article 1 states that "The national health service is made up of the complex of functions, structures, services and activities intended for the promotion, maintenance, and

recovery of physical and mental health of the entire population without distinction of individual or social conditions and according to methods that ensure the equality of citizens about the service." And in article 2 it establishes that "The national health service within the scope of its competences pursues: a) overcoming territorial imbalances in the socio-health conditions of the country;"[5]

To this end, in 2001 the Italian National Health Service prepared an exact codification of the services guaranteed (Essential Levels of Care - LEA) by the National Health Service itself according to the 5 principles of the LEAs:

1. "the principle of the **dignity of the human person**, according to which every individual has equal dignity and equal rights, regardless of personal characteristics and the role played in society;
2. the principle of **health need**, according to which the right to healthcare is recognized for all (and only) those who are in conditions of need concerning health;
3. the principle of **equity in access to care**, aimed at explicitly addressing social inequalities in health conditions, in the use of health services, and in vulnerability to the consumption of inappropriate services;
4. the principle of the **quality of care** and its **appropriateness** concerning specific needs;
5. the principle of **economy** in the use of resources" (Dirindin, Vineis, 2004).

Then, since 2005, the Italian National Health Service has defined a system for monitoring the maintenance of Essential Levels of Care. The Regions subject to verification of these obligations are those with ordinary statute and Sicily. And today instead with the Next Generation EU and with the establishment of a new ESF+ structural fund and with the activity of the ERDF which together have led to the National Health Equity Program 2021-2027 which intervenes, I remind you, in the health services of the 7 regions of Southern Italy (Basilicata, Calabria, Campania, Molise, Puglia, Sardinia and Sicily) emerges in all its urgency that the objective for which the Italian National Health Service was born - an equal health service for all citizens and in all territories - the Italian National Health Service has failed to guarantee it, losing the characteristics of efficiency in the use of resources to achieve individual health.

### LEAs Monitoring

The analysis of the results of monitoring the Essential Levels of Care by the regional health services in the years just preceding 2020, the year of the COVID-19 pandemic, and those of the pandemic years highlight a particular weakness in the field of primary prevention and for the screenings for the early detection of cancers and in particular for those relating to female cancers.

### Regional Scores of the LEA Grid, Trend 2012–2019

In 2019, in the monitoring of the Essential Levels of Care, concerning the scores, 17 Regions out of 21 between Regions and Autonomous Provinces (P.A.) were evaluated positively, obtaining a score equal to or higher than 160 (minimum acceptable level) based on the LEA Grid. In particular, the ten Regions that achieve a score above 200 are: Veneto, Tuscany, Emilia Romagna, Lombardy, Marche, Umbria, Liguria, Friuli Venezia Giulia, Abruzzo and Lazio. Seven other Regions have a score between 200 and 160 (minimum acceptable level): Puglia, Piedmont, Autonomous Province of Trento, Sicily, Basilicata, Campania and Valle d'Aosta. The Autonomous Province of Bolzano, Molise, Calabria, and Sardinia are characterized by scores lower than 160 (Ministry of Health - General Directorate of Health Planning, Office VI, 2021).

From the table 1 it emerges that in the period 2012-2019 among the regions participating in the National Health Equity Program 2021-2027 Calabria, Campania and Molise were for a long time among the non-compliant or compliant regions with commitment to the provision of the Essential Levels of Care of the National Health Service. Basilicata appears to be in the best situation from this grid compared to the 7 regions affected by the Program.

**TABLE 1**
**REGIONAL SCORES LEA GRID, TREND 2012-2019**

| Regione | 2019 | 2018 | 2017 | 2016 | 2015 | 2014 | 2013 | 2012 |
|---|---|---|---|---|---|---|---|---|
| Veneto | 222 | 222 | 218 | 209 | 202 | 189 | 190 | 193 |
| Toscana | 222 | 220 | 216 | 208 | 212 | 217 | 214 | 193 |
| Emilia Romagna | 221 | 221 | 218 | 205 | 205 | 204 | 204 | 210 |
| Lombardia | 215 | 215 | 212 | 198 | 196 | 193 | 187 | 184 |
| Marche | 212 | 206 | 201 | 192 | 190 | 192 | 191 | 165 |
| Umbria | 211 | 210 | 208 | 199 | 189 | 190 | 179 | 171 |
| Liguria | 206 | 211 | 195 | 196 | 194 | 194 | 187 | 176 |
| Friuli Venezia Giulia* | 205 | 206 | 193 | | | | | |
| Abruzzo | 204 | 209 | 202 | 189 | 182 | 163 | 152 | 145 |
| Lazio | 203 | 190 | 180 | 179 | 176 | 168 | 152 | 167 |
| Puglia | 193 | 189 | 179 | 169 | 155 | 162 | 134 | 140 |
| Piemonte | 188 | 218 | 221 | 207 | 205 | 200 | 201 | 186 |
| P.A. Trento* | 187 | 185 | 185 | | | | | |
| Sicilia | 173 | 171 | 160 | 163 | 153 | 170 | 165 | 157 |
| Basilicata | 172 | 191 | 189 | 173 | 170 | 177 | 146 | 169 |
| Campania | 168 | 170 | 153 | 124 | 106 | 139 | 136 | 117 |
| Valle d'Aosta* | 160 | 159 | 149 | | | | | |
| P.A. Bolzano* | 157 | 142 | 120 | | | | | |
| Molise | 150 | 180 | 167 | 164 | 156 | 159 | 140 | 146 |
| Calabria | 125 | 162 | 136 | 144 | 147 | 137 | 136 | 133 |
| Sardegna* | 111 | 145 | 140 | | | | | |

* Regioni non sottoposte alla Verifica adempimenti

Source: Ministero della Salute – Direzione Generale della Programmazione Sanitaria, Ufficio VI (2021)

**LEA Grid Monitoring 2019 - Primary Prevention and Screening for Female Cancers**

For primary prevention, the monitoring of LEAs in 2019, the year before the pandemic, shows data of less than 95% vaccination coverage in children at 24 months per basic cycle (3 doses) (polio, diphtheria, tetanus, hepatitis B, pertussis, Hib) for 7 Italian regions distributed throughout the national territory with two regions (Sicily and P.A. Bolzano) below 92% coverage (table 2). The data are significantly worse for the 2017, 2018, and 2019 LEA monitoring of vaccination coverage in children at 24 months for one dose of measles, mumps, rubella (MMR) vaccine. 10 regions are below the 95% coverage threshold and above 92%. In this group all 7 regions of the South are included in the National Health Equity Program 2021-2027. In the North, Valle d'Aosta and P.A. of Bolzano are below 92% coverage, but improving (table 3). For vaccination coverage for influenza vaccination in the elderly (≥65 years), no Italian region reaches the target of 75% coverage. Sardinia and Calabria are among the 4 regions with coverage below 60% and not improving (table 4). Again, taking into account the 3 LEA monitoring sessions 2017, 2018, 2019, the proportion of people who have carried out first level screening tests, in an organized program, for the uterine cervix, breast, colon-rectum (score[6]) presents a strong lack of homogeneity between the Centre-North of Italy and the South. The 7 Southern regions included in the National Health Equity Program 2021-2027 are essentially the only ones to be below the normal value (score equal to 9) and 4 have an unacceptable deviation with a score between 0 and 4 and 2 with a significant deviation but improving, with scores between 5 and 6 (table 5). It should be noted that the optimality threshold of the indicator is very modest,

identifying as a normal value the achievement of a proportion of people who have carried out first-level screening of 60% for breast cancer 50% for cervical and colorectal cancer.

Therefore, the situation of primary prevention, but even more so of secondary prevention with screening for cervical, breast and colorectal cancer even before the pandemic was deficient or very deficient in many areas of the country and in particular in Southern Italy, despite a National Health Service based on the guarantee of Essential Levels of Care and centered on equity and equality.

**TABLE 2**
**VACCINATION COVERAGE IN CHILDREN AT 24 MONTHS FOR BASIC CYCLE (3 DOSES) (POLIO, DIPHTHERIA, TETANUS, HEPATITIS B, PERTUSSIS, HIB) (%)**

| Regione | 2019 | | | | | |
|---|---|---|---|---|---|---|
| | Polio | Difterite | Tetano | Pertosse | Epatite B | Hib |
| Piemonte | 96,0 | 96,0 | 96,0 | 96,0 | 95,9 | 95,8 |
| Valle d'Aosta | 93,2 | 93,2 | 93,2 | 93,2 | 93,0 | 93,0 |
| Lombardia | 95,9 | 95,8 | 95,8 | 95,8 | 95,7 | 95,7 |
| P.A. Bolzano | 81,2 | 81,1 | 81,2 | 81,1 | 81,1 | 81,1 |
| P.A. Trento | 94,9 | 94,9 | 94,9 | 94,9 | 94,9 | 94,9 |
| Veneto | 95,2 | 95,2 | 95,2 | 95,2 | 95,0 | 95,0 |
| Friuli Venezia Giulia | 93,4 | 93,4 | 93,4 | 93,4 | 93,0 | 92,8 |
| Liguria | 95,6 | 95,6 | 95,6 | 95,6 | 95,5 | 95,3 |
| Emilia-Romagna | 95,8 | 95,8 | 95,8 | 95,8 | 95,8 | 95,5 |
| Toscana | 96,8 | 96,8 | 96,8 | 96,8 | 96,5 | 97,2 |
| Umbria | 96,1 | 96,1 | 96,1 | 96,1 | 96,2 | 96,1 |
| Marche | 94,7 | 94,5 | 94,5 | 94,5 | 94,5 | 94,1 |
| Lazio | 95,6 | 95,6 | 95,5 | 95,5 | 95,5 | 95,5 |
| Abruzzo | 97,5 | 97,5 | 97,5 | 97,5 | 97,4 | 97,5 |
| Molise | 97,1 | 97,1 | 97,1 | 97,1 | 97,3 | 97,1 |
| Campania | 95,1 | 95,1 | 95,1 | 95,1 | 95,0 | 95,0 |
| Puglia | 94,5 | 94,6 | 94,6 | 94,6 | 94,5 | 94,5 |
| Basilicata | 96,6 | 96,6 | 96,6 | 96,6 | 96,6 | 96,6 |
| Calabria | 96,0 | 96,0 | 96,0 | 96,0 | 96,0 | 96,0 |
| Sicilia | 91,1 | 91,1 | 91,1 | 91,1 | 91,1 | 91,1 |
| Sardegna | 95,2 | 95,2 | 95,2 | 95,2 | 95,2 | 95,2 |

| Valore normale 9 | Scostamento minimo 6 | Scostamento rilevante ma in miglioramento 3 | Scostamento non accettabile 0 |
|---|---|---|---|
| Tutte ≥ 95,0 % | Tutte ≥92 % | Una < 92,0 % | Più di una < 92,0 % |

Source: Ministero della Salute – Direzione Generale della Programmazione Sanitaria, Ufficio VI (2021)

**TABLE 3**
**VACCINATION COVERAGE IN CHILDREN AT 24 MONTHS FOR ONE DOSE OF MEASLES, MUMPS, RUBELLA (MMR) VACCINE (%)**

| Regione | 2017 | 2018 | 2019 |
|---|---|---|---|
| Piemonte | 94,7 | 94,7 | 95,5 |
| Valle d'Aosta | 90,3 | 91,3 | 91,5 |
| Lombardia | 93,9 | 94,1 | 95,5 |
| P.A. Bolzano | 71,8 | 70,8 | 75,5 |
| P.A. Trento | 91,6 | 94,3 | 95,5 |
| Veneto | 92,3 | 96,4 | 95,1 |
| Friuli Venezia Giulia | 86,5 | 91,2 | 92,5 |
| Liguria | 90,8 | 94,0 | 93,0 |
| Emilia-Romagna | 93,4 | 95,1 | 95,1 |
| Toscana | 93,5 | 95,0 | 96,1 |
| Umbria | 94,5 | 94,6 | 95,2 |
| Marche | 88,2 | 92,0 | 93,7 |
| Lazio | 95,3 | 94,9 | 95,7 |
| Abruzzo | 89,2 | 94,5 | 95,0 |
| Molise | 90,5 | 92,0 | 93,4 |
| Campania | 92,0 | 93,4 | 94,7 |
| Puglia | 91,1 | 94,2 | 94,4 |
| Basilicata | 92,9 | 93,0 | 92,6 |
| Calabria | 92,8 | 92,7 | 93,1 |
| Sicilia | 85,6 | 90,9 | 92,2 |
| Sardegna | 93,0 | 92,3 | 93,6 |

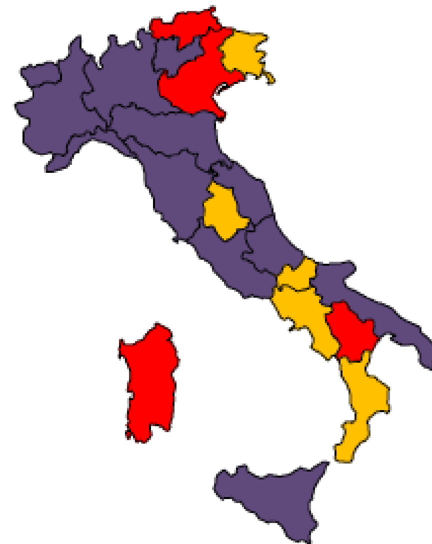
Indicatore 1.2 - Anno 2019

| Valore normale 9 | Scostamento minimo 6 | Scostamento rilevante ma in miglioramento 3 | Scostamento non accettabile 0 |
|---|---|---|---|
| ≥ 95,0 % | 92 %– 94,9 % | < 92,0 % e in aumento | < 92,0 % e non in aumento |

Source: Ministero della Salute – Direzione Generale della Programmazione Sanitaria, Ufficio VI (2021)

**TABLE 4**
**VACCINATION COVERAGE FOR INFLUENZA VACCINATION IN THE ELDERLY (≥65 YEARS) (%)**

| Regione | 2017 | 2018 | 2019 |
|---|---|---|---|
| Piemonte | 47,9 | 49,0 | 51,0 |
| Valle d'Aosta | 44,1 | 45,2 | 45,4 |
| Lombardia | 47,7 | 48,2 | 49,9 |
| P.A. Bolzano | 35,3 | 38,3 | 32,5 |
| P.A. Trento | 53,5 | 54,8 | 55,2 |
| Veneto | 55,1 | 55,6 | 53,9 |
| Friuli Venezia Giulia | 55,7 | 57,7 | 60,7 |
| Liguria | 50,1 | 50,1 | 53,0 |
| Emilia-Romagna | 53,3 | 54,7 | 57,4 |
| Toscana | 55,3 | 56,0 | 56,4 |
| Umbria | 63,4 | 64,8 | 64,3 |
| Marche | 50,0 | 51,6 | 56,9 |
| Lazio | 51,8 | 52,3 | 52,7 |
| Abruzzo | 49,1 | 52,4 | 55,3 |
| Molise | 61,0 | 61,7 | 65,4 |
| Campania | 57,4 | 60,3 | 62,1 |
| Puglia | 59,4 | 51,4 | 51,4 |
| Basilicata | 53,2 | 66,6 | 58,5 |
| Calabria | 61,2 | 59,8 | 61,8 |
| Sicilia | 54,3 | 53,0 | 59,4 |
| Sardegna | 44,0 | 46,5 | 46,2 |



Indicatore 1.3 - Anno 2019

| Valore normale 9 | Scostamento minimo 6 | Scostamento rilevante ma in miglioramento 3 | Scostamento non accettabile 0 |
|---|---|---|---|
| ≥75% | 60% - 74,9% | <60% e in aumento | <60% e non in aumento |

Source: Ministero della Salute – Direzione Generale della Programmazione Sanitaria, Ufficio VI (2021)

**TABLE 5**
**PROPORTION OF PEOPLE WHO HAVE CARRIED OUT FIRST LEVEL SCREENING TESTS, IN AN ORGANIZED PROGRAM, FOR UTERINE CERVIX, BREAST, COLON-RECTUM (SCORE)**

| Regione | 2017 | 2018 | 2019 |
|---|---|---|---|
| Piemonte | 11,0 | 13,0 | 11,0 |
| Valle d'Aosta | 15,0 | 15,0 | 15,0 |
| Lombardia | 9,0 | 9,0 | 7,0 |
| P.A. Bolzano | 9,0 | 9,0 | 11,0 |
| P.A. Trento | 15,0 | 15,0 | 15,0 |
| Veneto | 15,0 | 15,0 | 15,0 |
| Friuli Venezia Giulia | 15,0 | 15,0 | 15,0 |
| Liguria | 9,0 | 11,0 | 9,0 |
| Emilia-Romagna | 15,0 | 15,0 | 15,0 |
| Toscana | 13,0 | 13,0 | 13,0 |
| Umbria | 11,0 | 11,0 | 13,0 |
| Marche | 9,0 | 9,0 | 9,0 |
| Lazio | 9,0 | 9,0 | 9,0 |
| Abruzzo | 9,0 | 9,0 | 9,0 |
| Molise | 9,0 | 7,0 | 3,0 |
| Campania | 3,0 | 3,0 | 3,0 |
| Puglia | 4,0 | 4,0 | 4,0 |
| Basilicata | 9,0 | 13,0 | 6,0 |
| Calabria | 2,0 | 2,0 | 2,0 |
| Sicilia | 3,0 | 3,0 | 5,0 |
| Sardegna | 3,0 | 5,0 | 5,0 |

Indicatore 2 - Anno 2019

| Valore normale 9 | Scostamento minimo 6 | Scostamento rilevante ma in miglioramento 3 | Scostamento non accettabile 0 |
|---|---|---|---|
| Score ≥9 | Score 7 - 8 | Score 5 - 6 | Score 0 – 4 |

Source: Ministero della Salute – Direzione Generale della Programmazione Sanitaria, Ufficio VI (2021)

**Years 2020–2021: Monitoring of LEAs With the New Guarantee System (NSG)**

Starting from 1 January 2020, the New Guarantee System (NSG) for healthcare monitoring came into force. The subset of “CORE” indicators, provided for by the New Guarantee System, has replaced the LEA Grid within compliance verification starting from the 2020 evaluation year.

There are 88 indicators identified, distributed by macro-areas:

– 16 for collective prevention and public health
– 33 for district assistance
– 24 for hospital care
– 4 context indicators for estimating healthcare needs
– 1 social equity indicator
– 10 indicators for monitoring and evaluating diagnostic-therapeutic care pathways - PDTA (COPD, heart failure, diabetes, breast cancer in women, colon cancer and rectal cancer).

Within the NSG, a subset of 22 indicators, so-called “CORE”, has been identified to replace the “LEA Grid” (in force until 2019), to be used to synthetically evaluate the provision of LEAs by the Regions. These indicators are divided into three macro-areas:

- collective prevention in public health
- district assistance

- hospital care.

For each indicator belonging to the CORE subset, thanks to a specific valorization function, a score is calculated on a scale from 0 to 100, with the score 60 corresponding to the minimum guarantee threshold (i.e. ‘sufficiency”). Further scores or penalties are assigned based on the temporal and geographical variability of the indicator value. The final score is then calculated for each macro-area of assistance: unlike the LEA Grid, in fact, the new methodology does not summarize the evaluation of the Regions in a single score, but measures the global compliance with the requirements independently for each macro-area of the LEA.

In order for the outcome of the global evaluation to be positive, and therefore for a Region to be “compliant”, the score for all three macro-areas must be no less than 60 (so as not to allow compensation between different macro-areas).

The evaluation system for maintaining the Essential Levels of Care becomes more stringent, enhancing the results that the Regions obtain in the three distinct macro-areas of Health Care.

The monitoring results for 2020 and 2021 with the New Guarantee System were calculated only for information purposes due to the emergency situation due to the COVID-19 pandemic and not for the purpose of evaluating the performances of the regional health services.

However, from the monitoring results, it can be seen that for the prevention area, the NSG highlights for 2021 that Calabria and Sicily reported an insufficiency score of less than 60 points, together with the P.A. of Bolzano (table 6). As regards vaccination prevention, vaccination coverage in children at 24 months for the basic cycle (polio, diphtheria, tetanus, hepatitis B, pertussis, Hib) sees Sicily and Sardinia below 60 points and, therefore, with insufficient performances. The 100% rating is still achieved with 95% vaccination coverage. Regarding vaccination coverage in children at 24 months for the first dose of measles, mumps, rubella (MMR) vaccine Valle d’Aosta, P.A. of Bolzano, Calabria and Sicily obtained a score of 0 for not having achieved coverage of more than 90%, Liguria and Sardinia are below the threshold of 60 points. The maximum score of 100 is still obtained with vaccination coverage above 95%. There is no longer the indicator relating to the flu vaccine for those over 65. For the indicator relating to the proportion of people (of the target age) who have carried out first level screening tests in an organized program, for uterine cervix, breast, colorectal in 2021 with monitoring through the New Guarantee System, the defaulting regions with a score lower than 60 are now 9: Lombardy (58.23 points), Lazio (56.50), Abruzzo (58.96), Molise (58.71), Campania (21.35), Puglia (33.44), Calabria (0.00), Sicily (40.50) and Sardinia (21.00). Basilicata is now at 75.90 points (table 7). The Covid years have been difficult for prevention and organized screening, but the extremely critical situation in the southern Italian regions has not substantially changed. The thresholds considered optimal to obtain 100 points are still the participation of 60% of the target population for breast cancer screening, and 50% for cervical and colorectal cancer screening.

**TABLE 6**
**NSG RESULTS – CORE SUBSET SCORES BY AREA, YEARS 2021-2017 (1/2)**

| Regione | 2021 | | | 2020 | | |
|---|---|---|---|---|---|---|
| | Area Prevenzione | Area Distrettuale | Area Ospedaliera | Area Prevenzione | Area Distrettuale | Area Ospedaliera |
| Piemonte | 86,05 | 84,47 | 81,36 | 76,08 | 91,26 | 75,05 |
| Valle d'Aosta | 45,31 | 49,31 | 52,59 | 74,06 | 56,58 | 59,71 |
| Lombardia | 86,84 | 93,09 | 85,33 | 62,02 | 95,02 | 75,59 |
| P.A. Bolzano | 51,97 | 68,05 | 80,75 | 51,90 | 57,43 | 66,89 |
| P.A. Trento | 92,55 | 79,33 | 96,52 | 88,42 | 78,07 | 93,07 |
| Veneto | 84,63 | 95,60 | 84,65 | 80,74 | 98,37 | 79,67 |
| Friuli V.G. | 85,32 | 79,42 | 78,22 | 75,63 | 80,35 | 74,06 |
| Liguria | 73,05 | 85,92 | 73,60 | 50,85 | 83,12 | 65,50 |
| Emilia Romagna | 90,73 | 95,96 | 94,50 | 89,08 | 95,16 | 89,52 |
| Toscana | 91,37 | 95,02 | 88,07 | 88,13 | 92,94 | 80,00 |
| Umbria | 91,97 | 73,64 | 82,31 | 89,64 | 68,55 | 71,61 |
| Marche | 82,62 | 89,38 | 85,90 | 79,01 | 91,68 | 75,05 |
| Lazio | 80,78 | 77,61 | 77,12 | 74,46 | 80,19 | 71,76 |
| Abruzzo | 77,74 | 68,46 | 69,25 | 54,03 | 76,94 | 63,47 |
| Molise | 82,99 | 65,40 | 48,55 | 64,21 | 67,12 | 41,94 |
| Campania | 78,37 | 57,52 | 62,68 | 61,53 | 57,14 | 59,08 |
| Puglia | 67,85 | 61,66 | 79,83 | 66,83 | 68,13 | 71,73 |
| Basilicata | 79,63 | 64,22 | 63,69 | 57,07 | 62,85 | 51,90 |
| Calabria | 52,96 | 48,51 | 58,52 | 32,73 | 48,18 | 48,44 |
| Sicilia | 45,53 | 62,19 | 75,29 | 43,44 | 62,06 | 69,26 |
| Sardegna | 61,63 | 49,34 | 58,71 | 70,79 | 48,95 | 59,26 |

*Area Distrettuale 2021: con indicatore D04C; Area Distrettuale 2020: con indicatore D03C.*

*In rosso i valori inferiori a 60 punti (soglia di sufficienza), in verde i valori uguali o superiori.*

Source: Ministero della Salute – Direzione Generale della Programmazione Sanitaria, Ufficio VI (2023)

**TABLE 6**
**NSG RESULTS – CORE SUBSET SCORES BY AREA, YEARS 2021-2017 (2/2)**

| Regione | 2019 | | | 2018 | | | 2017 | | |
|---|---|---|---|---|---|---|---|---|---|
| | Area Prevenzione | Area Distrettuale | Area Ospedaliera | Area Prevenzione | Area Distrettuale | Area Ospedaliera | Area Prevenzione | Area Distrettuale | Area Ospedaliera |
| Piemonte | 91,72 | 88,83 | 85,78 | 93,04 | 88,31 | 85,59 | 92,90 | 84,05 | 84,14 |
| Valle d'Aosta | 72,16 | 48,09 | 62,59 | 72,30 | 36,70 | 71,54 | 64,12 | 34,52 | 74,38 |
| Lombardia | 91,95 | 89,98 | 86,01 | 89,94 | 83,44 | 79,93 | 86,84 | 77,05 | 77,13 |
| P.A. Bolzano | 53,78 | 50,89 | 72,79 | 51,86 | 40,60 | 71,38 | 53,37 | 44,82 | 73,97 |
| P.A. Trento | 78,63 | 75,06 | 96,98 | 93,02 | 72,90 | 94,18 | 83,56 | 82,45 | 94,75 |
| Veneto | 94,13 | 97,64 | 86,66 | 91,72 | 94,65 | 85,93 | 80,75 | 95,10 | 83,67 |
| Friuli V.G. | 80,39 | 78,35 | 80,62 | 73,20 | 76,42 | 82,94 | 53,18 | 74,02 | 80,72 |
| Liguria | 82,09 | 85,48 | 75,99 | 83,50 | 86,84 | 75,84 | 73,94 | 84,16 | 79,99 |
| Emilia Romagna | 94,41 | 94,51 | 94,66 | 93,26 | 94,32 | 90,70 | 93,03 | 86,82 | 88,51 |
| Toscana | 90,67 | 88,50 | 91,39 | 88,48 | 89,79 | 90,91 | 87,07 | 82,67 | 94,27 |
| Umbria | 95,65 | 69,29 | 87,97 | 93,92 | 67,48 | 87,33 | 92,89 | 67,91 | 80,59 |
| Marche | 89,45 | 85,58 | 82,79 | 82,03 | 76,70 | 77,04 | 69,00 | 78,51 | 69,84 |
| Lazio | 86,23 | 73,51 | 72,44 | 84,99 | 62,40 | 73,25 | 86,18 | 57,99 | 70,78 |
| Abruzzo | 82,39 | 79,04 | 73,84 | 86,24 | 74,05 | 68,54 | 66,54 | 63,76 | 67,92 |
| Molise | 76,25 | 67,91 | 48,73 | 79,55 | 44,49 | 44,74 | 74,18 | 31,25 | 40,66 |
| Campania | 78,88 | 63,04 | 60,40 | 74,67 | 64,30 | 58,07 | 72,51 | 55,16 | 44,83 |
| Puglia | 81,59 | 76,53 | 72,22 | 79,39 | 70,57 | 72,14 | 66,21 | 64,60 | 65,90 |
| Basilicata | 76,93 | 50,23 | 77,52 | 84,16 | 45,09 | 75,83 | 78,69 | 49,86 | 72,56 |
| Calabria | 59,90 | 55,50 | 47,43 | 64,03 | 58,44 | 47,22 | 65,49 | 47,35 | 50,63 |
| Sicilia | 58,18 | 75,20 | 70,47 | 50,76 | 75,64 | 50,60 | 50,20 | 74,87 | 73,05 |
| Sardegna | 78,30 | 61,70 | 66,21 | 75,78 | 34,50 | 64,60 | 76,36 | 35,16 | 63,74 |

*In rosso i valori inferiori a 60 punti (soglia di sufficienza), in verde i valori uguali o superiori.*

Source: Ministero della Salute – Direzione Generale della Programmazione Sanitaria, Ufficio VI (2023)

**TABLE 7**
**NSG RESULTS - CORE SUBSET, PREVENTION AREA, YEAR 2021 (1/2)**

| Regione | P01C Copertura vaccinale nei bambini a 24 mesi per ciclo base (polio, difterite, tetano, epatite B, pertosse, Hib) | | P02C Copertura vaccinale nei bambini a 24 mesi per la 1° dose di vaccino contro morbillo, parotite, rosolia (MPR) | | P10Z Copertura delle principali attività riferite al controllo delle anagrafi animali, della alimentazione degli animali da reddito e della somministrazione di farmaci ai fini delle garanzie di sicurezza alimentare per il cittadino | | P12Z Copertura delle principali attività di controllo per la contaminazione degli alimenti, con particolare riferimento alla ricerca di sostanze illecite, di residui di contaminanti, di farmaci, di fitofarmaci e di additivi negli alimenti di origine animale e vegetale | |
|---|---|---|---|---|---|---|---|---|
| | Valore Indicatore (%) | Punteggio finale | Valore Indicatore (%) | Punteggio finale | Valore Indicatore (%) | Punteggio finale | Valore Indicatore (%) | Punteggio finale |
| Piemonte | 94,08 | **84,68** | 93,78 | **83,79** | 80,55 | **74,06** | 100,00 | **100,00** |
| Valle d'Aosta | 90,66 | **19,77** | 90,00 | **0,00** | 88,58 | **87,77** | 66,60 | **33,20** |
| Lombardia | 96,07 | **100,00** | 95,49 | **100,00** | 84,87 | **79,82** | 100,00 | **100,00** |
| P.A. Bolzano | 75,61 | **0,00** | 71,17 | **0,00** | 65,22 | **53,62** | 100,00 | **100,00** |
| P.A. Trento | 94,84 | **97,91** | 94,41 | **92,10** | 82,82 | **77,10** | 100,00 | **100,00** |
| Veneto | 95,48 | **100,00** | 95,18 | **100,00** | 48,90 | **31,86** | 99,24 | **95,48** |
| Friuli Venezia Giulia | 94,96 | **100,00** | 93,66 | **85,12** | 65,97 | **54,63** | 98,80 | **97,60** |
| Liguria | 93,36 | **78,14** | 91,32 | **39,52** | 74,98 | **66,63** | 100,00 | **100,00** |
| Emilia Romagna | 96,38 | **100,00** | 95,97 | **100,00** | 97,51 | **96,68** | 83,40 | **66,80** |
| Toscana | 95,98 | **100,00** | 95,04 | **100,00** | 79,00 | **71,99** | 98,72 | **97,44** |
| Umbria | 96,08 | **100,00** | 95,10 | **100,00** | 88,67 | **81,88** | 97,32 | **94,64** |
| Marche | 94,14 | **88,53** | 92,81 | **70,74** | 94,44 | **92,58** | 100,00 | **100,00** |
| Lazio | 95,90 | **100,00** | 97,64 | **100,00** | 64,29 | **52,39** | 100,00 | **100,00** |
| Abruzzo | 93,26 | **73,80** | 93,34 | **77,91** | 87,96 | **86,95** | 99,36 | **98,72** |
| Molise | 95,06 | **100,00** | 93,95 | **89,06** | 88,99 | **85,31** | 98,32 | **96,64** |
| Campania | 95,02 | **100,00** | 94,72 | **99,28** | 91,79 | **89,05** | 98,80 | **97,60** |
| Puglia | 92,48 | **66,37** | 92,44 | **65,93** | 83,98 | **78,63** | 100,00 | **100,00** |
| Basilicata | 94,18 | **86,03** | 92,31 | **64,16** | 90,02 | **86,69** | 100,00 | **100,00** |
| Calabria | 93,98 | **83,35** | 89,44 | **0,00** | 88,10 | **84,13** | 97,76 | **95,52** |
| Sicilia | 86,28 | **0,00** | 89,19 | **0,00** | 87,26 | **83,01** | 99,60 | **99,20** |
| Sardegna | 91,86 | **55,81** | 91,87 | **56,20** | 80,97 | **74,62** | 100,00 | **100,00** |

*Fonti informative indicatori:*

*P01C, P02C: dati comunicati dalle Regioni*

*P10Z: Piattaforma VETINFO (Sistema Informativo Veterinario)*

*P12Z: flussi NSIS*

Source: Ministero della Salute – Direzione Generale della Programmazione Sanitaria, Ufficio VI (2023)

**TABLE 7**
**NSG RESULTS - CORE SUBSET, PREVENTION AREA, YEAR 2021 (2/2)**

| Regione | P14C Indicatore composito sugli stili di vita (Istat) | | P15C Proporzione di persone (in età target) che hanno effettuato test di screening di primo livello in un programma organizzato, per cervice uterina, mammella, colon-retto | | | |
|---|---|---|---|---|---|---|
| | Valore Indicatore (%) | Punteggio finale | Valore Indicatore cervice (%) | Valore Indicatore mammella (%) | Valore Indicatore colon-retto (%) | Punteggio finale |
| Piemonte | 37,52 | **66,61** | 48,70 | 57,40 | 49,14 | **97,46** |
| Valle d'Aosta | 36,33 | **69,78** | 58,87 | 21,11 | 59,71 | **73,55** |
| Lombardia | 32,84 | **79,10** | 9,87 | 55,97 | 38,21 | **58,23** |
| P.A. Bolzano | 30,67 | **84,87** | 54,82 | 68,30 | 30,83 | **89,78** |
| P.A. Trento | 31,06 | **83,85** | 102,35 | 96,95 | 62,51 | **100,00** |
| Veneto | 33,91 | **76,23** | 61,80 | 65,64 | 67,67 | **100,00** |
| Friuli V.G. | 36,59 | **69,10** | 91,38 | 56,97 | 55,53 | **97,38** |
| Liguria | 34,76 | **73,98** | 41,20 | 47,75 | 34,47 | **80,49** |
| Emilia Romagna | 35,84 | **71,08** | 61,91 | 84,10 | 73,62 | **100,00** |
| Toscana | 35,97 | **70,75** | 64,06 | 64,30 | 45,75 | **97,73** |
| Umbria | 37,52 | **66,60** | 79,19 | 71,60 | 42,51 | **96,00** |
| Marche | 37,69 | **66,16** | 33,87 | 43,51 | 29,18 | **69,50** |
| Lazio | 36,24 | **70,03** | 29,61 | 35,26 | 20,73 | **56,90** |
| Abruzzo | 39,08 | **62,46** | 30,78 | 33,87 | 23,33 | **58,96** |
| Molise | 46,53 | **53,47** | 28,36 | 30,80 | 25,51 | **58,71** |
| Campania | 49,47 | **47,53** | 19,45 | 20,94 | 5,36 | **21,35** |
| Puglia | 42,34 | **57,66** | 26,17 | 26,01 | 7,83 | **33,44** |
| Basilicata | 49,62 | **50,38** | 29,15 | 52,08 | 33,57 | **75,90** |
| Calabria | 43,47 | **56,53** | 7,06 | 2,46 | 0,91 | **0,00** |
| Sicilia | 44,63 | **55,37** | 25,60 | 25,95 | 15,56 | **40,50** |
| Sardegna | 37,87 | **62,68** | 20,07 | 19,47 | 9,39 | **21,00** |

*Fonti informative indicatori:*

*P14C: Indagini campionarie Istat - Indagine multiscopo sulle famiglie "Aspetti della vita quotidiana"*

*P15C: Sistema informativo screening - dati elaborati dall'Osservatorio Nazionale Screening*

Source: Ministero della Salute – Direzione Generale della Programmazione Sanitaria, Ufficio VI (2023)

**Will the Intervention Program Financed by the Next Generation EU and by the National Health Equity Program 2021–2027 Be Enough to Change the Prevention Situation for Women's Health in Italy and in the South in Particular?**

To try to answer this question, I report the summary of the analyzes developed in January 2024 by the Osservatorio Nazionale Screening (National Screening Observatory)[7] edited by Paola Mantellini, head of the S.C. Screening and secondary prevention of the Institute for the study, prevention and oncology network (Ispro) of the Tuscany Region and director of the Osservatorio Nazionale Screening (Ons).

"Oncology screening programs are included among the essential levels of assistance (Lea - Prime Ministerial Decree 12 January 2017) and their activity is monitored through a series of analyzes carried out by the Ons and Passi surveillance. In the case of the three consolidated screenings (mammographic, cervical, colorectal), based on the new recommendations on oncological screening issued by the European Council in December 2022, the general objective is to ensure the provision of screening to at least 90% of citizens eligible in all member countries by 2025 [and the offer of a defined and free in-depth care and therapeutic path, ed.]. It is clear that to align with European indications it is necessary for our country to make very important changes and certainly the digital transformation in healthcare must also be able to concern oncological screening.

To understand the future implementation of the planned actions it is necessary to analyze in detail the most recent data on the extension (number of people invited out of the total of those entitled in the reference year) and adherence (number of responding users out of the total users invited in the reference year) to screening programs for breast, colorectal and cervical cancer, referring to 2021 [...].

At a national level, the value of the extension stands at 85.9% for mammographic screening (range from 101.6% in the North to 58.3% in the South), at 88.3% for cervical (from 129.6% in the Center to 68.8% in the South) and 79.4% for colorectal (from 100% in the Center to 43.7% in the South). It can clearly be seen that the current offer for mammographic and cervical screening is close to the value set by Europe for 2025, while for colorectal screening, we are more than 10 percentage points away from the target. The adherence data in Italy highlight a North-South gradient, similarly to the extension. Overall participation in the mammographic program is 56.2% with important differences between macro areas (North 64.7%; Center 50.2%; South and Islands 41.3%). Participation in cervical screening is 39.2% with a range that varies from 47.8% in the North to 33.4% in the Center and 32.6% in the South and Islands. A similar trend is recorded for colorectal screening: the national value for programs with fecal occult blood testing is 38.7% with higher values in the North (47.6%) than in the Center (31.5%) and the South and Islands (23.7%). Furthermore, the positive impact of screening programs on the population's health status is proportional to the share of people who undergo the screening test ("coverage"). The combination of data on the extension of invitations and participation by the population determines, in the regions of the South and Islands, coverage values mostly between 20 and 30%, with situations in which the data is less than 10%.

Although there are also significant participation problems in some regions of the Center, the real challenge for achieving the community objective is played out in the southern regions. The adoption of the National Health Equity Program (Pnes), whose objective is to strengthen health services and make access more equal in seven regions of the South, is the context in which to work to overcome this challenge. Regarding oncological screening, the program "aims to broaden the base of people who join it, also bringing to light the people who escape the invitation and those who, although invited, do not join". In essence, "an action is envisaged to strengthen the capacity of screening services, aimed at expanding the offer of oncology screening points and increasing participation, through the introduction of new organizational models, the promotion of effective communication methods and the adaptation of staff skills".

[…] As already mentioned, guaranteeing the invitation is not enough, for screening to be effective it is necessary for the population to participate. This means that it is essential to adopt permanent population awareness campaigns combined with a widespread and usable offer. To this end, the scientific and health community must deepen its reflection on Ministerial Decree 77 of 2022 in which prevention in general and screening in particular are only marginally mentioned, and it therefore becomes necessary for these issues

to be fully taken into account in the scope of the reorganization of local healthcare." (Osservatorio Nazionale Screening, 2024).

## ISS-PASSI Surveillance on Screenings for the Prevention of Cervical, Breast and Colorectal Cancer

The Passi surveillance of the Istituto Superiore di Sanità is characterized as a public health surveillance that collects, continuously and through sample surveys, information from the adult Italian population (18-69 years) on lifestyles and behavioral risk factors connected to onset of chronic non-communicable diseases and on the degree of knowledge and adherence to the intervention programs that the country is implementing for their prevention.

With data at national level (regional data are not updated on the site and must be requested from each regional coordinator of PASSI surveillance) of the PASSI surveillance sample surveys for screening for the prevention of cervical, breast, and colorectal cancers for the period 2021-2022 it is possible to have information on socio-demographic aspects in addition to the regional differences already recorded with the data from the monitoring of the Essential Levels of Care. It must be underlined that the 2021-2022 data discount the effects of the Covid 19 pandemic on treatment and prevention, but with an impact now mitigated by the availability of vaccines and the extension of the vaccination campaign with a return to normal economic, work and social activities.

### *Cervical Screening*

The PASSI 2021-2022 survey shows that the overall coverage of the preventive Pap test is high in Italy, but still insufficient in some regions, especially in southern and insular Italy, where just over one in two women carries it out in the right interval of time. Half of the women took the test as part of the programs organized by the local health authorities, while the other half took the test on their own initiative. This characteristic of the Pap test practice in Italy has some important consequences on compliance with the recommended interval and on equity. The share of women who undergo cervical screening is higher among the more educated or with greater economic resources among Italian citizens compared to foreigners, and among married or cohabiting women. Women with a lower level of education and with economic difficulties, as well as those with foreign citizenship, undertake effective prevention less frequently than others. However, these differences are very small or even non-existent in organized programs, while they are larger in screening carried out on personal initiative (table 8). The invitation letter, in association with the healthcare professional's advice, is the most effective tool for increasing compliance with screening.

### *Mammographic Screening*

The PASSI 2021-2022 data show that in Italy the share of women who undergo mammographic screening is higher among those who are more educated or with greater economic resources, among women of Italian citizenship compared to foreigners, and among married or cohabiting women. For the share of tests carried out outside of organized screening programs, greater differences are highlighted by age group, education, economic difficulty and citizenship (table 9). During the Covid 19 pandemic, the greatest reductions in coverage were recorded among women with a low level of education, those with many reported economic difficulties and foreigners. Even for the share of preventive mammograms performed within organized screening programs, or other free offers from local health authorities, greater variations were highlighted among women with low education and those with foreign citizenship.

The PASSI survey highlights a key factor that must characterize mammographic screening. The effectiveness of screening promotion increases if the Local Health Authority invitation is accompanied by the advice of your trusted doctor or a healthcare professional. The invitation letter alone is not enough to guarantee women's participation in screening, while medical advice is essential.

### *Colorectal Screening*

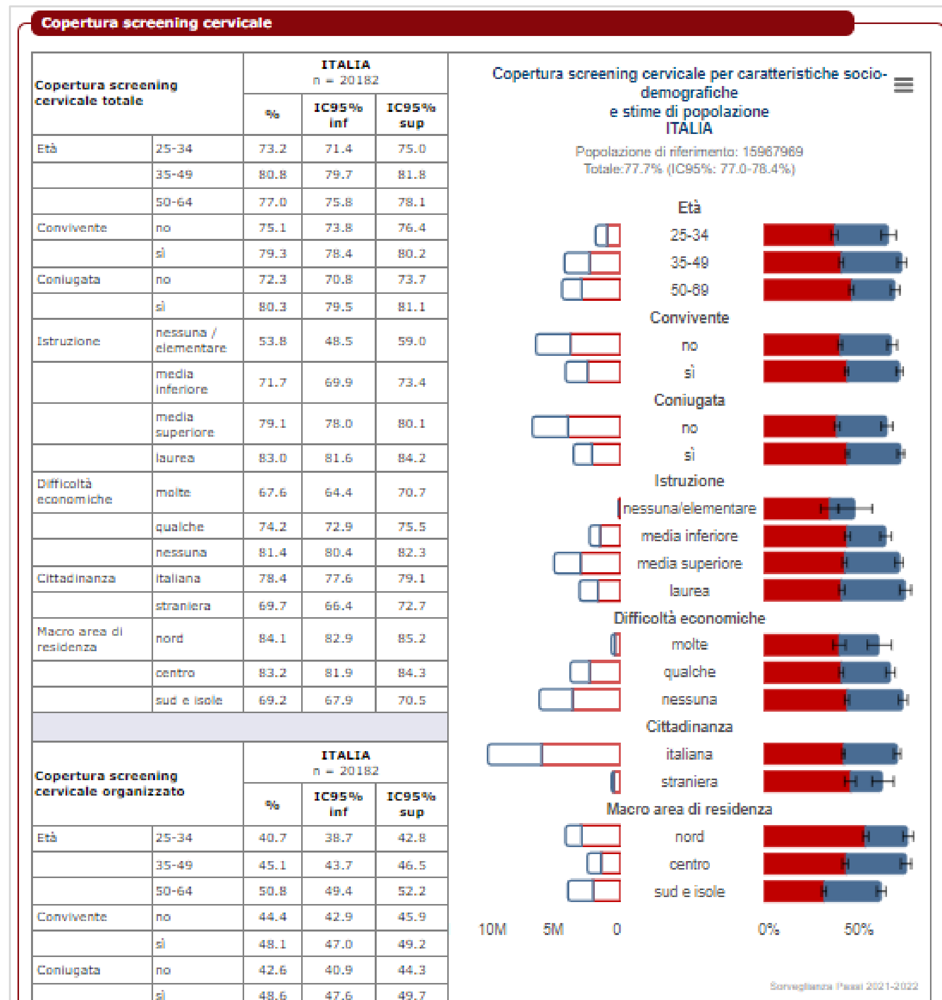
Fecal occult blood (SOF) testing is the most widely used preventive test for the early detection of colorectal cancer. In the two-year period 2021-2022, 38% of interviewees between 50 and 69 years of age report doing so in the two years preceding the interview. It is more common for older people (60-69 years)

to undergo this test, Italian citizens than foreigners and more economically advantaged or educated people. There is no significant gender difference (table 10).

In the two years 2021-2022, 64% of the target population reports having been reached by some screening promotion intervention (letter from the Local Health Autority advice from a healthcare professional, information campaign), the effectiveness of which grows as the number of received inputs increases, reaching the maximum with the combination of all interventions. On the contrary, compliance with screening is almost zero among people not reached by any promotion intervention (4%).

From these summary data on the influence of people's sociodemographic characteristics on adherence to screening for early detection of cervical, breast, and colorectal cancers, it emerges that structures closer to citizens in the area (NRRP) and interventions to promote access to care and both primary and secondary prevention (screening) in the regions of Southern Italy especially for the disadvantaged population (National Health Equity Program 2021-2027) can significantly change the health results obtained even though these interventions are non-permanent and should have been decided and implemented in previous years by the National Health Service in compliance with its founding principles.

**TABLE 8**
**ISTITUTO SUPERIORE DI SANITÀ, PASSI SURVEILLANCE, DATA FOR ITALY – CERVICAL SCREENING COVERAGE, YEARS 2021-2022**


Copertura screening cervicale

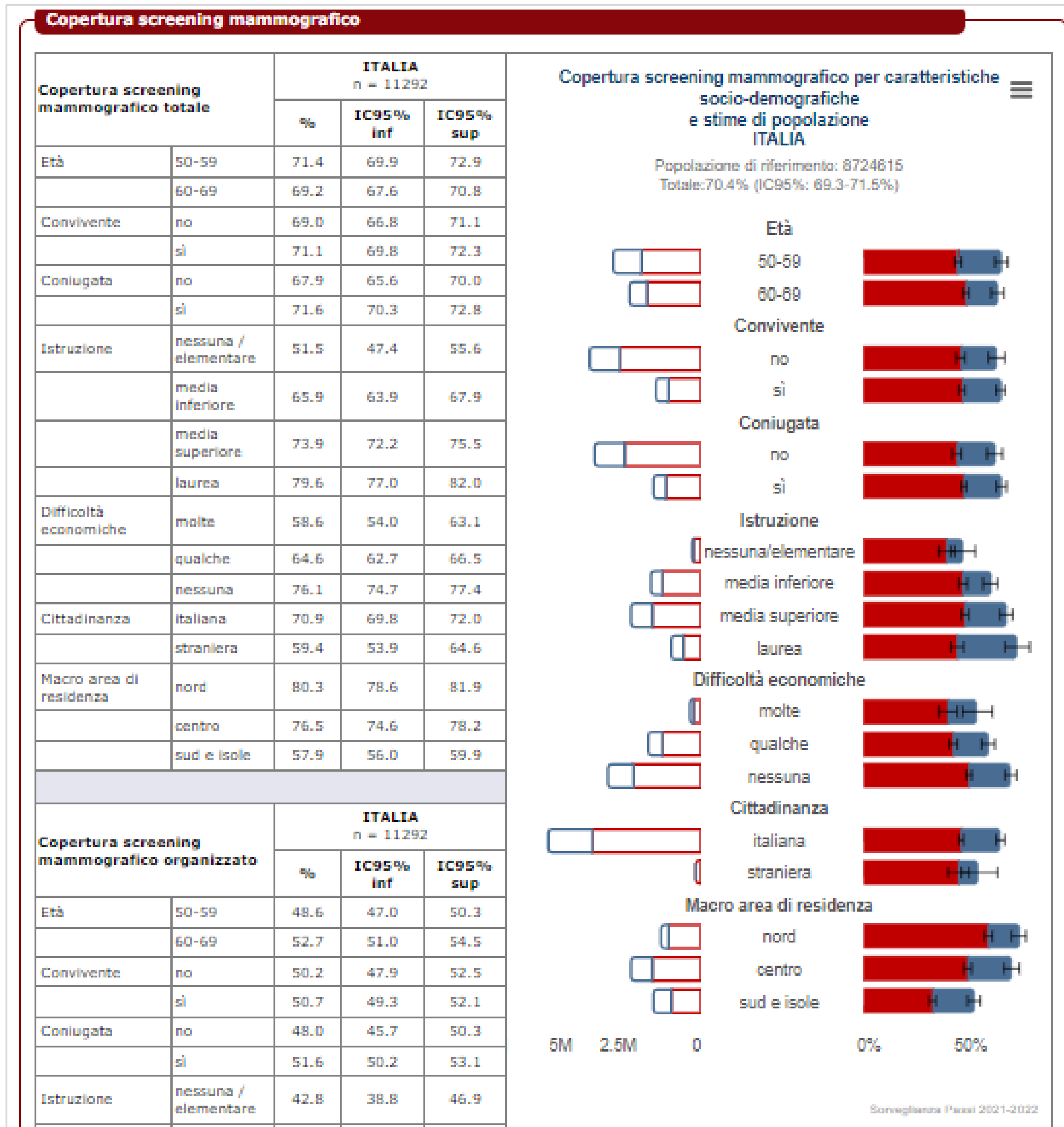
| Copertura screening cervicale totale | | ITALIA n = 20182 | | |
|---|---|---|---|---|
| | | % | IC95% inf | IC95% sup |
| Età | 25-34 | 73.2 | 71.4 | 75.0 |
| | 35-49 | 80.8 | 79.7 | 81.8 |
| | 50-64 | 77.0 | 75.8 | 78.1 |
| Convivente | no | 75.1 | 73.8 | 76.4 |
| | sì | 79.3 | 78.4 | 80.2 |
| Coniugata | no | 72.3 | 70.8 | 73.7 |
| | sì | 80.3 | 79.5 | 81.1 |
| Istruzione | nessuna / elementare | 53.8 | 48.5 | 59.0 |
| | media inferiore | 71.7 | 69.9 | 73.4 |
| | media superiore | 79.1 | 78.0 | 80.1 |
| | laurea | 83.0 | 81.6 | 84.2 |
| Difficoltà economiche | molte | 67.6 | 64.4 | 70.7 |
| | qualche | 74.2 | 72.9 | 75.5 |
| | nessuna | 81.4 | 80.4 | 82.3 |
| Cittadinanza | italiana | 78.4 | 77.6 | 79.1 |
| | straniera | 69.7 | 66.4 | 72.7 |
| Macro area di residenza | nord | 84.1 | 82.9 | 85.2 |
| | centro | 83.2 | 81.9 | 84.3 |
| | sud e isole | 69.2 | 67.9 | 70.5 |

| Copertura screening cervicale organizzato | | ITALIA n = 20182 | | |
|---|---|---|---|---|
| | | % | IC95% inf | IC95% sup |
| Età | 25-34 | 40.7 | 38.7 | 42.8 |
| | 35-49 | 45.1 | 43.7 | 46.5 |
| | 50-64 | 50.8 | 49.4 | 52.2 |
| Convivente | no | 44.4 | 42.9 | 45.9 |
| | sì | 48.1 | 47.0 | 49.2 |
| Coniugata | no | 42.6 | 40.9 | 44.3 |
| | sì | 48.6 | 47.6 | 49.7 |



Source: Istituto Superiore di Sanità (2024a)

**TABLE 9**
**ISTITUTO SUPERIORE DI SANITÀ, PASSI SURVEILLANCE, DATA FOR ITALY – MAMMOGRAPHIC SCREENING COVERAGE, YEARS 2021-2022**



Copertura screening mammografico

| Copertura screening mammografico totale | | ITALIA n = 11292 | | |
|---|---|---|---|---|
| | | % | IC95% inf | IC95% sup |
| Età | 50-59 | 71.4 | 69.9 | 72.9 |
| | 60-69 | 69.2 | 67.6 | 70.8 |
| Convivente | no | 69.0 | 66.8 | 71.1 |
| | sì | 71.1 | 69.8 | 72.3 |
| Coniugata | no | 67.9 | 65.6 | 70.0 |
| | sì | 71.6 | 70.3 | 72.8 |
| Istruzione | nessuna / elementare | 51.5 | 47.4 | 55.6 |
| | media inferiore | 65.9 | 63.9 | 67.9 |
| | media superiore | 73.9 | 72.2 | 75.5 |
| | laurea | 79.6 | 77.0 | 82.0 |
| Difficoltà economiche | molte | 58.6 | 54.0 | 63.1 |
| | qualche | 64.6 | 62.7 | 66.5 |
| | nessuna | 76.1 | 74.7 | 77.4 |
| Cittadinanza | italiana | 70.9 | 69.8 | 72.0 |
| | straniera | 59.4 | 53.9 | 64.6 |
| Macro area di residenza | nord | 80.3 | 78.6 | 81.9 |
| | centro | 76.5 | 74.6 | 78.2 |
| | sud e isole | 57.9 | 56.0 | 59.9 |

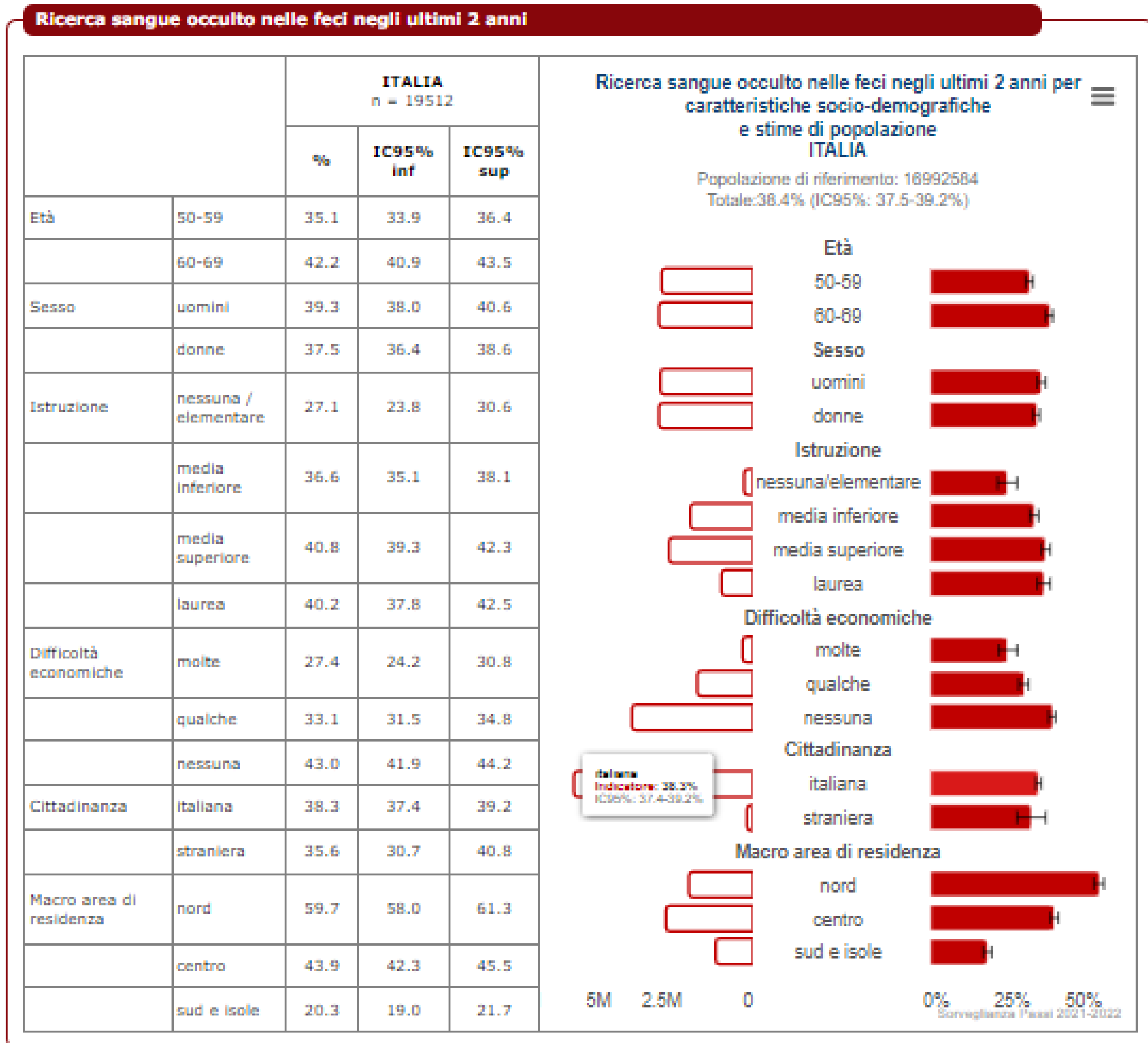
| Copertura screening mammografico organizzato | | ITALIA n = 11292 | | |
|---|---|---|---|---|
| | | % | IC95% inf | IC95% sup |
| Età | 50-59 | 48.6 | 47.0 | 50.3 |
| | 60-69 | 52.7 | 51.0 | 54.5 |
| Convivente | no | 50.2 | 47.9 | 52.5 |
| | sì | 50.7 | 49.3 | 52.1 |
| Coniugata | no | 48.0 | 45.7 | 50.3 |
| | sì | 51.6 | 50.2 | 53.1 |
| Istruzione | nessuna / elementare | 42.8 | 38.8 | 46.9 |



Copertura screening mammografico organizzato:
Copertura screening mammografico spontaneo:

Source: Istituto Superiore di Sanità (2024b)

**TABLE 10**
**ISTITUTO SUPERIORE DI SANITÀ, PASSI SURVEILLANCE, DATA FOR ITALY – COLORECTAL SCREENING COVERAGE, YEARS 2021-2022**



Ricerca sangue occulto nelle feci negli ultimi 2 anni

| | | ITALIA n = 19512 | | |
|---|---|---|---|---|
| | | % | IC95% inf | IC95% sup |
| Età | 50-59 | 35.1 | 33.9 | 36.4 |
| | 60-69 | 42.2 | 40.9 | 43.5 |
| Sesso | uomini | 39.3 | 38.0 | 40.6 |
| | donne | 37.5 | 36.4 | 38.6 |
| Istruzione | nessuna / elementare | 27.1 | 23.8 | 30.6 |
| | media inferiore | 36.6 | 35.1 | 38.1 |
| | media superiore | 40.8 | 39.3 | 42.3 |
| | laurea | 40.2 | 37.8 | 42.5 |
| Difficoltà economiche | molte | 27.4 | 24.2 | 30.8 |
| | qualche | 33.1 | 31.5 | 34.8 |
| | nessuna | 43.0 | 41.9 | 44.2 |
| Cittadinanza | italiana | 38.3 | 37.4 | 39.2 |
| | straniera | 35.6 | 30.7 | 40.8 |
| Macro area di residenza | nord | 59.7 | 58.0 | 61.3 |
| | centro | 43.9 | 42.3 | 45.5 |
| | sud e isole | 20.3 | 19.0 | 21.7 |



Copertura screening mammografico organizzato:
Copertura screening mammografico spontaneo: :

Source: Istituto Superiore di Sanità (2024c)

## CONCLUSIONS

It will gradually be possible to evaluate the effects of the interventions carried out in Italy with the Italian National Recovery and Resilience Plan and the National Health Equity Program 2021-2027, as many of the projects are still in the initial phase.

But these European intervention programs are expected to end between 2026 and 2027 and therefore together with the development of the NRRP and PNES 2021-2027 projects, the Italian National Health Service will have to find its own innovative and long-term strategy to obtain the strengthening of prevention and of gender services and strategies, guaranteeing homogeneity of structures and access for all territories of the Country, above all by repairing the shortcomings in health protection in the regions of Southern Italy

present since the establishment of the Service in 1978 and highlighted in continuously by the monitoring instituted after the advent of healthcare federalism in 2001.

Once again, for Italy, and in this case for the only institution which, given its founding characteristics, should not have needed it, also a European emergency intervention after a pandemic and an exceptional European structural intervention for the protection of disadvantaged groups touch crucial and sensitive points of our National Health Service and can change its evolution perspective in guaranteeing equity and protecting gender needs.

However, it should be remembered that at the same time as the implementation of the equity and gender health promotion measures (unprecedented for Italy) of the Next Generation EU and the National Health Equity Program 2021-2027, Italy is internally debating these recent years on differentiated autonomy[8] for its administrative regions with ordinary statute.

## ENDNOTES

1. This paper constitutes the initial part of a study on the effects of post-Covid 19 European funding on Italian healthcare, study financed with individual research support funds (RFO) from the Italian Ministry of Research.
2. In 2002 a meeting of the European Council in Barcelona set targets to improve the provision of childcare in the European Union (Mills et al. 2014). The intention of the so called `Barcelona targets´ was to encourage EU member states to remove disincentives to female labour force participation. Taking into account the demand for childcare facilities, it was agreed to provide childcare by 2010 to at least 90 percent of children between three years old and the mandatory school age, and to at least 33 percent of children under three years of age (Barcelona European Council 2002).
3. The European Social Fund Plus (ESF+) is the EU's main tool for investing in people, building a more social and inclusive Europe and advancing the European Pillar of Social Rights. The ESF+ helps shape policies related to employment, social matters, education, and skills across the EU.
   The ESF+ brings together four financing instruments which were distinct in the 2014-2020 programming period: the European Social Fund (ESF), the Fund for European Aid to the Most Deprived (FEAD), the Youth Employment Initiative and the European Program for Employment and Social Innovation (EaSI).
4. In 2021-2027, the ERDF will enable investments to make Europe and its regions:
   - more competitive and smarter, through innovation and support to small and medium-sized businesses, as well as digitization and digital connectivity
   - greener, low-carbon and resilient
   - more connected by enhancing mobility
   - more social, by supporting employment, education, skills, social inclusion and equal access to healthcare, as well as by enhancing the role of culture and sustainable tourism
   - closer to citizens, supporting locally-led development and sustainable urban development across the EU.
5. It is true that the years preceding the 2020 Covid 19 pandemic were challenging for the Italian National Health Service in terms of the availability of resources, in a period of spending review, and of extensive discussions on its financial sustainability. The debate in Italy on the concept of sustainability to be adopted to analyze and manage the Italian National Health Service was already very intense before the Covid 19 pandemic in 2020. The Permanent Hygiene and Health Commission of the Senate in the XVII Legislature 2013-2018 worked intensely on this theme and still today this work is the basis of reflections on the sustainability of the National Health Service in the post-pandemic period (Senato della Repubblica, 2018).
6. The total score of the indicator is calculated by adding the scores of the individual screening programs to which a score ranging from 0 to 5 can be attributed:

| SCORE | 0 | 1 | 3 | 5 |
|---|---|---|---|---|
| Scr. Mam | 0% - 5% | 6% - 34% | 35% - 59% | ≥ 60% |
| Scr.. Cerv. | 0% - 5% | 6% - 24% | 25% - 49% | ≥ 50% |
| Scr. Colo-rettale | 0% - 5% | 6% - 24% | 25% - 49% | ≥ 50% |

7. The Osservatorio Nazionale Screening (National Screening Observatory) (Ons) was founded in 2001, with the name of National Observatory for the Prevention of Female Cancer, as a network of screening centers,

thanks to the financial support of the Italian League for the Fight against Cancer (Lilt). In 2005 the Ons took on its current name, expanding its competences based on the growing activation of colorectal screening programmes. The Italian Mammographic Screening Group (Gisma) and the Italian Cervical Carcinoma Group (Gisci) and, more recently, the Italian Colorectal Screening Group (Giscor) have joined the Ons since its establishment.

Since then, the Ons has worked as a technical tool to support both the Regions, for the implementation of screening programs, and the Ministry of Health, for the definition of operational methods, monitoring and evaluation of the programs.

The decree of the Minister of Health of 4 August 2011 provides for the reorganization of the institutional structure of the Osservatorio Nazionale Screening and establishes its structural integration into the institutional screening governance mechanism, identifying it as a technical tool for the implementation of screening policies.

8. Article 116, third paragraph of the Italian Constitution provides for the possibility of attributing particular forms and conditions of autonomy to the Regions with ordinary statute (so-called "differentiated regionalism" or "asymmetric regionalism", as it allows some Regions to endow themselves with powers different from the others), without prejudice to the particular forms enjoyed by the Regions with special statute (art. 116, first paragraph). https://temi.camera.it/leg17/temi/lautonomia_differenziata_delle_regioni_a_statuto_ordinario

## REFERENCES


ASviS - Alleanza Italiana per lo Sviluppo Sostenibile. (2023). *Italy and the Sustainable Development Goals, Report 2023*. Retrieved from https://asvis.it/public/asvis2/files/Rapporto_ASviS/Rapporto_ASViS_2023/Report_ASviS_ENG_2023_FINAL.pdf

Barcelona European Council. (2002, March 15–16). *Presidency Conclusions,* document SN 100/1/02 REV 1. Retrieved from http://www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/en/ec/71025.pdf

Council of the Ministers of the Italian Republic. (2021). *Recovery and Resilience Plan, approved on 12 January 2021*. Retrieved from https://www.mef.gov.it/export/sites/MEF/en/focus/documents/PNRR-NEXT-GENERATION-ITALIA_ENG_09022021.pdf

Dirindin, N., & Vineis, P. (2004). *Elementi di Economia Sanitaria*. Bologna, Il Mulino

Istituto Superiore di Sanità, Sorveglianza PASSI. (2024a). *I dati per l'Italia – Copertura Screening Cervicale, anni 2021-2022*. Retrieved from https://www.epicentro.iss.it/passi/dati/ScreeningCervicale.

Istituto Superiore di Sanità, Sorveglianza PASSI. (2024b*). I dati per l'Italia – Copertura Screening Mammografico, anni 2021-2022.* Retrieved from https://www.epicentro.iss.it/passi/dati/ScreeningMammografico.

Istituto Superiore di Sanità, Sorveglianza PASSI. (2024c*). I dati per l'Italia – Copertura Screening Colorettale, anni 2021-2022*. Retrieved from https://www.epicentro.iss.it/passi/dati/ScreeningColorettale.

Mills, M., Präg, P., Tsang, F., Begall, K., Derbyshire, J., Kohle, L., . . . Hoorens, S. (2014). *Use of Childcare in the EU Member States and Progress towards the Barcelona Targets*. Short Statistical Report No.1. Prepared for the European Commission Directorate General for Justice. Retrieved from http://www.cite.gov.pt/pt/destaques/complementosDestqs/140502_gender_equality_workforce_ssr1_en.pdf

Ministero della Salute – Direzione Generale della Programmazione Sanitaria, Ufficio VI. (2021). *Monitoraggio dei LEA attraverso la cd. Griglia LEA. Metodologia e Risultati dell'anno 2019*, Maggio 2021.

Ministero della Salute – Direzione Generale della Programmazione Sanitaria, Ufficio VI. (2023). *Monitoraggio dei LEA attraverso il Nuovo Sistema di Garanzia. Metodologia e risultati dell'anno 2021*, Maggio 2023.
Osservatorio Nazionale Screening. (2024). *I Numeri del Cancro: Le Statistiche dell'Ons*, 24 gennaio 2024. Retrieved from https://www.osservatorionazionalescreening.it/content/i-numeri-del-cancro-le-statistiche-dell%E2%80%99ons.
Senato della Repubblica. (2018). *Documento conclusivo dell'indagine conoscitiva sulla sostenibilità del Servizio Sanitario Nazionale con particolare riferimento alla garanzia dei principi di universalità, uguaglianza ed equità*. [online] www.senato.it. Retrieved from https://www.senato.it/leg/17/BGT/Schede/docnonleg/35564.htm. Indagine svolta dalla 12esima Commissione Permanente (Igiene e Sanità) del Senato della Repubblica. Relatori: sen. Luigi D'Ambrosio Lettieri e sen. Nerina Dirindin.