

# **Prevenzione e Qualita' dell'Aria nel PNP 2014-2014**

***Liliana La Sala  
DG Prevenzione Sanitaria  
Ministero della Salute***



Anno	<i>Piano Sanitario Nazionale</i>	<i>Piano Nazionale Vaccini</i>	<i>Piano Nazionale Malattie Rare</i>	<i>Piano Oncologico Nazionale</i>	<i>Piano Nazionale Malattia Diabetica</i>	<i>Piano Nazionale della Prevenzione</i>
1978						
...↓...						
1993						
1994						
1995	✓1994-1996					
1996						
1997						
1998						
1999	✓1998-2000					
2000						
2001						
2002						
2003		✓2003-2005				
2004	✓2003-2005					
2005						
2006		✓2005-2007				✓2005-2007
2007	✓2006-2008					
2008		✓2008-2010				✓2008
2009						✓2009
2010		✓2010-2012				
2011				✓2010-2012		✓2010-2012
2012	✓2011-2013	✓2012-2014				
2013		(PNPV)	? (bozza 2013-16)		✓2013	
2014	?					? bozza 2014-2018

Fonte: Ministero della Salute. Disponibile online: <http://www.salute.gov.it/>.

# Piano Nazionale di Prevenzione (PNP) 2014-2018

- **Intesa Stato-Regioni 13.11.2014**
- **Criteri valutazione Accordo Stato Regioni 31.01.2015**
- **Adozione PRP entro 31.05.2015**





*Ministero della Salute*

**Piano Nazionale  
della Prevenzione**

**2014-2018**

# PNP 2014-2018

## ➤ **10 Obiettivi**

## ➤ **Obiettivo 2.8 Ridurre le esposizioni ambientali potenzialmente dannose per la salute**



# **PNP 2014-2018**

## **OBIETTIVO 2.8**

**Contrastare i fattori di rischio per la salute umana legati all'esposizione ambientale ad inquinanti chimici, fisici e microbiologici attraverso le diverse matrici ambientali (aria, acqua, suolo, alimenti)**

# PNP 2014-2018 STRATEGIE

- **Sviluppare le conoscenze dei livelli espositivi della popolazione generale ad inquinanti ambientali**
- **Potenziare le attività di sorveglianza epidemiologica**

# PNP 2014-2018 STRATEGIE

- **Implementare le valutazioni preventive degli effetti sulla salute di progetti, piani, programmi e politiche (VIS)**
- **Implementare strumenti che facilitino l'integrazione tra servizi ambientali e sanitari del territorio**

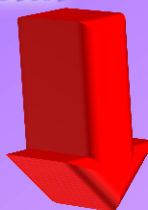
  
*Ministero della Salute*

**Piano Nazionale  
della Prevenzione**

**2014-2018**

## ➤ **Ruolo centrale Dipartimenti di Prevenzione delle ASL**

**A.S.L.** **ASL** **EG**



**per integrare le azioni tra settore sanitario  
(ASL) ed ambientale (Arpa)  
a supporto delle scelte politiche**



# VALUTAZIONE DI IMPATTO SULLA SALUTE (VIS)

- **La VIS come strumento di supporto per i decisori politici**
- **Necessità di aumentare l'attenzione verso gli aspetti sanitari nelle politiche di altri settori (trasporti, agricoltura, industria etc., la "salute in tutte le politiche")**











## Association of Improved Air Quality with Lung Development in Children

W. James Gauderman, Ph.D., Robert Urman, M.S., Edward Avol, M.S., Kiros Berhane, Ph.D., Rob McConnell, M.D., Edward Rappaport, M.S., Roger Chang, Ph.D., Fred Lurmann, M.S., and Frank Gilliland, M.D., Ph.D.

### ABSTRACT

#### BACKGROUND

Air-pollution levels have been trending downward progressively over the past several decades in southern California, as a result of the implementation of air-quality-control policies. We assessed whether long-term reductions in pollution were associated with improvements in respiratory health among children.

#### METHODS

As part of the Children's Health Study, we measured lung function annually in 2120 children from three separate cohorts corresponding to three separate calendar periods: 1994-1998, 1999-2001, and 2007-2011. All children were 11 years of age at the beginning of the period and 15 years of age at the end. Linear regression models were used to examine the relationship between declining air-pollution levels over time and lung-function development from 11 to 15 years of age, measured as the increases in forced expiratory volume in 1 second (FEV<sub>1</sub>) and forced vital capacity (FVC) during that period (referred to as 4-year growth in FEV<sub>1</sub> and FVC).

#### RESULTS

Over the 15 years spanned by the three cohorts, improvements in 4-year growth of both FEV<sub>1</sub> and FVC were associated with declining levels of nitrogen dioxide (P<0.001 for FEV<sub>1</sub> and FVC) and of particulate matter with an aerodynamic diameter of less than 2.5 μm (P= 0.008 for FEV<sub>1</sub> and P<0.001 for FVC) and less than 10 μm (P<0.001 for FEV<sub>1</sub> and FVC). These associations persisted after adjustment for several potential confounders. Significant improvements in lung-function development were observed in both boys and girls and in children with asthma and children without asthma. The proportions of children with clinically low FEV<sub>1</sub> (defined as <80% of the predicted value) at 15 years of age declined significantly, from 7.9% to 6.3% to 3.6% across the three periods, as the air quality improved (P=0.001).

#### CONCLUSIONS

We found that long-term improvements in air quality were associated with statistically and clinically significant positive effects on lung-function growth in children. (Funded by the Health Effects Institute and others.)

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Risoluzione 68° WHA  
Revisione LG WHO AQ

## The Global Burden of Chronic Diseases Overcoming Impediments to Prevention and Control

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Corinna Hawkes, PhD

C. Linn Gould, MS, MPH

Karen J. Hofman, MD

**C**HRONIC DISEASES ARE THE largest cause of death in the world (FIGURE 1), led by cardiovascular disease (17 million deaths in 2002, mainly from ischemic heart disease and stroke) and followed by cancer (7 million deaths), chronic lung diseases (4 million), and diabetes mellitus (almost 1 million).<sup>1</sup> These leading diseases share key risk factors: tobacco use, unhealthy diets, lack of physical activity, and alcohol use (TABLE).<sup>2</sup> The current burden of chronic diseases reflects past exposure to these risk factors, and the future burden will be largely determined by current exposures.

The global prevalence of all the leading chronic diseases is increasing, with the majority occurring in developing countries and projected to increase substantially over the next 2 decades (FIGURE 1).<sup>3</sup> Cardiovascular disease is already the leading cause of mortality in developing countries (FIGURE 2).<sup>1</sup> Between 1990 and 2020, mortality from ischemic heart disease in developing countries is expected to increase by 120% for women and 137% for men.<sup>4</sup> Predictions for the next 2 decades include a near tripling of ischemic heart disease and stroke mortality in Latin America, the Middle East, and sub-Saharan Africa. The global number of individuals with diabetes in 2000 was estimated to be 171 million (2.8% of the world's population), a figure projected to increase in 2030 to 366 million (6.5%), 298 million of whom

will live in developing countries.<sup>5</sup> Cancer incidence increased 19% between 1990 and 2000, mainly in developing countries.<sup>6</sup> Death and disability due to chronic obstructive pulmonary disease are increasing across most regions.<sup>7</sup> Risks for chronic disease are also escalating, as smoking prevalence and obesity levels among adolescents in developing countries have risen over the past decade and portend rapid increases in chronic disease risk and mortality profiles.<sup>8</sup> In

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Numerous developing countries and countries in transition have witnessed a rapid deterioration of their chronic disease risk and mortality profiles.<sup>9</sup> In

the world's most populous country, China, age-specific death rates from cardiovascular disease increased between 200% and 300% in those aged 35 through 44 years between 1986 and 1999, and by more than 100% in those aged 45 through 54 years.<sup>10</sup> During the same period, cancer death rates in-

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# PREVENZIONE

# BUDGET

## budget limitati.

**OCSE: 3%**

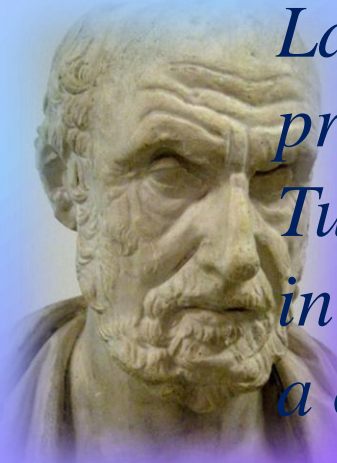
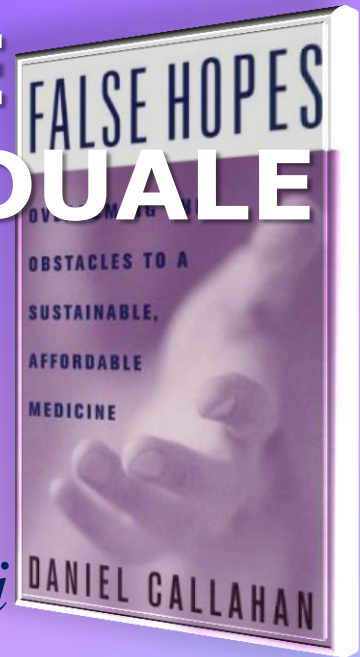
**ITALIA: 1%**

I maggiori budget vengono impiegati per interventi di diagnosi, assistenza, terapia delle malattie croniche non trasmissibili

# SANITA' PUBBLICA E RESPONSABILITÀ INDIVIDUALE

*La riduzione dei rischi collettivi è il primo compito della Sanità Pubblica. Tuttavia essa deve contribuire a mettere in luce anche i rischi per la salute legati a comportamenti **individuali** non salutari.*

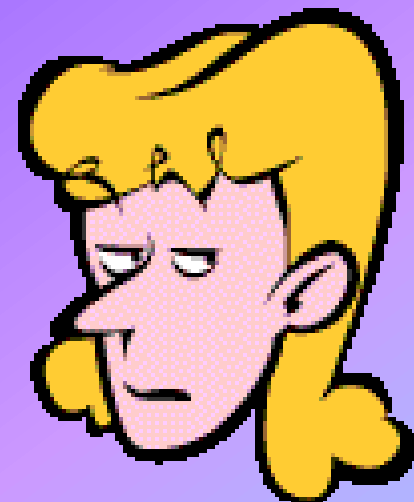
*Se vogliamo garantire una medicina sostenibile, dobbiamo **conciliare** gli interventi di sanità pubblica con la promozione di stili di vita individuali salutari.*







**GRAZIE PER  
L'ATTENZIONE**



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