

MAINTAINING EQUITY IN THE ITALIAN NATIONAL HEALTH SERVICE AT THE TIME OF THE MEASURES FOR REORGANIZING THE OFFERINGS OF OUTPATIENT SPECIALIST SERVICES

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ABSTRACT

In Italy, the establishment in 1978 of a National Health Service (NHS) providing universal coverage for comprehensive and essential healthcare services marked a clear step forward in social policies and the concrete assertion of the safeguard of health as a fundamental right of the individual and collective interest. In addition to the universality of access, the system guarantees equality of access to healthcare services (eliminating geographical barriers and guaranteeing free medical care) and envisages financial contribution from individuals regardless of their risk of disease and the services obtained, but determined solely on the basis of their ability to contribute.

With the way the welfare system has been set up from Beveridge up to the present, any deviation from the sanctioned rules in the NHS entails major changes in the national social security system (and in the logic of the associated tax system), generating inequalities in the spending, savings, and investment opportunities of households.

This study intends to present the implications for household well-being and finances of the solutions adopted after 2010 to deal with the problems of waiting lists and the control of spending for the services of early detection of breast cancer, redirecting the services toward the screening of public health.

Despite the proposals for empowerment and for the promotion of the listening to and involvement of the citizens, the system of guarantees of the NHS principles has not worked.

Approaching the issue from a user's point of view, the author analyzes the feasibility of applying to the functioning of the NHS a supplementary guarantee instrument, such as an independent regulatory agency, and considers its effects to safeguard the equity in accessing the services and contribute actively to improving the system.

Key words: Equity; National Health Service; Breast Cancer; Early Detection Services;

JEL Classification: I18, I14, K32

I. INTRODUCTION

Since the end of World War II, Europe has progressively created a welfare system in which the access to medical treatment for the entire population has been the basis of a comprehensive policy for social progress: a social security system fully developed and aimed at ensuring income security against want, disease, ignorance, squalor and idleness (Beveridge, 1942, p. 6)¹. At the basis of this effort was a social contract accepted by the citizens in which the State did not need to accumulate reserves for actuarial risks, as it was able to finance the social security system with its power to compel successive generations of citizens to become insured and through taxation (Beveridge, 1942, p. 13).

In Italy the establishment in 1978 of a National Health Service providing universal coverage for comprehensive and essential healthcare services marked a noticeable progress in social policies and the concrete assertion of the safeguard of health as a fundamental right of the individual and collective interest (Legge 833/1978, articolo 1). It should be remembered that, in addition to the universality of access, the system guarantees the equality of access to healthcare services (with the elimination of geographical barriers and guaranteeing free medical care) and envisages financial contribution from individuals regardless of their risk of disease and the services obtained, but only determined by their ability to contribute. Over the years the system has been equipped with increasingly appropriate instruments to meet its objectives, and has had to deal with a growing demand for healthcare services and an increase in public health spending.

The work was carried out within the framework of the teaching of Health Economics held by the author at the School of Economics, Statistics and Management at the University of Bologna. The approach given to the course received a mention from the Social Partners in the consultation carried out by the School for its degree programmes in October 2014. The work has benefited of a short stay at the Library of the London School of Economics.

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¹ A recent reflection on the Beveridge Report in Layard (2013).

Due to the characteristics of the system, any solution adopted for the management of the demand for healthcare services and the control of expenditure should be in accordance with the founding principles and the general taxation origin of the NHS funding².

This study intends to present, using an actual current case study concerning the metropolitan area of the city of Bologna, the solutions applied to address the problems of waiting lists (and the control of spending) for the services of early detection of breast cancer, in order to verify whether the system currently provides its citizens with management and control tools that safeguard them during the reorganisation processes, ensuring compliance with the fundamental principles that form the basis of the social contract.

Approaching the issue from a user's point of view, the author suggests supplementary guarantee instruments, such as an independent regulatory agency, to supplement the ones already in place, to safeguard the citizen when accessing the services of the public healthcare system and considers its effects to safeguard the equity and to actively contribute to improving the system.

II. THE RELEVANCE OF THE ANALYSED CONTEXT AND THE DESIGN OF THE STUDY

The case studied concerns one of Italy's most advanced local healthcare systems, in both structures and organisation, for the needs of the citizens³, and may therefore be considered an example of the real capabilities of the current organisation of the national healthcare system and of its control system to respond to the reorganisation processes, guaranteeing the maintaining of its fundamental principles. On the other hand the case studied concerns breast cancer that in the European Union is the most common cancer and the most common cause of death due to cancer in women. In Italy breast cancer is the first cause of mortality amongst the female population between 45 and 64 years of age, accounting for 14% of total deaths and epidemiological data show how in general, even if from the early 1990s to the present there has been a gradual decline in mortality, the incidence of this disease seems to stabilise only in the most recent years and the prevalence is on the rise (Ministero della Salute, 2014). In Graph 1 and Graph 2 we show the trends of the standardized incidence and mortality rates (all ages and ages 50-69 years) for breast cancer from the annual report on cancer of the Associazione Italiana di Oncologia Medica-AIOM and of the Associazione Italiana Registri Tumori-AIRTUM (AIOM and AIRTUM, 2016).

Therefore in the fight against breast cancer in Italy the problem does not seem to be specifically the control of the demand for the services of early detection of breast cancer (which generated the waiting lists), but, as it appears from the Report of a European survey on the organisation of breast cancer care services from the European Commission – Joint Research Centre of 2014 (European Commission – Joint Research Centre, 2014), it seems to be rather the implementation of an advanced system of early detection, treatment, follow-up, and psychological support activities for women suffering from breast cancer.

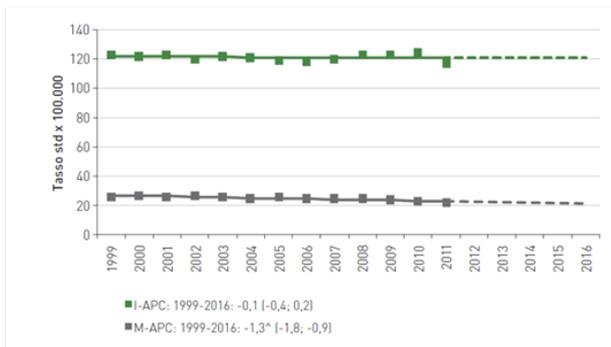
The study is made up of two parts. The first part presents the measures implemented starting in 2010 at the regional and local levels with the aim of reducing the waiting lists for mammograms, and describes and comments on the changes made with regard to the access procedures for the service and the organisation of the structures for the early detection of breast cancer in Bologna. Next, the reactions of the users, associations, and media are presented, and the responses of the Local Health Authority of Bologna are analysed. Lastly, an analysis is made of the consequences on the possibilities for access to the services which were formerly offered to the city's women via spontaneous access, and the new costs for users are assessed. The second part essentially analyses the system of tools implemented to safeguard the principle of equity within the National Health Service and by the Emilia-Romagna regional body, evaluating whether it has been able to report the effects of the reorganisation process presented and influence their control. Having verified that these tools are substantially inapplicable to such reorganisation processes, a proposal has been made of an alternative tool for safeguarding the rights of national healthcare system users, such as the possibility of creating an independent administrative authority tasked with the direction, control and sanction of the National Health Service, as a guarantee of founding principles and users' rights.

The method of analysis adopted is the study of the events that occurred and the repercussions that derived through the documentary information and statistical data available in the institutional websites and by consulting directly the organisations involved. It is reconstructed the path of the complaints through the different channels,

² On the differences between the concepts of "security" and "assistance" and the different management of devoted funding see Castellino, Fornero (2002). On the preference for the National Health Service compared to the Social Health Insurance see OECD (2015).

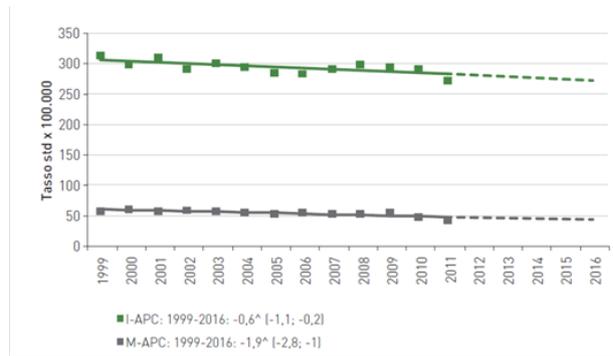
³ In the last published report, for the year 2013, of the Italian Ministry of Health on the monitoring of the achievement of the objectives of public health protection, Emilia-Romagna was at the top of the ranking of the Italian regions for the compliance with the Essential Care Levels (LEA) (Ministero della Salute – Direzione Generale della Programmazione Sanitaria, 2015).

highlighting the reactions and effects achieved. The study assumes the characteristics of the analysis of an experiment.



Graph 1. Breast cancer incidence and mortality

Source: AIOM and AIRTUM, 2016, p.67



Graph 2. Breast cancer incidence and mortality - age 50-69

PART A. CASE STUDY

1. THE ORIGINS

The starting point for this study is an analysis of a change of strong impact for the female population of the city of Bologna with regard to the offering of mammograms for the early detection of breast cancer made by the Local Health Authority (Azienda Unità Sanitaria Locale: AUSL) of Bologna in recent years.

In 2012, a new oncology centre was set up at the Bellaria Hospital, with a new Breast Unit, and the new regional strategy for improving access to outpatient specialist services, in application of Regional Council Decree 1532/2006, “Regional plan for the reduction of waiting lists”, was adopted. The plan includes measures designed to reduce waiting lists for mammographic exams, while the rules for scheduled access (screening programmes) and spontaneous access to mammograms for the early detection of breast cancer in the metropolitan area of the city of Bologna were changed.

The Breast Diagnostic Centre of Bologna’s Maggiore Hospital

As of May 2011, it was no longer possible to book mammograms (even with one-year waiting lists) at the breast diagnostic centre of the Maggiore Hospital in Bologna (“*Senologia del Maggiore*”: Breast Pathology Department). The users of the Single Booking Centre (*Centro Unico di Prenotazione*: CUP 2000) were subsequently informed that the screening service and care pathways were being transferred to the Breast Unit of the Bellaria Hospital in Bologna, in the newly created oncology centre.

The women covered by the AUSL of Bologna were accustomed to a spontaneous access for routine breast exams at the centre of the Maggiore Hospital, and therefore during that period many users contacted the booking service, but were told that the booking was closed and the reason why was unknown.

The trade unions immediately went into action, seeking to find out the reason for the suspension, and asserting that it was not possible to close the booking and that this was a guarantee that had been given by the Province and the AUSL.

When contacted, the Bologna AUSL explained that the reason for the suspension of the booking service for the Maggiore hospital was the start-up of the new Breast Unit at Bellaria Hospital, which would have brought together, within a single oncological centre, all the early detection, treatment, follow-up, and psychological support activities for women suffering from breast cancer, while the Maggiore Breast Pathology Department would have been transferred to the same centre. The mammograms not included in the screening programme, formerly available at the Maggiore Breast Pathology Department, would have been bookable at the other facilities in Bologna and its province. The AUSL stated that the care pathways and screenings, too, would have been transferred to the Breast Unit at the Bellaria Hospital (*Il Resto Del Carlino* – Bologna, 2011) .

The new Breast Unit of Bellaria Hospital

“The new Breast Unit of the Bellaria looks to the future. In fact, the European provisions state that within the next three years the prevention and treatment of breast tumours are to be performed exclusively by Breast Units

certified by EUSOMA (European Society of Breast Cancer Specialists). The Bellaria Breast Unit has already initiated the certification procedure.

[...]

The new Breast Unit is housed, together with Radiotherapy, in the new Pavilion H of Bellaria Hospital. The pavilion has an area of 2,750 square metres, situated on 5 floors; it was built with an investment of 5,302,656 euro, in addition to 1,100,000 euro for the facilities necessary for the diagnostic equipment. The Breast Unit also received a donation from the Fondazione Del Monte of a 3D digital mammography system, a stereotaxic biopsy system, two ultrasound tomography machines, and three systems for burning CDs, for a total value of 500,000 euro.

Altogether, at the Breast Pathology Department of the Breast Unit there are 4 mammography systems, one of which for stereotaxic biopsy, two ultrasound tomography machines, and one ultrasound machine, situated in three mammography rooms connected to three outpatient ultrasound clinics, and in one biopsy room.” (Regione Emilia-Romagna – Portale Saluter, 2012)

The consequences

Since 2011 the female population of Bologna no longer had the availability of a Breast Pathology Unit open to the public for the early detection of breast cancer, which was included within the context of the Maternity and Paediatrics services of the Maggiore Hospital and located in the city centre, easily reachable by public transport. Therefore a facility that received women not when they were already clearly ill, but throughout their entire lifetime, one where they could take care of their health as a whole. And it thus also covered the early detection of breast cancer, using the most advanced methods and instruments.

2. CHARACTERISTICS OF THE FACILITIES AVAILABLE AS OF SEPTEMBER 2015 FOR MAMMOGRAMS OF ORGANISED SCREENING AND SPONTANEOUS ACCESS, ACCORDING TO THE INFORMATION PROVIDED BY THE BOLOGNA LOCAL HEALTH AUTHORITY, “AUSL”

The website of the Bologna AUSL (Azienda Unità Sanitaria Locale di Bologna, 2014a) indicates that, for screening programmes, mammograms are performed:

- at the 3 multi-purpose clinics of the Bologna AUSL: Casalecchio, San Lazzaro di Savena, San Pietro in Casale;
- at the 5 hospitals of the Bologna AUSL: Bazzano, Bellaria, Bentivoglio, San Giovanni in Persiceto, Vergato,
- and at the University Hospital of Bologna.

The Bologna AUSL website also states that mammograms for early detection, with spontaneous access to the services of the Regional Health Service (SSR), can be had in 10 reported facilities (Figure 1), of which only two are in the city of Bologna; these are private facilities without any specialisation in the breast pathology field (Azienda Unità Sanitaria Locale di Bologna, 2015).

This is the only written source to which the study being conducted can refer, as the Single Booking Centre (CUP 2000) does not yet envisage the possibility to provide, at a user’s request, the results of the requests for services made at its windows. That is, it does not provide the list of the facilities made available by the Bologna AUSL for the specific service, making it impossible to verify the immediate situation of the waiting lists for the service requested (in this case, for bilateral mammograms for the early detection of breast cancer with women’s spontaneous access to the exams).

The service access attempts made from 2011 up to the present have always resulted in the operators giving the information of waiting times of varying lengths mostly for the radiology clinic of Bazzano and, in response to the last requests made in May 2014 and April 2015, they announced an immediate availability at an accredited private facility in Pieve di Cento. The operator stated that there have no longer been any open slots for Sant’Orsola Hospital for some time now, and that no waiting lists have been set up for that facility either (according to the operator, waiting lists for mammograms no longer exist).

A useful source of information (and of documentation for the citizen) on the requests for healthcare services with the Regional Health Service (Servizio Sanitario Regionale: SSR) and the meeting of such requests would be possible if a trace of the request sessions remained in the person’s Electronic Healthcare File (Fascicolo Sanitario Elettronico: FSE), just as a trace remains in the CUP 2000 system. A great deal of other information on the

relations between users and SSR should be stored in the FSE, such as the accesses made to private freelance medical services within public facilities as a result of the non-availability of the services under the SSR.

For all centres – both for the organised screening for early detection of breast cancer and for the early detection of breast cancer as a mindful, informed choice by women receiving mammograms via spontaneous access – the pages of the Bologna AUSL website do not state whether the facilities where the mammograms are performed are certified by EUSOMA, as envisaged by the European Union (Commission of European Communities, 2003; Perry et al., 2013; European Parliament, 2006) and ratified by Italy in 2014 in the guidelines for the establishment of the network of the breast units (Conferenza Stato Regioni, 2014), for a real protection of women’s health and an effective use of resources. Also not indicated, as requested by EUSOMA, are the type of mammography unit (except, through the website, for one of the private facilities in Bologna) and the structure responsible for its almost daily maintenance. Except for the Sant’Orsola University Hospital⁴ (information available on the University Hospital’s website) and one of the private facilities in Casalecchio di Reno (from facility website), the team or names of the team members are not indicated either. Other information always omitted includes the number of mammograms read by each breast pathologist each year, and whether a double reading of the mammograms is envisaged (Wilson et al., 2013) (Table 1).

Only for the mobile unit does the page devoted to the breast cancer screening programme on the Bologna AUSL website specify: “Furthermore, since July 2007 they are also performed in the Mobile Mammography Unit. The vehicle, equipped with a latest-generation digital mammography unit, reaches all the towns that do not have a mammography facility in the immediate vicinity or which, due to particular morphological conditions of the territory, are poorly served by transport. [...] The mobile mammography unit is totally autonomous, and therefore does not require backing by any healthcare facility. The mammogram is performed aboard the vehicle by a radiologist, and the results are then evaluated by a physician [*underscoring ours*] of the Breast Pathology Department of the Bellaria-Maggiore Hospital. The breast cancer screening campaign is conducted with the involvement of a team of professionals from the Oncology Operational Units (e.g. Breast Pathology, Radiology, Anatomical Pathology) and Screening Centre.” (Azienda Unità Sanitaria Locale di Bologna, 2014a).

⁴ The 5 hospitals of the Bologna AUSL of Bazzano, Bellaria, Bentivoglio, San Giovanni in Persiceto, Vergato do not have any website.

FIGURE 1. – Facilities that perform mammograms in spontaneous access in Bologna metropolitan area with the Regional Health Service (SSR)

MAMMOGRAFIA BILATERALE		
Mammografia bilaterale		
Cosa Serve: Prescrizione, Tesserino Team		
Dove posso trovare la prestazione		
Ambulatorio radiologia Distretto Casalecchio di Reno - BAZZANO - <i>Ambulatori Ospedale Bazzano</i>	Su prenotazione	
Ambulatorio radiologia Distretto Casalecchio di Reno - CASALECCHIO DI RENO - <i>Poliambulatorio</i>	Su prenotazione	
Ambulatorio radiologia Distretto Porretta Terme - VERGATO - <i>Casa della salute</i>	Su prenotazione	
Ambulatorio radiologia Distretto Pianura Est - PIEVE DI CENTO - <i>Poliambulatorio Francesco Duranti</i>	Su prenotazione	
Ambulatorio radiologia Distretto Pianura Est - MOLINELLA - <i>Poliambulatorio</i>	Su prenotazione	
Ambulatorio radiologia Distretto Pianura Ovest - SAN GIOVANNI IN PERSICETO - <i>Area ambulatoriale San Giovanni in Persiceto</i>	Su prenotazione	
Ambulatorio radiologia Distretto Casalecchio di Reno - CASALECCHIO DI RENO - <i>Casa di cura Villa Chiara</i>	Su prenotazione	
Ambulatorio radiologia Distretto S.Lazzaro di Savena - SAN LAZZARO DI SAVENA - <i>Poliambulatorio</i>	Su prenotazione	
Ambulatorio radiologia Distretto Città di Bologna - BOLOGNA Navile - <i>Casa di cura Villa Erbosa</i>	Su prenotazione	
Ambulatorio radiologia Distretto Città di Bologna - BOLOGNA S. Donato - <i>Antalgik</i>	Su prenotazione	

Source: Azienda Unità Sanitaria Locale di Bologna (2015)

TABLE 1. – Information provided by the facilities that perform mammograms in spontaneous access in Bologna metropolitan area with the Regional Health Service (SSR)

FACILITIES	LOCATED IN THE CITY OF BOLOGNA	INFORMATION PROVIDED					
		SPECIALISATION IN BREAST PATHOLOGY FIELD	INFORMATION IF EUSOMA CERTIFIED	INDICATION OF TYPE MAMMOGRAPHY UNIT	NAME OF TEAM MEMBERS	N. OF MAMMOGRAMS READ EACH YEAR BY B. PATH.	IF DOUBLE READING OF MAMMOGRAMS ENVISAGED
Ambulatorio radiologia Distretto Casalecchio di Reno - BAZZANO - Ambulatori Ospedale Bazzano	NO	NO	NO	NO	NO	NO	NO
Ambulatorio radiologia Distretto Casalecchio di Reno - CASALECCHIO DI RENO - Poliambulatorio	NO	NO	NO	NO	NO	NO	NO
Ambulatorio radiologia Distretto Porretta Terme - VERGATO - Casa della Salute	NO	NO	NO	NO	NO	NO	NO
Ambulatorio radiologia Distretto Pianura Est - PIEVE DI CENTO - Poliambulatorio Francesco Duranti	NO	NO	NO	NO	NO	NO	NO
Ambulatorio radiologia Distretto Pianura Est - MOLINELLA - Poliambulatorio	NO	NO	NO	NO	NO	NO	NO
Ambulatorio radiologia Distretto Pianura ovest - SAN GIOVANNI IN PERSICETO - Area ambulatoriale San Giovanni in Persiceto	NO	NO	NO	NO	NO	NO	NO
Ambulatorio radiologia Distretto Casalecchio di Reno - CASALECCHIO DI RENO - Casa di Cura Villa Chiara	NO	NO	NO	NO	YES	NO	NO
Ambulatorio radiologia Distretto S.Lazzaro di Savena - SAN LAZZARO DI SAVENA - Poliambulatorio	NO	NO	NO	NO	NO	NO	NO
Ambulatorio radiologia Distretto Città di Bologna - BOLOGNA Navile - Casa di Cura Villa Erbosa	YES	NO	NO	NO	NO	NO	NO
Ambulatorio radiologia Distretto Città di Bologna - BOLOGNA S. Donato - Antalgik	YES	NO	NO	YES	NO	NO	NO

Source: Our elaboration on Azienda Unità Sanitaria Locale di Bologna (2015)

3. WAITING TIMES FOR SPONTANEOUS ACCESS TO MAMMOGRAMS FOR EARLY CANCER DETECTION

The Bologna AUSL information on waiting lists

On its website, the Bologna AUSL provided, at least until May 2014 (Azienda Unità Sanitaria Locale di Bologna, 2014b; Gatti, 2014), information on the waiting lists for specialist services for which the waiting times are monitored, together with the locations of facilities throughout the territory for the years 2013 and 2014.

These range from 574 waiting days in October 2013 to 22 waiting days in January and March 2014 (Table 2), but a personal check at the CUP 2000 (without the issue, as previously mentioned, of any written documentation) revealed that the waiting times were reduced by the recourse to facilities outside the city of Bologna, where the mammograms are not performed in Breast Pathology Diagnostics Units (Società Italiana di Radiologia Medica – SIRM, 2004, p. 581) or in accordance with the quality standards set by European Union.

It is no longer possible to book ultrasound scans of the breast, which are now considered second-level diagnostic services, provided only within pathways for patients already under a specialist's care. It is not clear how this decision can comply with the recommendations of the Italian Medical Radiology Association to use ultrasound scans in combination with mammograms both in cases of spontaneous access and in organised screening programmes, particularly for women with breasts that are radiologically dense, and in addition to an examination by a breast pathologist (Società Italiana di Radiologia Medica – SIRM, 2004, p. 583).

Table 2. - Waiting times (in days) recorded from 1st October 2013 to 3rd March 2014 for the outpatient specialist services subject to monitoring of the waiting times with institutional territorialisation. (Bologna AUSL structures, Accredited private structures, Policlinico Sant'Orsola, Istituto Ortopedico Rizzoli)

BOLOGNESE METROPOLITAN AREA						
GROUP OF SERVICES	W.T. on 1 October 2013	W.T. on 4 November 2013	W.T. on 2 December 2013	W.T. on 7 January 2014	W.T. on 3 February 2014	W.T. on 3 March 2014
BREAST ULTRASOUND	100	556	158	2 L No Cup	2 L No Cup	2 L No Cup
ELECTROMYOGRAM	23	22	14	20	28	120
MAMMOGRAM	574	66	64	22	29	22
LOWER ABDOMEN MRI	165	207	136	273	122	199
BRAIN MRI	3	14	2	7	8	10
SPINAL MRI	7	3	2	3	4	7
MUSCULOSKELETAL MRI	2	12	12	1	5	9
VASCULAR SURGERY VISIT	7	7	92	6	7	7
GASTROENTEROLOGY VISIT	2	2	3	6	2	4

Source: Azienda Unità Sanitaria Locale di Bologna (2014b)

Legenda:

2 L No Cup = from January 2014 ultrasound scans of the breast are considered as second-level diagnostic service, provided only within pathways for patients already under a specialist's care.

4. THE POLICY OF THE BOLOGNA AUSL ON THE SPONTANEOUS ACCESS WAITING LISTS FOR MAMMOGRAMS FOR EARLY DETECTION OF BREAST CANCER

The press release from the Local Health Authority of Bologna of September 2012 presents its decisions on waiting lists and policies for the providing of specialist services (examinations and tests):

“The information contained in the cases reported today by “*Il Resto del Carlino*” does not permit a precise reconstruction.

[...]

With regard to the request for bilateral mammograms, it must be remembered that since 1997 in Bologna, as in the entire Emilia-Romagna region, there is a specific cancer screening programme for breast cancer. The screening involves all women aged 45 through 74 years – approximately 176,000 in the metropolitan area of Bologna – who are all offered screening mammograms and in-depth diagnostic tests, in addition to access to any necessary therapies and treatments. Urgent and postponable urgent mammograms are ensured, for the clinical conditions defined by the regional indications, within 72 hours and 7 days, respectively. Women being followed by the SSR, who must undergo follow-up procedures after cancer pathologies, do not need to book their tests, because they access them directly through their specialists.

From the elements contained in the article, it can only be inferred that the mammogram request was not of an urgent nature.

The Authority is willing, through its Citizens Relations Office (Ufficio Relazioni con il Pubblico: URP), to provide more complete information to those interested.

Examinations and tests in the metropolitan area of Bologna

Approximately 14 million specialist services (examinations and tests) were provided in 2011 by the Bolognese healthcare facilities to citizens residing in the metropolitan area, broken down into over 2,000 different types and 6,000 specialist facilities. Compared to the regional average, in the territory of Bologna the number of specialist services provided is 8% higher.

The reduction of the waiting times, in line with the regional indications, has been achieved thanks to the adoption of innovative organisational and instrumental solutions like booking schedules that are always open, thus guaranteeing that the citizen will always be able to book any service, whether a first or follow-up appointment, without time restrictions; there are also 20 “guaranteed” pathways for examinations and tests for which critical factors have been recorded previously.

[...]

Furthermore, particular commitment has been devoted to the distinction and separation of the booking of the first appointment from the subsequent ones, arranged directly with the specialists. The direct and complete taking on of the case by the outpatient clinic specialist is an important innovation. Thanks to dedicated IT platforms, the specialist books directly the diagnostic services after the first one, for example the follow-up appointments. This procedure is already present today for 24 diagnostic-therapeutic-care pathways for patients with cancer, orthopaedic problems with trauma pathologies, complex rheumatology pathologies, thyroid pathologies, women included in the screening programme for breast cancer, and pregnant women being followed by family clinics.

The creation of new diagnostic-therapeutic-care pathways and the strengthening of the already-existing ones will guarantee for citizens, through the direct booking by the specialist, definite and appropriate times and places for diagnostic services and check-ups, and the maximum simplification of the access. This will improve the quality of care, in particular for persons with chronic pathologies, and will have a positive impact on the appropriateness of prescriptions.

[...]

(Azienda Unità Sanitaria Locale di Bologna, 2012)

5. REMARKS ON THE POLICY OF THE BOLOGNA AUSL ON THE SPONTANEOUS ACCESS WAITING LISTS FOR MAMMOGRAMS FOR THE EARLY DETECTION OF BREAST CANCER

The press release (unlike the data on waiting lists, the press release has not been removed from the AUSL Bologna site) documents and clarifies how the current policy on providing outpatient services and the management of early detection breast cancer works, starting from choices of the Regional Administration.

With regard to this approach, it has already been pointed out that the Bologna AUSL website and other information sources do not mention the quality of the facilities (and personnel) performing bilateral mammograms made available for the early detection of breast cancer, whether by spontaneous access or through organised screening programmes.

The reference to the presence of a screening programme highlights the trend of recent years to shift the safeguard of women's healthcare concerning breast cancer to public health services, rather than focus on individual prevention (Ministero della Salute, 2014, p. 34). But it should be noted that, taking into account how the screening programmes are currently organised in Italy, the two levels of healthcare services are quite separate and distinct within the Essential Care Levels (Livelli Essenziali di Assistenza: LEA⁵) established by the National Health Service since 2001. The screenings belong to the "areas of activity of collective prevention and public health" and the providing of bilateral mammograms for early cancer detection via spontaneous access belong to the "areas of activity of district healthcare", specifically to the "area of outpatient specialist care"⁶.

This distinction between objectives and functions also corresponds to a separation of the funding lines and their source.

The two areas have different aims (public health on the one hand and the response to the need for individual health on the other) which determine protocols that are very different and appropriate for the specific aims towards which they operate, and profoundly different ways of monitoring the results and the inexpensiveness of the actions. The decisions to be made concerning (on keeping or changing) a generalised screening programme for the early detection of breast cancer take place within a logic of cost/effectiveness assessment (Mantellini, Lippi, 2011); the method for assessing the effects and costs of non-prevention (or no early detection) at the individual level in clinical, functional, and even sociocultural terms is quite different and more complex. Evidence of the differences can be found in the damage payments awarded in civil liability lawsuits against doctors. In this case there are no thresholds of successful extension. Every life lost is an inestimable damage. And it is the individual that is the reason for which the healthcare systems were born.

The strategic choices of the European Commission on screenings were made considering important social and health aspects. The European programme was launched after acknowledging that there are strong territorial differences in the implementation of screening programmes and in their quality, with the programmes of Sweden and Finland being the best, and today the situation is still characterised by great differences (European Commission – Joint Research Centre, 2014). Both the European Commission and the Italian Ministry of Health (Ministero della Salute – Direzione Generale della Prevenzione, 2005), as well as the Emilia-Romagna region, stress how screening programmes are implemented to reduce the social inequality of breast cancer survival and to provide a certified system that makes it possible to access effective early detection services (in addition to permitting the access to surgery, treatments, and therapies with the highest standards of appropriateness, quality, rapidity, and customisation).

From this perspective, the first level of early detection with the Regional Health Service (Servizio Sanitario Regionale: SSR) via spontaneous access [the bilateral mammogram (yearly, if so decided by the breast pathologist) plus ultrasound scan and breast examination, in addition to the possibility of being adequately informed of the possibilities for primary breast cancer prevention through a conversation with the breast pathologist] in high-quality facilities (the Breast Unit) for asymptomatic women over the age of 40 should be the point of arrival of a campaign for social inclusion and qualification of facilities initiated with the generalised screening programme (for the Emilia-Romagna region, the implementation of organised screening for early breast cancer detection has existed for 19 years now). The opposite, on the other hand, should not be true, but appears evident from various indicators in Bologna, such as the disappearance of the Breast Pathology Department of the Maggiore Hospital, the uncertainty about the quality of the facilities offering mammograms in the metropolitan area of Bologna, the disappearance of the spontaneous access to the providing of mammograms in the facilities that are probably the most qualified (Sant'Orsola and Bellaria), and the substantial disappearance of availability in the city of Bologna, the waiting lists for which, in fact, remain somewhat a mystery (and which the operator of CUP2000 claims no longer exist).

⁵ On the principles of the Essential Care Levels see Dirindin (2000). On the mechanisms of implementing of the Essential Care Levels see Torbica and Fattore (2005).

⁶ In the United States of America the reported literature shows the distinction between NBCCEDP breast cancer screening for medically uninsured and underinsured low-income women and the women that access the early detection for breast cancer within their health insurance program (Escoffery *et al*, 2012; Hoerger *et al*, 2011).

Most probably, the general effect on wellbeing of the women (and cost) of the non-access (or access to inadequate facilities) with the SSR at the first level of early diagnosis with spontaneous access by women living in Bologna will be quantifiable only after a number of years, in terms of lives not saved, years of life lost, and quality of living lost in the remaining years of life. It must also be taken into account that, at present, only one third of the women who answer the call of the organised screening programme are able to access the one and only existing Breast Unit (certified EUSOMA) at Bellaria Hospital.

And it will also be possible to measure the (social) effect on families, the offspring involved, and the workforce: a workforce in which 60.9% of the women of Emilia-Romagna between the ages of 15 and 64 are employed. In an Universal Healthcare System by working, these women participate in a social security and tax system that reduces their net pay to less than 50% of the gross expense paid by their employers, but promises social guarantees⁷.

I asked the regional Health Department – which is responsible for overseeing the operation of the region's Local Health Authorities (AUSLs), as specified by the Health Programming Directorate of the Ministry of Health – for the data on the access to the mammography services in Bologna and in the other AUSLs of the region before and after the changes made in the Bologna AUSL's offering for initial examinations and tests. The answer on December 28, 2015 was that for my research I have to refer to the published data on Screening Program (<http://salute.regione.emilia-romagna.it/screening/tumori-femminili/>) and to the data on the website of the AUSL of Bologna (www.ausl.bologna.it/per-i-cittadini/scr/Screening-del-tumore-della-mammella).

One last observation to be made on the Bologna AUSL press release of 2012 is that regarding the Authority's willingness, through its Citizens Relations Office, to provide those interested with more complete information. Since May 2012 my reports to the Public Relations Office on the impossibility of accessing the pre-existing quality structures (Maggiore Breast Pathology Department, now the Breast Unit of the Bellaria) for preventive mammograms with spontaneous access received an answer from the Bologna AUSL (under which I am registered) in February 2013 (it should take 30 days at most), only after I reported the case to the Prefect of Bologna and after that his office pressed the AUSL to provide the answer.

6. THE CHARACTERISTICS OF ORGANISED SCREENING FOR EARLY DETECTION OF BREAST CANCER IN EMILIA-ROMAGNA AND BOLOGNA

The Ministry of Health, in the document of the working group for the definition of specific rules for the organisation and assistance of the network of breast units of 2014, states that “It is a fact that the screening program is ‘only’ an approach organised to maximise the efficiency of early detection and to reduce inequalities in access to this service” (Ministero della Salute, 2014, p. 34).

From the information that it was possible to gather on the screening programme for early detection of breast cancer in Emilia-Romagna and Bologna, this does not appear to be exactly true.

Women should receive a letter of invitation with a prescheduled appointment at a specific structure, which can be changed only on request.

Only one third of them will be called, or will manage to negotiate, to receive a mammogram at the Breast Unit at the Bellaria Hospital, certified EUSOMA. The remaining women will be directed to the facilities indicated on the website of the AUSL of Bologna of which little or nothing is known about all the aspects that determine the effectiveness of early detection (mammography unit, experience and updating of operators, dedicated units, ...).

Women, as we have already pointed out, will not be received by a breast pathologist, but only by a mammographer who will perform the mammogram, and who will be unable to decide whether to add an ultrasound scan and, remaining within the aims of the screening programme, will have to optimise the time necessary for the exam.

They should receive the letter with the results of the exam within one month, after reading and analysis of the report by two specialists. The operators of the Screening Centre of the Bologna AUSL state over the phone that the women invited for the organised screening programme express dissatisfaction over the fact that the screening does not provide them with the disc of the test results. The answer from the Regional Coordination Office of the cancer screening programme was that it is possible to obtain the disc on request. From the information given on the AUSL Bologna website, it does not appear exactly clear that there is currently a double reading of the report.

⁷ In 2016 it has been 5 years since the closure of the Maggiore Breast Pathology Department. In a context of an Universal Healthcare System probably we can no longer just talk about a lack of equity in the SSR, but we have to talk about discrimination of a large group of women in the city of Bologna.

The frequency of the call for the mammogram is every two years for women in the age group 50-74 years and once a year for women between 45 and 49, because “many scientific studies have shown that the benefit of a range of one year is limited to the age group 45-49 years, while in the range 50-74, it has been shown that two years is a time sufficient for early diagnosis in the great majority of cases” (Servizio Sanitario Regionale Emilia-Romagna, 2013): sufficient, evidently, but not optimal.

In 2010 (the only year for which data are provided and before the reorganisation of 2011-2012), 2,164 women, equal to 35%, took part in the screening for the first time, with a slightly higher participation (41%) among those aged 45-49 years (9,004 of the 21,788 invited) (Azienda Unità Sanitaria Locale di Bologna, 2014a).

This participation rate is very low, even compared to the national average of 55% (Conferenza Stato Regioni, 2014), and much lower than the acceptable level of 50% (Osservatorio Nazionale Screening, 2014). The AUSL of Bologna does not provide details on mammograms performed in spontaneous access through the SSR, which should be of the same reliability as those from screening. Therefore we do not know (for 2009) what women’s choices are for the early detection of breast cancer: whether, if they are not included in the organised screening programme, they do no prevention at all, or if they take advantage of the availability of the Maggiore Breast Pathology Department, opting for spontaneous access through the SSR.

The fact that between 40 and 50 women a day turn to the Breast Unit of Bellaria to request (now against payment through an in-house freelance system) a mammogram for early detection might indicate that there was a highly developed system of self-planned prevention by women in the city of Bologna with the SSR, and they now want to continue with the standards that were previously guaranteed them.

Such low screening programme participation data might indicate that the regulatory system organised in Bologna may help very little with access equity (will it be the women of lower social classes who give up their right to prevention?), and ends up discouraging the women who are normally accustomed to prevention.

And the general critical issues of this organised screening may be confirmed by the considerable resources made available by the European Union with the aim of achieving significant results (European Commission, 2014).

7. THE POSSIBILITIES FOR ACCESS TO THE SERVICES FORMERLY OFFERED VIA SPONTANEOUS ACCESS AND THE NEW COSTS : THE IMPLICATIONS FOR HOUSEHOLD ECONOMIC WELL-BEING AND FINANCES

a) Deregulation (the same mammography service available before with spontaneous access and now provided against payment under a private freelance system within a public facility at Bellaria Breast Unit)

When asked to be able to receive the early breast cancer detection service previously offered by the SSR at the Breast Pathology Department of the Maggiore Hospital with spontaneous access, the operators of the CUP2000 (and not only) inform that the service is now available as a private freelance service within a public facility at the Breast Unit of the Bellaria Hospital, and a check shows a substantial absence of waiting times. In March 2015 the secretary’s office of the Bellaria states that 40-50 women a day request a mammogram for early breast cancer detection from the in-house freelance system (against payment), following a secondary prevention regimen that, with the offering of the adequate services at the Breast Pathology Department of Maggiore Hospital, had become routine for the women of Bologna.

The same bilateral mammogram performed by the breast pathology team of the Bellaria is available by reservation from the CUP (now with a separate phone number for the in-house freelance services), or directly from the secretary’s office of the Breast Pathology department of the Bellaria, through the in-house freelance system and against payment of 106.81 euro (which may become 128.19 euro if both bilateral mammogram and ultrasound scan are performed). Other breast pathologists of the Bellaria Breast Unit offer bilateral mammograms (with ultrasound scans) in-house at slightly lower prices.

Paid access to mammograms performed by the team of the Bellaria Hospital Breast Unit means that the customised, high-quality spontaneous-access service of the Regional Health System (plus the reading and reporting of the results, latest-generation mammograms, contact with the breast pathologist, ultrasound scan, and possibility for guidance, also for primary prevention and, if necessary, for access to the complete care pathway with the same team) that the Breast Pathology Department of the Maggiore (with the very same specialists) offered the city of Bologna up until 2011 has been privatised. This system should not have been suppressed, but rather strengthened, also considering the fact that during a meeting on 1 April 2014 with the Health Commissioner of the Emilia-Romagna region, Dr Carlo Lusenti, the problems of a lack of funds indicated at the time the Maggiore Breast Pathology Department was closed did not appear to be so significant. For these declared problems of lack of funds Federconsumatori, consumer association to the chairmanship of the Joint Consultative

Committee for the “City of Bologna” district of the Bologna AUSL, declared that they had curbed their actions regarding the situation of the Breast Pathology Department in Bologna in spite of pressure from Bolognese citizens.

What is more, even if mammograms are provided by the in-house freelance system, in a field as sensitive as that of early breast cancer detection, the guarantee of patient protection that characterises the relationship with a (public) hospital organisation no longer exists. The relationship becomes one between private parties (doctor and patient), even if the physician in this case is not essentially a freelance professional, but a member of the Breast Unit⁸.

In this sense we may speak of deregulation. It is not only the privatisation of a service that had previously been provided with spontaneous access by the SSR, but the type of relationship changes (and seemingly for the worse). The woman is no longer followed by a member of a complex healthcare organisation with extremely coded rules of conduct (including EUSOMA certification), but by a single doctor with his individual responsibilities, who is in a totally peculiar position, being a member of the only (it seems) Breast Unit in Bologna that can provide the levels of quality required for early breast cancer detection by the European Commission and (perhaps) also for the treatment of any cancer that may be diagnosed.

b) Private diagnosis and treatment facilities in Bologna

The search in Bologna for private facilities capable of providing (against payment) a service comparable to that of the Bellaria Breast Unit (and up to 2011, of the Breast Pathology Department of Maggiore Hospital) for the first level of early breast cancer detection via spontaneous access revealed a variety of offerings in private centres and clinics. On the web pages of the most important private facilities consulted we found the names of the team members, but not the specific characteristics of the mammography units, result reporting procedures, or even indications of EUSOMA certification. A phone call to the booking centre of one of the largest private institutes revealed that for a bilateral mammogram, ultrasound scan, and breast examination, the cost was 245 euro. In another private structure with breast pathology department, the web page stated that the breast pathology pathway offered is not accredited with the Regional Health System, but they specify that the costs are in line with the public rates.

PART B: HOW COULD THIS HAPPEN?

1. THE CASE AS AN EXPERIMENT TO VERIFY THE RELIABILITY OF THE PROCEDURES IN PLACE TODAY FOR THE PROTECTION OF EQUITY IN ITALY

The changes in the offerings and access procedures for mammograms for the early detection of breast cancer in the metropolitan area of Bologna have been the subject of numerous protests by women, who have seen a radical worsening of their position under the SSR and a sizable increase in the costs for receiving the same service (privately). What is more, it will be necessary to verify how many of them, during a period of economic crisis, have waived prevention, going without their yearly or biyearly (depending on the breast pathologist’s indications) mammograms and ultrasound scans, thus relinquishing an important part of their health protection. But the case described here offers a chance to analyse the factors that in an advanced national healthcare system may nevertheless permit the implementation of changes of such a heavy impact on a specific group of persons, and attempt to propose institutional tools that will prevent changes of such impact taking place without taking the equity of the Italian national healthcare system into account.

All this while considering the fact that, from Beveridge’s ideas in 1942 up to today’s Italian healthcare system, the concept of equity has had to deal with an increasingly strong refinement of treatments, the concept of health itself, and the ways to protect and restore it. As in the other sectors of society, in the health sector, too, the objective of an increasingly costly, innovative, and complex system is not only that of guaranteeing a minimum level of care for all and permitting the elimination of need and illness for the weakest social classes, but also of guaranteeing a high level of care for all, in a society that needs an increasingly higher number of individuals capable of tackling challenges and overcoming them. Also, the pact between taxpayers and national healthcare system probably holds up thanks to these lofty aims.

⁸ The transparency, the government and the management of times and waiting lists, and the in-house freelance activity in the Italian National Health Service are studied in deep in the 2016 Anti-Corruption Plan (Piano Nazionale Anticorruzione 2016) of the Italian National Anti-Corruption Authority (Autorità Nazionale Anticorruzione, 2016).

In this case the women of the city of Bologna are undergoing a lack of services from the NHS and to maintain the previous levels of the services for the early detection of breast cancer they experience cuts in their spending, savings, and investment opportunities.

2. A CONTEXT HISTORICALLY FOCUSED ON SOCIAL COHESION AND THE REDUCTION OF INEQUALITIES

This experiment is even more important because it is applied to a region which, ever since the post-war period, has made social cohesion and inclusion the very basis of its makeup. Its people have provided themselves with institutions and organisations for this purpose. The public policies in the social, cultural, healthcare, and education field have been based on these aims (Finzi, 1997).

3. A CONTEXT HISTORICALLY MINDFUL OF WOMEN'S HEALTH

The region's projects for the protection of women's health date from the 1970s, for example with the establishment of family advisory centres, and led – in 1996, with regional funds – to the implementation of regional screening programmes for early breast and cervical cancer detection, before the National Health Service specified the need for them, for the protection of individual and collective health, and established Essential Care Levels (*Livelli Essenziali di Assistenza*: LEA).

But precisely the early development of screening programmes for the early detection of breast cancer in Emilia-Romagna led women to acquire, with time, a good awareness of the necessity to take care of their health and of how to do so. These women created a customised programme of quality controls following the indications received during check-ups and tests, and in the years before 2011, they were able to achieve this in Bologna through access, under the National Health Service, to the Breast Pathology Department of the Maggiore Hospital. These prevention routines had developed not only in the more highly educated and affluent groups of the population, but in all the historic social groups of the city, achieving an aim that is at the basis of every policy for overcoming health inequalities (Costa et al., 2014). Of course, the programme encouraging women to practise prevention had not ended in a city where the demographic mobility and capacity for reception are high, and the environment created by the organised screening program and the quality facilities for spontaneous access was undoubtedly conducive to social inclusion and an overcoming of health inequalities.

4. BUT IS EQUITY ASSESSED IN THE ITALIAN NATIONAL HEALTHCARE SYSTEM?

Equity is one of the three main underlying principles of the national healthcare system (SSN) since its foundation in 1978. But which, among the various meanings of “equity” are those currently stressed by the Italian SSN? The founding law focuses on the equality of citizens in accessing the service regardless of their individual or social conditions, ensuring the overcoming of the country's regional imbalances in social and healthcare conditions. Operationally speaking, the Ministry of Health emphasises its commitment to ensure, for all citizens, equal access for equal health needs. And it specifies the tools for implementation: a) a guarantee of quality, efficiency, appropriateness, and transparency of the service, in particular the services provided, for all; b) the providing – by physicians, nurses, and healthcare workers – of a proper communication regarding the healthcare services necessary for the citizen, adequate for his or her level of education and comprehension (informed consent, management and treatment of the particular case). (Ministero della Salute, 2013).

But how is the equity monitored by the SSN? Barsanti and Nuti (2014, p.e236) point out that “*In Italy, the government demonstrates a general commitment to equality issues, but there is no formal mechanism for coordinating the implementation of policies on health inequalities across government departments; emphasis has been given to geographical equity, primarily concerning the distribution of public health care facilities*”. The National Agency for Regional Healthcare Services (AGENAS), in its monitoring and assessment activity, a) verifies the distribution of the Essential Care Levels by the Regions in conditions of appropriateness and effectiveness in the use of resources; b) it monitors the health expenditure of the Regions and the sharing in the medical expense (co-pay, called “ticket” in Italy); c) with the National Results Programme (*Programma Nazionale Esiti*: PNE), it develops the assessment of the results of medical procedures in the Italian Healthcare System; d) within the regional health services, it promotes the development of processes of individual, organisational, and community empowerment. In each of these tasks, a crucial role is played by the assessment of the equity. In monitoring the compliance with the LEA, of particular importance is the assessment of the geographical equity; for the expenditure of the Regions, the commitment for equity extends to the distribution of payments for healthcare amongst the entire population (fair financing) (Barsanti and Nuti, 2014, p. e234); the

PNE comprises a comparative assessment amongst population groups (for example by socioeconomic level, residence, etc.), especially for programmes for the assessment and promotion of equity in health; in the project on empowerment, the participation and involvement of citizens, patients, and professionals are identified as being decisive for increasing the values of treatment effectiveness and equity in the use of resources.

In addition, for the vertical equity at the national level, *“the first explicit mention of social inequalities in healthcare planning and the need for their management is now rather old, dating back to the 1998-2000 National Health Plan, which in fact included amongst the nine core objectives the reduction of the gap in the healthcare of disadvantaged and less disadvantaged groups”* (Marra, 2014, p. 299).

For vertical equity at the regional level, Barsanti and Nuti (2014) indicate that *“Indicators of the equity of access to health care according to socioeconomic conditions may be included in a performance evaluation system (PES) in the regional context level and in the planning and strategic control system of healthcare organisations. [...] The PES, in the experience of the Tuscany region in Italy, adopted indicators of vertical equity over time”*.

5. EMILIA-ROMAGNA: A CONTEXT OF STRONG COMMITMENT IN THE POLICIES FOR EQUITY IN PUBLIC HEALTH

Emilia-Romagna has achieved good performance in the AGENAS assessment and monitoring systems, in some cases becoming the point of reference for guaranteeing the levels of care and the appropriateness and effectiveness of the use of resources.

In recent years, within the activity of the Community, Equity and Participation Area, the Regional Health and Social Agency undertaken the Observatory on Equity and Diversity Management, becoming a regional point of reference for the SSR Authority and the local authorities of Emilia-Romagna on the subject of guarantees of equity, respect for differences (of age, sex, nationality/origin, disability, sexual identity and orientation, religion and personal beliefs...), and fighting health inequalities, both for users and for workers (diversity management), a) providing guidelines for the Authority's/local programming and assessment with regard to equity, respect for differences, and diversity management (DM), in line with the guidelines provided by national and international laws and regional policies, and with the regional objectives for the Authority directorates. Furthermore, the Regional Health and Social Agency has b) contributed to increasing the knowledge on inequities in access and treatment pathways, and on the health inequalities in Emilia-Romagna; c) disseminated the DM culture and approach, and d) contributed to disseminate the knowledge of best organisational practices (national and international) capable of promoting equity, reducing inequalities, and fostering respect for differences (e.g. Health Equity Audit [HEA], an impact assessment in terms of equity).

Within the activity of the Community, Equity and Participation Area, the Regional Health and Social Agency has also worked with the Workshop for listening to and involving citizens, the community, and professionals, of which the Information System for citizens' reports (URP: Public Relations Office) is a part. The management of these reports (including complaints) is an Authority communication tool. This tool is included among those with which the healthcare organisation takes an active approach to users, one which goes beyond the concept of protection of rights, and is strongly oriented towards the involvement and participation of the users in the organisational life.

6. AND YET IT HAPPENED IN BOLOGNA

AGENAS's tools and the regional services for verifying and protecting equity often refer to ex-post type assessments, which undoubtedly have important effects on the distribution of resources and the replanning of activities. In other cases, such as the Health Equity Audit, they are ex-ante tools, but referring to the territorial health policy programming plans. It seems there is, as yet, no consolidated way of assessing the maintaining of the principle of equity (horizontal, vertical, ...) vis-à-vis a single initiative of reorganisation of the services, such as the regional measures of 2010 for the elimination of waiting lists and for the creation of the new Breast Unit at Bellaria Hospital during the same period. And in fact no trace of these assessments was found in the minutes (available online since 2011) of the Joint Consultative Committee meetings of the Bologna AUSL. In addition to the absence of an assessment of the impact in terms of equity in the access, there is also no trace of an assessment of women's health by these measures, for comparison with the planned financial savings. It seems that even the Public Relations Office – a “tool included among those with which the healthcare organisation takes an active approach to users, one which goes beyond the concept of protection of rights, and is strongly oriented towards the involvement and participation of users in the organisational life” (Azienda Sociale Sanitaria Regionale Emilia-Romagna, 2013) – also failed. The replies to women's complaints had to arrive either through newspapers or reports filed with the Prefect of Bologna.

The changes adopted and the current organisation of the Bologna AUSL's offering of services for early breast cancer detection did not even take into account the recommendations of the scientific associations involved and the European Union's guidelines on screening for breast cancer mentioned earlier in this paper.

The case appears to be a topical one, as far as the ministerial measures for reorganising the procedures for providing outpatient specialist services of September 2015 are concerned. It seems that no heed was paid to the guidelines of the Italian Society of General Medicine, which consider *"inviolable the decision to adopt tools that already exist which, starting from the need of the individual patient, identify the most appropriate and virtuous actions to take and are capable of guiding professionals towards choices that are effective in terms of short- and medium-term clinical results"*. The system was thus driven towards "payment for performance" solutions *"that reward the single professionals in differentiated manners, not on the abstract and indeterminate savings of expense, but on the real capacity to restructure the costs in relation to the clinical effectiveness of the actions taken"* (Cricelli, Atella, 2015).

7. A CITIZENS' HEALTH PROTECTION PROPOSAL

The AGENAS' proposals on the empowerment and the proposals on the promotion of listening to and involving citizens and workers in a perspective of an organisational improvement and guarantee of equity made by the Emilia-Romagna Health and Social Agency, as well as the analyses on health inequalities, promote a dialogue between an authority that undertakes the responsibility for the individual's health and the individual him- or herself, so that the authority can better perform its institutional role.

In the case presented, this system has not worked. The model inclusive of citizens' requests did not exist.

The proposal we would like to make is that of changing the viewpoint of the relationship between the authority managing public health and the citizenry. To be more effective in safeguarding the equity and health of citizens, in addition to the actions of empowerment and dialogue guided by the institution, it may be necessary to introduce a public authority that guarantees the principles of the national healthcare system, to which individuals or groups of citizens can report cases of poor service and unfair changes (or those perceived as such), and to which they can turn for an assessment by a party possessing all the economic and regulatory instruments necessary for giving an answer and implementing corrections in a relatively short time.

In fact, in Italy the independent regulatory agencies operate in "sensitive" sectors, in which the presence of constitutionally guaranteed rights requires the intervention of agencies that are independent from politics and in possession of particular technical qualifications.

The heads of the governing bodies are appointed via procedures in which the essential role is played by the parliamentary bodies.

In spite of the fact that they are not based on an archetype or a general model, the authorities have several traits in common, such as their organisational and regulatory autonomy, which varies in intensity, and the power to pass regulations, apply penalties, and settle disputes, including the respective awards (Chieppa and Cirillo, 2010).

According to the law on administrative procedure the authority differentiates its operations into three distinct phases: a first intervention of supervision and monitoring; a second divided in a phase of initiative and a preliminary investigation and the last phase of decision, in the event that the prohibition is infringed. This differentiation in its operations can give to the citizens a broad spectrum of signalling and intervention. With the Authority they can reach decisions that are valid for all citizens and can correct the action of the NHS.

CONCLUSIONS

The study of a case of strong impact on the population of a vast geographical area can help to properly evaluate the characteristics and the importance of the effects that changes have on maintaining the principles of the national healthcare system and, in particular, on the guarantees of equity (in particular, in access to services) for all social groups, without the need for some of these groups to leave the public system if they want to receive services guaranteed by the Essential Care Levels.

Highlighted weaknesses in the control system and safeguard the equity lead to indicate an integration of methods of protection and control, by entering a single authority close to citizens and users.

The choice of an authority that acts as guarantor of the principles of the national healthcare system, to which individuals or groups of citizens can report cases of poor service and unfair changes for an assessment, and the

implementation of corrections in a relatively short time, could ultimately ensure a more stable relationship between the taxpayer and the SSN, thus avoiding exit phenomena (in Italy the underground economy is at the 11.5% of Italian GDP) and instead fostering processes of voice and improvement of the relationship.

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