Health Surveillance in Italian workers formerly exposed to asbestos: a call to action for policy makers

Sorveglianza sanitaria nei lavoratori ex esposti ad amianto: un invito all’azione per i politici

As referred by the third Italian Consensus Report on Pleural Mesothelioma (MM), recently published in La Medicina del Lavoro (1), health surveillance programs aimed at workers formerly exposed to asbestos are defined according to current laws (2). In the case of occupational exposure to asbestos, Italian law requires extensive health surveillance of workers after the cessation of their employment. Nonetheless, Italian laws neither specify the timeframe of these clinical checks, nor who has financial and organizational responsibility for this surveillance (3). Although medical surveillance of workers previously exposed to asbestos has been made mandatory by several laws since 1991, the medical protocols have not yet been established. For this reason, over the years, some Italian Regions such as Piedmont, Lombardy, Campania, Tuscany, Emilia Romagna, Friuli Venezia Giulia, and Veneto have promulgated their own laws on this issue. In a recent study Zona and Bruno compared the diverse health surveillance programmes that have been adopted at different times by some Italian regional administrations to address the needs of subjects with past exposure to asbestos (4). As a result of the Italian National Prevention Plan 2014-2018 (5), the National Plan for Asbestos (6) has developed guidelines for the health surveillance of workers formerly exposed to asbestos. According to these, the INAIL/ISPESL (Italian Workers’ Compensation Authority) and the CORs (Operative Regional Centers) must organize the data collected by the ASL (Italian Local Health Authorities); moreover, the Regions are expected to create a specific follow-up for this category of former workers. As a result of the National Plan for Asbestos, in 2013, 14 Italian Regions have developed their own health surveillance programs for workers formerly exposed to asbestos. Surprisingly, in January 2015, the Ministry of Finance expressed a negative opinion about the National Plan for Asbestos, and consequently the Conference State-Regions did not ratify it (7). Nevertheless, data from the last report of the National Mesothelioma Registry (RENAM) by INAIL/ISPESL showed that mesothelioma is a challenge for the middle and southern Regions of Italy, above all Campania, Apulia, Latium, Tuscany, Marche, and Sicily (8). So, in May 2015, the Regions submitted a proposal to the Italian Parliament for the application of a sole protocol for the health surveillance of workers formerly exposed to asbestos (7). It will be interesting to see if the recent financial crisis will cause negative consequences for the fulfillment of a uniform protocol for this category of former workers. A Spanish study has highlighted that post-occupational health surveillance as well as medical and legal recognition of asbestos-related diseases in Spain are “inadequate”, with “inter-regional inequalities among affected workers.” (9). In Italy, the National Health Service was established in 1978 to guarantee all citizens access to a broad range of health services, provided on a free (or almost free) basis (10). The decentralization process, so called “fiscal federalism”, which emerged in 2000, has taken place in a context characterized by huge
disparities between one region and another in terms of economic conditions, culture, politics, and the efficiency of administrative bodies (10, 11). The autonomy enjoyed today by Italian regions is such that it has led to the existence of twenty different Regional Health Services, rather than one uniform all around the Country (12). The 2011 OECD Report highlighted a critical situation in Italy, portraying a picture of inter-regional inequality, and giving particular attention to regional differences (13). According to CENSIS, the Italian Institute for socio-economic research, the gap between the rich Italian North and the poor South is widening, and Italy is the country with the most relevant territorial inequality. In the welfare system the gap concerns both the essential levels of assistance (LEA) as well as the economic and financial status. According to the 2000 WHO Report (14), Italy had the second best National Health Service in the world. However, since 2001, the 19 Italian Regions and 2 Autonomous Provinces have exercised their autonomy very differently, with northern Regions being more successful in establishing effective structures of healthcare delivery, management and monitoring, as compared to the Regions in the South (15, 16). In Italy inequalities tend to increase during economic crisis, and especially affect people from lower social classes and individuals living in depressed areas of the country; for this reason, in my opinion, in the context of the socio-economic and health inequalities, and with the South being so underprivileged, it’s urgent to approve a national law regarding health surveillance aimed at workers formerly exposed to asbestos: an intervention by policy makers, equalizing future policies in order to alleviate the gap between northern and southern Regions of Italy and to improve the monitoring system of asbestos effects in Italian workers after cessation of their professional exposure.

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References

2. Legislative Decree no. 57/2006 and Legislative Decree no. 81/2008


