Healthy, prosperous lives for all in Italy

National report of the Italian Health Equity Status Report
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Healthy, prosperous lives for all in Italy

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List of abbreviations

AGENAS National Agency for Regional Health Services
BES Fair and Sustainable Well-being initiative
COVID-19 novel coronavirus disease (SARS-CoV-2)
EQLS European Quality of Life Survey
EU European Union
HBSC Health Behaviour in School-aged Children
HESR(i) Health Equity Status Report (initiative)
INMP National Institute for Health, Migration and Poverty
Acknowledgments

The WHO European Office for Investment for Health and Development would like to thank the following people and groups for their contributions to the report.

The Italian Health Equity Status Report initiative is led by the WHO European Office for Investment for Health and Development (the Venice Office of the WHO Regional Office for Europe) under the collaborative agreement between the Venice Office and the Italian Ministry of Health. The work of the initiative is carried out in collaboration with the Italian National Institute of Health (ISS), the Italian National Institute of Statistics (ISTAT), the Italian National Agency of Regional Health Services (AGENAS), the Italian National Institute for Health, Migration and Poverty (INMP), and the Ca' Foscari University of Venice. Chris Brown, Head of the Venice Office, is responsible for the overall coordination of the work.

Extensive technical contribution – in terms of technical concept, study design, data collection, data analysis, writing and review – was provided by Lin Yang, Andrea Bertola, Michele Marra, Sara Darias-Curvo, Chris Brown, and Isabel Yordi Aguirre of the Venice Office, as well as by Helen Crump of Cogency Analysis & Research, United Kingdom.

Original microdata was provided by the ISS, the ISTAT and Eurofound.

Substantial contributions to data disaggregation and analysis were provided by the following teams. Marta Buoncristiano, Silvia Ciardullo, Benedetta Contoli, Serena Donati, Chiara Donfrancesco, Alice Maraschini, Maria Masocco, Benedetta Mattioli, Emanuela Medda, Valentina Minardi, Paola Nardone, Luigi Palmieri, Roberto Pasetto, Daniela Pierannunzio, Enrica Pizzi, Silvia Rossi, Michele Antonio Salvatore, Angela Spinelli, and Aldina Venerosi were focal points for the ISS to the National Surveillance System for children aged 0–2 years Working Group (2017–2020), the Italian Obstetric Surveillance System (ItOSS) Working Group, “OKkio alla SALUTE” Working Group Surveillance System, the Working Group HBSC Italia 2018, and the
Surveillance Systems “PASSI” and “PASSI d’Argento” Working Group (2008–2019). Raffaella Bucciardini was the focal point for the ISS team. Miriam Di Cesare and Natalia Magliocchetti were the focal points for the Italian Ministry of Health’s Mental Health Information System (SISM), along with Emanuele Aliverti, Alessia Buratin, Francesca Parpinel and Claudio Pizzi from Ca’ Foscari University of Venice.

The work has benefited from substantial contributions from members of the Scientific Expert Working Group. In particular, the following contributors are gratefully acknowledged:

James Allen (Public Health Wales, United Kingdom), Benjamin Barr (University of Liverpool, United Kingdom), Luigi Bertinato and Raffaella Bucciardini (ISS, Italy), Mojca Gabrijelčič Blenkuš (National Institute of Public Health, Slovenia), Urban Bojka (Social Protection Institute, Slovenia), Stefano Campostrini (Ca’ Foscari University of Venice, Italy), Fabrizio Carinci (AGENAS, Italy), Giuseppe Costa (University of Turin, Italy), Gianfranco Costanzo and Alessio Petrelli (INMP, Italy), Hans Dubois and Massimiliano Mascherini (Eurofound, Ireland), Paula Franklin (European Trade Union Institute, Belgium), Peter Goldblatt (University College London, United Kingdom), Johanna Hanefeld (Robert Koch Institute, Germany), Daniel La Parra Casado (University of Alicante, Spain), Filomena Maggino (Office of the Prime Minister, Italy), Giovanni Nicoletti, Gianfranco Pasquadibisceglie and Maria Grazia Pompa (Ministry of Health, Italy), Gabriella Sebastiani (ISTAT, Italy), Andrej Srakar (University of Ljubljana, Slovenia), Alberto Zucconi (Person-Centred Approach Institute (IACP), Italy).
Executive summary

The Italian Ministry of Health and WHO Regional Office for Europe jointly launched the Italian Health Equity Status Report initiative (HESRi) “Healthy Prosperous Lives for All in Italy” in March 2020. The initiative is a collaborative project involving multiple Italian and international partner institutions, with the main goal of supporting national and regional policy-makers to prioritize investments to tackle current health and well-being gaps and to create the conditions to enable all people living in Italy to lead a healthy and prosperous life.

About the HESRi approach

This initiative is intended to support decision-makers in Italy working to create the conditions for every person to be able to flourish in health and in life. The HESRi approach is designed to pinpoint and assess the scale of existing inequities in order to support decision-makers in their work to reduce the social gradient in health.

Equity is one of the guiding principles of the Italian National Health Service, alongside universality of coverage, and solidarity of financing. In recent years the Italian Government has taken steps to understand in detail how inequities affect individuals and families across Italy’s population, and to close these gaps.

One of the contributions of the Italian HESRi is the generation of a new set of disaggregated indicators, derived specifically for the Italian HESRi analysis. This dataset brings together indicators of the current status and trends in inequities in health, gaps and trends in the five essential conditions needed to live a healthy life, and progress and trends in policy performance to reduce these inequities\(^1\).

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\(^1\) The Italian HESRi dataset and interactive charts are accessible online at https://whoeurope.shinyapps.io/Health_Equity_Dataset_Italy/.
Health status and trends

Drawing on the new set of disaggregated indicators derived from national microdata sources for the Italian HESRI, the report opens with an assessment of the current status and recent trends in gaps in health and well-being, highlighting key gender inequities and inequities across the stages of the life-course, as well as inequities between socioeconomic groups, and migrant status in health and well-being indicators.

Until the advent of the novel coronavirus disease (SARS-CoV-2) (COVID-19) pandemic in 2019, life expectancy in Italy had been increasing, although there were still significant socioeconomic and regional inequities. Women generally live longer than men, though their longer years of life are not necessarily lived in good health. The self-reported health of people living in Italy has also been improving in recent years, with fewer people reporting poor or fair health than was the case in the early 2010s. However, there is a clear social and educational gradient throughout the majority of the health indicators, with those with fewer years of education and less financial security experiencing poorer health than those with more years of education and greater financial security.

There has been a statistically significant narrowing of the gap in the proportion of both men and women of working age reporting poor or fair health, comparing those with university education to those with only compulsory education across the 10-year period between 2008 and 2018. There has also been a statistically significant narrowing of the gap between the most and least advantaged men aged 65 years and over, when evaluated by education level or income quintile. However, there has been no statistically significant narrowing of the gap between the best-off and worst-off young people over the same period, when evaluated by income quintile (data by education level are not available for this group); nor has the gap narrowed for older women when evaluated by income quintile or education level.

Those with fewer years of education and less financial security are likely to have higher levels of noncommunicable diseases (NCDs), greater levels of overweight, a higher prevalence of mental health issues, such as depression, and are more likely to be active smokers. For many of these health indicators, the size of the gap between the best-off and the worst-off has remained the same, and for some (such as prevalence of overweight in adolescent girls) it has increased.

For multiple health and lifestyle indicators the data show a worse picture for women in Italy than for the population at large. For instance, since 2013 there has been a statistically significant widening
of the gap between working-age women with the highest and lowest levels of education reporting that they have one or more long-term conditions, but this is not the case for working-age men. Gaps between the most and least advantaged are wider for women than for men, where overweight is concerned, and these gaps continue to grow. Women are less likely to engage in physical activity than men, and between 2009 and 2019 a greater proportion of women at all education levels reported experiencing symptoms of mental health issues, such as depression.

The essential conditions needed for health equity

Using the Italian HESRi dataset and additional microdata, the report analyses the status and trends in the essential conditions needed to live a health life in Italy in the 21st century. The essential conditions to achieve equity in health span five policy areas: Health services, Income security and social protection, Living conditions, Social and human capital, and Employment and working conditions.

The five essential conditions can be defined as follows:

- **Health services** comprises indicators and interventions relating to the availability, accessibility, affordability and quality of prevention, treatment and health-care services and programmes.

- **Income security and social protection** encompasses indicators and interventions relating to basic income security and the reduction of health-related risks and consequences of poverty over the life-course.

- **Living conditions** includes indicators and interventions relating to differential opportunities, access and exposure to environmental and living conditions that each have an impact on health and well-being.

- **Social and human capital** covers indicators and interventions relating to human capital for health through education, learning and literacy, and relating to the social capital of individuals and communities in ways that protect and promote health and well-being.

- **Employment and working conditions** refers to indicators and interventions relating to the health impact of working, including availability, accessibility, security, wages, physical and mental demands and risks associated with working.
Using a decomposition analysis, the significant contributors to health inequities in Italy are identified based on the five essential conditions, highlighting the multiple factors that impact health and well-being and showing the pathways leading to health inequities that can be targeted by policy action.

**Fig. 0.1. Decomposition of the impact of the five essential conditions on the gap in health status between the richest and poorest 40% in Italy**

Disparities in the quality of and access to **health services** account for 9% of the total contribution from the five conditions to the health gap between the top and bottom income groups (Fig. 0.1, Fig. 0.2). Seven times as many women and men aged 25–64 years with only compulsory education reported having unmet need for health care in 2018, compared to those with university education. Unmet need was higher for women in all years until 2017, when rates of unmet need for men in the top and bottom groups overtook those for women.
Disparities in ability to make ends meet due to **insecure income and social protection** account for 43% of the total contribution from the five conditions to the health gap (Fig. 0.1 and Fig. 0.3). Income inequality widened between 2008 and 2019 and has remained at higher levels than before the 2008 financial crisis. The gap between the proportion of women with only compulsory education and the proportion of women with university education experiencing in-work poverty has widened over the period analysed. In 2018, three times as many women and men with only compulsory education experienced in-work poverty as those with university education.
Disparities in **living conditions** account for 22% of the total contribution from the five conditions to the health gap (Fig. 0.1). Gaps in food and fuel insecurity have widened and persisted for both men and women after the 2008 recession – these make up 28% and 16% of the portion of the health gap attributed to living conditions, respectively (Fig. 0.4). This may have led to detrimental food consumption behaviours among disadvantaged households, with disproportionate reliance on low-cost, energy-dense foods influenced by marketing and product exposure techniques of commercial food organizations.

Disparities in **social and human capital** account for 15% of the total contribution from the five conditions to the health gap (Fig. 0.1). Lack of trust contributes 43% of this portion of the gap attributed to social and human capital (Fig. 0.5). In 2013 young people (aged 16–24 years) reported the lowest levels of trust, but from 2014 onwards those aged 65+ years were most likely to report higher levels of low trust. In Italy, low trust is significant across all education levels, but more working-age adults with only compulsory education do not feel that most people are trustworthy, compared to those with more years of education. This lack of trust increased among adults with only compulsory education between 2013 and 2018, but not among those with more years of education beyond the compulsory level.
The issue of trust, both in other people and in institutions, is particularly challenging in Italy, with lower levels of trust reported than in many other countries of the WHO European Region. As Italy begins its recovery from the acute initial stages of the COVID-19 pandemic, there is a risk that young people in particular – facing a future of social distancing and a vastly changed sense of what their own individual futures will look like – may experience a broadening of inequities around trust, belonging, voice and a sense of future and hope.

Disparities in employment and working conditions account for 11% of the total contribution from the five conditions to the health gap (Fig. 0.1, Fig. 0.6). Twice as many men with only compulsory education are unemployed as men with university education and, although youth unemployment decreased for both men and women between 2014 and 2019, rates of temporary employment among young people increased over the same period, from 62% to 67% for women and from 54% to 57% for men.

High economic inactivity among young people not in employment, education or training (NEET), and among women, shows untapped potential for productive participation in the economy and society. Precarious employment poses a particular risk for young people, women and migrants. A significant majority of young people are currently employed in temporary roles, with young women being particularly affected by this type of disadvantage.

Fig. 0.5. Decomposition of the social and human capital subfactor

In-work poverty is high among people in precarious work situations, such as part-time or temporary work, seasonal work and self-employment. This type of work is often undertaken by women, younger workers and migrant workers; these people are also overrepresented in many of the sectors that are likely to shrink in the medium term because of the impact of the COVID-19 pandemic – particularly hospitality, tourism, leisure, retail and care roles.

When the data are analysed by level of educational attainment, men with only compulsory education are currently the group with the highest rates of temporary employment. With twice as many men with only compulsory education being unemployed as men with university education, there is a risk that a section of the public may become caught in the position of being NEET. This risk is likely to be exacerbated by COVID-19, which has revealed a shift towards lower wages and less secure employment as the dual pressures of lockdowns and economic damage affect the job market.
Lessons from the Italian HESRi for long-term recovery and rebuilding following COVID-19

The report also analyses prospective policy options and priorities for facilitating a resilient recovery from the impacts of COVID-19, building on the findings of the health status and decomposition analyses and considering how equity might be used as a driver for sustainable health system recovery and development in the long term.

A synthesis of emerging evidence shows how COVID-19 is compounding existing inequities in health and the essential conditions for a healthy, prosperous life, as well as highlighting the new inequity risks and vulnerabilities that are emerging. This brings to light priority health and cross-sectoral measures with the potential to mitigate the deepening of existing inequities and the emergence of new inequities, and to foster recovery that leaves no one behind due to poor health and insecurity of the essential conditions.

Italy entered the COVID-19 pandemic with multiple existing inequities; for instance, in relation to the extent of NCDs, overweight and obesity, mental health issues (such as depression), and risky health behaviours. Inequities in health were particularly apparent among women and young people (evaluated by education level, income quintile and region).

Early evidence shows that COVID-19 and its containment measures may have exacerbated some of these existing inequities, creating multiple new vulnerabilities. In particular, a social gradient has been observed in exposure to COVID-19, in the consequences of disease, and in the interruption of health-care pathways not related to COVID-19. This effect can also be seen in the impact of confinement on physical and mental health, and in exposure to increased poverty, unemployment and reduced income. Severe illness from COVID-19 may be worse among disadvantaged groups because of the unequal distribution of underlying risk factors, such as having certain NCDs or working in riskier occupations.

There are early indicators that targeted interventions have the potential to lessen the impact of the pandemic on some vulnerable groups. By focusing on specific social and economic barriers, and pathways of impact, actionable policy options and measurable interventions can be identified and prioritized that have a positive impact on reducing inequities in health and risk factors, aiming for sustainable and inclusive recovery and longer-term development. Three broad areas of intervention have the potential to drive progress in reducing inequities during the COVID-19 recovery: (i) reducing health inequities by ensuring the sustainability and resilience of the health-care system; (ii) reducing poverty to improve health equity; and (iii) harnessing health equity as a driver and outcome of economic rejuvenation.
The following key recommendations have been compiled for the Italian Government, covering each of these three areas of intervention.

(i) Reducing health inequity by ensuring the sustainability and resilience of the health-care system

In considering the role of the health system in reducing inequities, the analysis in this report demonstrates the importance of considering equity of access to health care, but also the role that different health-care functions can play in protecting people against behaviours and lifestyles that harm health. Health and well-being functions performed by public services outside the health field (such as local and community support networks) are crucial to achieving sustainable progress, as is effective and coordinated public health messaging at national and regional levels.

Key recommendations for action in these areas are listed here.

- Equitable access to formal and informal care should be ensured (including mental health services and digital health care considerations), treating issues of access in conjunction with the multiple dimensions of the essential conditions needed for good health, such as trust in health institutions and flexibility of working hours to allow access to health services that are only open during office hours.

- People should be provided help with protecting against health-harming behaviours and risk factors, including community-based interventions for health promotion that strengthen local health services and those that aim to help women navigate the intersecting gender and socioeconomic factors that impact on harmful risk factors and behaviours.

- The role of schools in promoting health and well-being should be harnessed to mitigate inequities in nutrition, overweight and obesity, physical activity, and risky health behaviours among children, as well as to support the well-being and life chances of young people through skills acquisition.

- Trust should be built in health and other public institutions (along with trust between people) through clear and transparent communication, facilitating health improvement initiatives through continuing public support and engagement.
(ii) Reducing poverty to improve health equity

The earlier analysis shows an educational gradient in unemployment levels in Italy, with twice as many unemployed men with only compulsory education compared to unemployed men with university education. While youth unemployment has decreased, trends in temporary employment suggest that young people have taken jobs that are not necessarily secure or of high quality. This has been compounded by the COVID-19 pandemic, during which fewer jobs have been available, resulting in fewer people in the active workforce.

Income inequality has worsened since the 2008 recession and, as previously noted, research into the impact of the pandemic suggests employment and poverty levels have been significantly affected, but policies already in place in Italy may be mitigating some of these effects. Considering how to extend and adapt such policies will be important for Italy in future, as will addressing gender inequities that could hinder the ability of women to avoid some of the worst economic impacts of the pandemic. The following areas of focus are anticipated to be important in the coming years:

- redesigning sustainable income support in the longer term, including prioritizing cost-effective use of resources to act across the whole gradient while being implemented at a level and intensity that is proportionate to need, especially in light of increasing fiscal pressures due to the scale of COVID-19 support packages;

- tackling gender-related inequities and poverty by creating new, gender-sensitive employment training and opportunities that reduce dependence on informal work, along with broadening access to child care, closing gender pay gaps, and reducing resource inequities within households.
(iii) Harnessing health equity as a driver and outcome of economic rejuvenation

As emphasized by the Italian Government’s priorities set out in the Prime Minister’s first Parliamentary address in February 2021, the likely enduring impact of social distancing restrictions on key sectors of the Italian economy (such as tourism and hospitality) means continued activity will be necessary to support job creation. This can be supported at all levels, with input from major employers and institutions to community organizations, as well as by harnessing the economic power of the health system itself.

- Advantage should be taken of the potential power of institutions to rejuvenate local economies through support initiatives and community investment by anchor institutions (for example, public hospitals, universities and other large non-profit-making employers).

- Community-led economic initiatives should be empowered through local organizations and support groups, to address non-medical health needs stemming from social isolation, debt and job loss, supporting people to find routes back into the active economy.

- The health system should be used as an engine of sustainable growth by enabling productive employment and human capital formation, as well as stabilizing and increasing household income.
The Italian Ministry of Health and the WHO Regional Office for Europe jointly launched the Italian HESRi “Healthy Prosperous Lives for All in Italy” in March 2020. The initiative is a collaborative project involving multiple Italian and international partner institutions, with the main goal of supporting national and regional policy-makers to prioritize investments to tackle current health and well-being gaps and to create the conditions required to enable all people living in Italy to lead healthy and prosperous lives.

The evidence and policy imperatives for reducing avoidable social inequities in health for the benefit of the whole of society are clear: where individuals and families have poor health, the risks of social, economic and cultural exclusion are higher. Insecurity and poor quality of the essential goods and conditions needed for health equity in the 21st century prevent many people from living a full and prosperous life. This has been clearly highlighted from the emerging international evidence on the disproportionate impact of COVID-19, the associated containment measures and their socioeconomic impacts on those who are already living in vulnerable and insecure conditions and with poor health. Existing vulnerabilities have been exacerbated and new ones are emerging (1).

These health inequities are underpinned by gender and multidimensional socioeconomic factors observed across all countries of the WHO European Region, despite the presence of good health systems, welfare states and concerted government efforts to close gaps in some Member States (2). Left unchecked, poor health and vulnerability have the potential to undermine national and local efforts for sustainable growth, territorial cohesion, and peace and stability. Action across sectors is needed to support health authorities and other actors at national and subnational levels to rebuild the health of society, and to mitigate the wider socioeconomic consequences of the pandemic across the spectrum of life.

Drawing on the ground-breaking analytical and policy work of the WHO European HESRi (3,4) and building on the findings of the 2014 Health equity in Italy report (5), the Italian HESRi adds to this work crucial new insights to support decision-makers in understanding what is driving
health inequities within Italy and to review and prioritize policy options that can be tailored for implementation.

This initiative is intended to support decision-makers in Italy working to create the conditions for every person to be able to flourish in health and in life. The HESRi approach is designed to pinpoint and assess the scale of existing inequities in order to support decision-makers in their work to reduce the gap between the most and least advantaged. As such, the assessments in this report of the trends and status of current inequities inform a forward-looking perspective to identify areas of priority and solutions, rather than to evaluate past performance of policies and services. With this approach, the Italian HESRi aims to shift political and policy focus away from simply identifying the problem of health inequities to identifying solutions and enabling actions to increase equity in health.

This report presents the findings of the national-level work under the Italian HESRi programme. Regional applications of the HESRi methodology and rationale are also under way, aimed at evaluating the impact of social inequities on health in specific contexts and areas of interest.

The final section of the report provides a forward-looking analysis of what the findings from this research mean for Italy as decision-makers plan the country’s long-term recovery following the acute phase of the COVID-19 pandemic.
Setting the scene: work to address health inequities in Italy

Equity is one of the guiding principles of the Italian National Health Service, alongside universality of coverage, and solidarity of financing. In recent years the Italian Government has taken steps to understand in detail how inequities affect individuals and families across Italy’s population, and to close these gaps. Monitoring of health service delivery is coordinated by the Ministry of Health and the National Agency for Regional Health Services (AGENAS) through the National Outcomes Programme (PNE) (6,7), and the National Institute of Statistics (ISTAT) has been monitoring progress in improving the well-being of Italy’s population under the Benessere Equo e Sostenibile (BES) (Fair and Sustainable Well-being) initiative for 10 years (8).

In 2017 the Italian Ministry of Health launched a review, “Italy for Health Equity”, involving the National Institute for Health, Migration and Poverty (INMP), the National Institute of Health (ISS), the AGENAS, the Italian Medicine Agency, and the Piedmont region. Italy’s work under the Joint Action Health Equity Europe programme has resulted in the creation of an Italian Committee for Health Inequities, and the Italian Ministry of Health has included reducing health inequities as a priority objective in its National Prevention Plan.

At a regional level, each health-care system has an equity board, an equity action plan and a representative acting as a link between regional and national policy, to drive progress on equity. The Ministry has also developed a Health Equity Audit, which regions must include in their own prevention plans. This requires health inequities to be addressed as a concrete, operational issue, cutting across regional programmes, with specific quantitative and qualitative tools for regions to implement in regional planning.
Even given these efforts, guaranteeing equity principles in practice can be challenging, particularly in the context of a worsening economic situation in which some inequities appear to be increasing. Moreover, although health care is administered via regional health services, policy-making for non-health areas such as education, labour and welfare is led at a national level and there have historically been fewer explicit commitments to reduce inequities in these areas.

On the monitoring side, decentralization presents a challenge to the collection of timely and targeted data to produce disaggregated indicators needed for equity analysis. There are regional differences in the degree of local autonomy in policy actions, as well as varying capacity to collect, process and analyse data, which has been evident during the COVID-19 crisis.

The Benessere Italia Taskforce, based within the Office of the Prime Minister, is working to introduce the principles of well-being for all and of equitable and sustainable well-being into government activities, using specific methodologies and guidelines for quality-of-life indicators, and exploring best practice in the management of sustainable development goals and in coordinating governmental policies on fair and sustainable well-being. This programme of work is building a systematic picture of socioeconomic inequities in Italy and their effect on the health of citizens, and has focused in recent years on the impact of the economic crisis and barriers to accessing care.

In response to the COVID-19 pandemic, the taskforce is considering the role citizens' well-being should occupy at the centre of political decision-making, and considering the potential role of indicators in monitoring the well-being of citizens and evaluating policy interventions.

Looking to the future, Prime Minister Mario Draghi used his initial address to the Italian Parliament in February 2021 to set out the cornerstones of the Italian Government’s post-pandemic recovery plan. These include the following goals: to speed up vaccination against COVID-19, to strengthen local and community health services for a more sustainable and resilient health system, to protect jobs and innovate new forms of secure employment, and to close the gender wage and poverty gaps. The address also outlined steps to boost the availability of mental health care and ensure the home is the main place of care, and to invest in training in digital, technological and environmental skills, targeting women in particular to improve women's participation in the job market.

The findings and forward-looking policy proposals in this national report of the Italian HESRi strongly align with the priorities of the Italian national strategy, and provide evidence of the potential to accelerate progress in Italy towards equity in health and well-being through equity-oriented policy actions that support these goals.
About the HESRi data and analysis

A new set of disaggregated indicators

One of the contributions of the Italian HESRi is the generation of a new set of disaggregated indicators, derived specifically for the Italian HESRi analysis. This dataset brings together indicators of the current status and trends in inequities in health, gaps and trends in the five essential conditions needed to live a healthy life, and progress and trends in policy performance to close these inequities.

The microdata underlying these indicators were provided by the ISS and the ISTAT. Data are drawn from the years 2004–2019. However, as data are not always available across the full range of years for all indicators, analysis of different indicators can relate to different time periods.

The indicators were constructed from the microdata by collaborators at the ISS and at the Economics Department of the Ca’ Foscari University of Venice, and visualization and analysis of indicators was undertaken by the WHO European Office for Investment for Health and Development.

Visualizing inequities with charts

Throughout this report, gradient charts – shown as coloured dots distributed along a line – are used to depict the socioeconomic gradient for an indicator, allowing examination of how levels of the indicator vary between subgroups of people. In most cases, three or five subgroups are identified according to markers of socioeconomic status, such as number of years in education or levels of income or affluence. For people in each subgroup, the average level of the indicator is calculated and represented in the chart by a different coloured dot. To facilitate comparison between subgroups with different age profiles, health outcome indicators were directly age-standardized with the WHO.
Gap charts, displayed as bar charts, are used to show the difference, or gap, in average levels of the indicator in the most advantaged subgroup, compared to the most disadvantaged subgroup. For example, the charts show the difference between those in the highest and lowest income quintiles, or between those with most years of education (university level) and those with fewest years (lower secondary level; the compulsory level of schooling in Italy).

Decomposition charts are used to display the results of the decomposition analyses, as explained in Section 2, which show how insecurity in each of the five essential conditions collectively contributes to the socioeconomic gap for a given health indicator, such as mental health or limiting illness. Data for the decomposition analysis come from the Italian samples of the Eurofound EQLS microdata. The decomposition charts enable policy-makers to see clearly the relative weight of association between each essential condition and inequity in a specific health indicator (3).

**Methodological choices for the analysis**

Many of the indicators of health and well-being presented in the report are disaggregated by education level. This is the case for indicators for which the underlying data allow only imprecise subgroup definitions for economic status, such as whether respondents experience “none”, “some” or “many” economic difficulties. The educational subgroups, on the other hand, are precisely defined according to levels of education based on the 2011 International Standard Classification of Education (ISCED). In this report the ISCED education levels are grouped into three subgroups: 1) low, which includes pre-primary to lower-secondary education only; 2) medium, which includes upper-secondary to post-secondary non-tertiary education; and 3) high, which includes tertiary-level university education.

The proportions of people in each education group in Italy have evolved over time, with percentages in the university education group steadily increasing since 2004 and percentages in the lower-secondary education group steadily decreasing. Table 0.1 shows the percentages of women and men in Italy aged 25–64 years in each education group in 2019 and in 2004.
Table 0.1. Percentage of adults in each education subgroup, 2004 and 2019

<table>
<thead>
<tr>
<th></th>
<th>Lower secondary (%)</th>
<th>Upper secondary (%)</th>
<th>Tertiary (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women 2019</td>
<td>35.6</td>
<td>42.0</td>
<td>22.4</td>
</tr>
<tr>
<td>Men 2019</td>
<td>40.1</td>
<td>43.1</td>
<td>16.8</td>
</tr>
<tr>
<td>Women 2004</td>
<td>51.4</td>
<td>36.5</td>
<td>12.1</td>
</tr>
<tr>
<td>Men 2004</td>
<td>51.3</td>
<td>37.6</td>
<td>11.1</td>
</tr>
</tbody>
</table>


This can have implications for analysing trends in inequities, since the higher education groups now cover a larger portion of the population in Italy. Taking this into account, any trends due to improvements in health among those with more years of education affect a larger proportion of people over time, while trends due to improvements among those with fewest years of education affect a smaller proportion.

The analysis of inequities between these subgroups can be made from an absolute perspective, using the difference in prevalence rates of an indicator between groups, or from a relative perspective, using the ratio of the prevalence rates. It is possible for trends in relative and absolute inequities to diverge even when health improves for all subgroups considered. Reductions in relative inequities require the improvement in disadvantaged subgroups to be proportionally higher than in the subgroups that are better off, which has been empirically less commonly observed in practice, whereas reductions in absolute inequities have been more feasible and represent a public health achievement, provided the relative difference does not widen. As suggested by recent literature (12), the analysis in this report focuses on differences in outcomes, presenting data and charts according to absolute measures of inequity. Nevertheless, statements about narrowing and widening trends are made only when statistically significant for both the absolute (difference) and relative (ratio) measure.
Outline

**Section 1** provides a picture of health inequities in Italy prior to the COVID-19 pandemic and since the 2008 financial crisis, drawing from the new set of disaggregated indicators derived from national microdata sources for the Italian HESRI. This section:
- assesses the current status and recent trends in gaps in health and well-being;
- highlights key gender inequities and inequities across life-course stages, as well as inequities between socioeconomic groups, and migrant status in health and well-being indicators.

**Section 2** uses the Italian HESRI dataset and additional microdata to look at the status and trends in the essential conditions needed to live a healthy life in Italy in the 21st century. It analyses the association between health inequity and socioeconomic disparities in the essential conditions, and trends in the disparities in essential conditions prior to the COVID-19 pandemic and since the 2008 financial crisis. The essential conditions to achieve equity in health cover five policy areas: 1) Health services, 2) Income security and social protection, 3) Living conditions, 4) Social and human capital, and 5) Employment and working conditions.

A decomposition analysis identifies the significant contributors associated with health inequities in Italy based on the five essential conditions. This analysis highlights the multiple factors that impact health and well-being and shows the pathways to health inequities that can be targeted by policy action.

**Section 3** provides an analysis and discussion of prospective policy options and priorities for building a resilient recovery from the impacts of COVID-19, building on the findings of Sections 1 and 2 and using equity as a driver for sustainable recovery and development in the long term. This section:
- synthesizes emerging evidence on how COVID-19 is compounding existing inequities in health and the essential conditions, and explores what new inequity risks and vulnerabilities are emerging;
- highlights priority health and cross-sectoral measures with the potential to (a) mitigate the deepening of existing inequities and the emergence of new inequities, and (b) foster recovery that leaves no one behind due to poor health and insecurity of the essential conditions needed for a healthy life.
The Italian HESRi
This first section focuses on disparities and trends in the health status of the best-off and worst-off adults and children in Italy's population. The indicators of health and well-being in this section are primarily disaggregated by education level, since the educational categories provide the most standardized and reliable means of comparing different groups of the population. Analysis and discussion of the indicators, derived from survey data from the ISS and the ISTAT, are loosely organized around (i) health and well-being status, and (ii) lifestyle and risk factors that affect health.

**KEY FINDINGS**

Until the advent of the COVID-19 pandemic, life expectancy in Italy had been increasing, though there are still significant socioeconomic and regional inequities.

Women generally live longer than men, though their longer years of life are not necessarily lived in good health.

The self-reported health of people living in Italy has also been improving in recent years, with fewer people reporting poor or fair health than was the case a decade ago.

However, there is a clear social and educational gradient throughout the majority of the health indicators, with those with fewer years of education and less financial security experiencing poorer health than those with more years of education and financial security.

Those with fewer years of education and less financial security are likely to have higher levels of NCDs, greater levels of overweight, a higher prevalence of depressive illness, and are more likely to be active smokers.

For many of these health indicators, the size of the gap between the most and least advantaged has remained the same, and for some, such as overweight in adolescent girls, it has increased.
Inequities in health and well-being: status and trends since the 2008 financial crisis

SUMMARY

Life expectancy is increasing in Italy, and levels of poor and fair self-reported health are falling among working-age and older people, suggesting that, overall, people feel their health to be better than in previous years. While inequities between the proportion of those with most and fewest years of education reporting poor or fair health have decreased within the working-age population, this has not been true for older or younger people.

Although less poor or fair health is being reported, the fact that there has been no comparable reduction in the proportion of people reporting that they have one or more chronic conditions possibly implies that in some cases chronic conditions are being better controlled than in the past.

A clear educational gradient is evident across almost all indicators, with both diabetes and cardiovascular disease being more prevalent in those with fewer years of education. Women appear more likely to report symptoms of depression than men.

Until the advent of the COVID-19 pandemic, life expectancy had been increasing for both women and men, but those with fewer years of education, or living in southern Italy, still lived shorter lives on average. Older people with only compulsory education experience higher levels of health-based limitations.

- Life expectancy has been increasing in Italy, with women and men at all education levels expected to live longer in 2016 than in 2008 (Fig. 1.1).

- The difference in life expectancy between women and men in the group with only compulsory education and the groups with more years of education is much larger than the difference between the medium-level and high education groups, indicating that there is not a truly linear social gradient across all education levels.

- According to the Italian Atlas of Mortality Inequalities by Education Level (2019) (13), in every Italian region men have lower life expectancy than women. It is important to note that although women live longer, this does not necessarily equate to better quality years of life.

- People living in southern Italy lose an additional year in life expectancy regardless of education level, and social inequities in mortality are more marked in the poorer regions of southern Italy.

- COVID-19 appears to have interrupted the increasing trend in life expectancy, and even reversed it, particularly in parts of Italy worst
affected by the pandemic. At national level, life expectancy appears to have decreased by around 0.9 years, though this masks significant regional variation with a more marked impact in northern regions (14).

Levels of poor/fair self-reported health have been falling in working-age and older adults, but the picture for younger adults is less clear

- Self-reported measures of overall health, mental health and wellbeing are increasingly recognized as early detectors of mortality and morbidity risk, and are widely regarded as reliable indicators of objective health status (3).

- In general, overall levels of poor and fair self-reported health for working-age adults (age 25–64) have fallen in Italy at every education level across the 10-year period since the financial crisis between 2008 and 2018 (Fig. 1.2). In other words, as time passes, fewer people are reporting poor or fair health across all socioeconomic groups, and the size of the gap between those with most and fewest years of education has decreased.
This trend of decreasing levels of poor and fair self-reported health can also be seen in those aged 65 years and over at every education level across the same 10-year period.

However, those with fewer years of education are still more likely to report poor or fair health than those with more years of education within both the working-age and older age groups, with a 13.8 percentage point difference in the proportion of working age women with only compulsory education reporting poor or fair health in 2018, compared to university-educated women. For men, the difference was 13.5 percentage points.

The size of the gap between adults with medium and high levels of education reporting poor or fair health is larger than the size of the gap between people in these education groups for life expectancy.

The picture is less clear for young people aged 16–24 years. This may be due to challenges inherent in the examination of health inequities between young adult social and economic groups, a life stage where many

Source: authors' own compilation based on data from the European Union Statistics on Income and Living Conditions (EU-SILC) Italian survey (15).
people will make multiple changes to their living and employment circumstances over a relatively short period of time. This period can be characterized by change, waiting, and periods of uncertainty and insecurity which may include long periods of temporary employment, low pay, poor-quality work, or unemployment (16).

Inequities in self-reported health have narrowed among working-age people and men aged 65 years and over, but not younger people or women aged 65 years and over, suggesting a potential benefit from focusing equity-increasing policy interventions on younger people and older women.

- There has been a narrowing of the gap in the proportion of both women and men of working age reporting poor or fair health, comparing those with university education to those with only compulsory education, across the 10-year period between 2008 and 2018 (Fig. 1.3), with the size of the gap decreasing by 8.4 percentage points for women and 5.4 percentage points for men. This narrowing of the gap is statistically significant.

- There has also been a statistically significant narrowing of the gap in self-reported health between the most and least advantaged men aged 65 years and over, when evaluated by education level or by income quintile.

**Fig. 1.3. Difference in percentage of adults (aged 25–64 years; age adjusted) reporting poor or fair health, bottom versus top education level**

![Chart showing the difference in percentage of adults reporting poor or fair health between bottom and top education levels from 2008 to 2018.](chart)

Source: authors’ own compilation based on data from the EU-SILC Italian survey (15).
• By contrast, there has been no statistically significant narrowing of the gap between the most and least advantaged young people (aged 16–24 years) over the same period, when evaluated by income quintile (Fig. 1.4) (detailed data based on education level were not available for the younger age group), or for older women (aged 65 years and over) when evaluated by education level or by income quintile.

• There may be emerging signs of a decreasing trend in the size of the gap between the highest and lowest income quintiles among young men, but there is no similar pattern for young women. Interpretation of the trend for young people is made more complex due to young people staying in education and therefore deferring receiving higher income levels.

Fig. 1.4. Difference in percentage of young adults (aged 16–24 years; age adjusted) reporting poor or fair health, bottom versus top income quintile

Source: authors’ own compilation based on data from the EU-SILC Italian survey (15).
The gap has widened between the proportion of women with fewest and most years of education reporting one or more chronic disease, and prevalence of at least one chronic disease is higher in older women of all education levels, suggesting existing measures to prevent NCDs may be working less well in women

- As described earlier, the proportion of working-age (aged 25–64 years) and older (age 65+ years) people reporting only poor or fair health is decreasing overall, representing an increase in the proportion of working-age adults who say they are in good or very good health.

- However, there has not been a parallel reduction in the prevalence of some long-term conditions. Both women and men of working age (aged 18–64 years) with only compulsory education are more likely to report having at least one chronic disease, and women with only compulsory education are 1.5 times more likely than university-educated women to do so – the corresponding figure is 1.2 times more likely for men with only compulsory education.

- Working-age women are also slightly more likely than men in the same age group to report having two or more chronic conditions, with an educational gradient also in evidence.

- Between 2008 and 2019, there was no reduction in either the proportion of working-age adults reporting at least one long-term condition or the size of gap between those with most and fewest years of education reporting one long-term condition – in fact, since 2013 there has been a statistically significant widening of this gap among women.

- The percentage of working-age women with only compulsory education reporting at least one chronic disease is higher than for men with only compulsory education in most years across the 12-year period for which data were available, and this was the case in four of the most recent five years (2015–2019) (Fig. 1.5).

- For adults aged 65+ years, prevalence of at least one chronic condition was almost twice as high for women of all education levels as for men.

- Large proportions of older adults (aged 65+ years) with only compulsory education report that they face limitations in their daily activities due to health issues. In 2018 (the most recent year for which data were available) this was true for 55.3% of women and 47.8% of men with only compulsory education. By contrast, 29.5% of women and 25.2% of men with university education said this was the case.
Although fewer people are reporting poor or fair health, prevalence of diabetes and cardiovascular disease is higher in worse-off groups

- The proportion of men and women reporting having diabetes has remained broadly static over the period studied (Fig. 1.6), as has the proportion of men and women reporting having cardiovascular disease.

- Just under three times as many working-age women and just over three times as many men with only compulsory education report having diabetes, compared to those with university education. This gap has not changed significantly between 2008 and 2019.

**Fig. 1.5. Percentage of adults (aged 18–64 years; age adjusted) reporting at least one chronic disease, by education level**

Source: authors’ own compilation based on data gathered by the Italian Behavioural Risk Factor Surveillance System (PASSI) (17).
Both working-age men and women with only compulsory education are more likely to have cardiovascular disease than their university-educated peers. In 2019 the size of the gap between those with the most and fewest years of education was 1.4 percentage points in women and only 0.2 percentage points in men; however, this finding is unusual. Generally, cardiovascular disease is more prevalent among men than women.

Fig. 1.6. Percentage of adults (aged 18–64 years; age adjusted) reporting diabetes, by education level

Source: authors’ own compilation based on data gathered by the PASSI (17).
Depression affects a higher proportion of women than men for those of both working-age and older age, while older women and men are each more likely to report symptoms of depression than working-age people.

- A greater proportion of working-age (aged 18–64 years) women than men reported symptoms of depression at every education level (Fig. 1.7). In 2019 twice as many women as men with only compulsory education reported such symptoms. The gap between those with most and fewest years of education did not narrow at all during the period between 2009 and 2019, and for women, the gap widened noticeably between 2016 and 2019.

- Older women (aged 65 years and over) were also found to be more likely to report depressive symptoms than men in the same age range, and the proportion of older adults reporting such symptoms was greater than for working-age adults among both women and men.

Fig. 1.7. Percentage of adults (aged 18–64 years; age adjusted) reporting depressive symptoms, by education level

Source: authors’ own compilation based on data gathered by the PASSI (17).
Fewer young women were new mental health service users than men, but more working-age and older women than men used mental health services; it is not clear whether this suggests a greater extent of unmet need in younger women or in working-age and older men.

- A lower proportion of young women (aged 18–24 years) were new mental health service users than young men in the four-year period 2015–2018 (Fig. 1.8). This gender difference reverses for the age groups 25–64 years and 65+ years, with a higher proportion of female service users at these life stages.

Fig. 1.8. New mental health service users per 1000 young people (aged 18–24 years), by education level

Gaps in maternal mortality and healthy behaviours during pregnancy prevail, particularly for women with fewer years of education and among some immigrant groups.

- The maternal mortality ratio per 100 000 live births was more than twice as high among those with only compulsory education as among those with medium-level education in the pooled maternal mortality data between 2006 and 2015. Women with the most years of education do not have the lowest maternal mortality.

- In 2019 almost six times as many women with only compulsory education smoked during their pregnancy as university-educated women.

- By contrast, almost 1.4 times as many university-educated women consumed alcohol at least 1–2 times a month during their pregnancy as women with only compulsory education.
• Women with Asian citizenship had the highest levels of maternal mortality in Italy between 2006 and 2015, with citizens of eastern European countries having the lowest levels (Fig. 1.9).

• There is evidence that immigrants in Italian cities have lower rates of hospitalization than Italian citizens, in particular among men. Among women, rates of hospitalization due to pregnancy and childbirth are sometimes higher than for Italians. While hospitalizations have decreased over time, this has not been the case for immigrants (14).

![Fig. 1.9. Maternal mortality ratio per 100 000 live births, by citizenship, 2006–2015](image)

*Source: original analysis for the Italian HESR based on data from the National Institute of Health’s Italian Obstetric Surveillance System (ITOSS).*

• Past research has shown neonatal and post-neonatal mortality risk of about 1.5 times higher among children of immigrant mothers compared to children of Italian citizens, even after correcting for socioeconomic characteristics, although gap this appears to have closed over time. These gaps particularly affected immigrants from North Africa and sub-Saharan Africa, as well as those who had been living in Italy for more than five years (14).
Inequities in lifestyle factors that affect health: status and trends

SUMMARY
Entrenched gaps in lifestyle behaviours that have an impact on health status between those with the fewest and most years of education show there is significant potential to improve equity by supporting people to lead healthier lives.

Working-age men and women with fewest years of education are both significantly likely to be overweight, and inequities are widening between the most- and least-educated women in terms of overweight. The gap between the most and least active women is wider than for men at all life stages, and for women an educational gradient exists that appears to be embedded from childhood.

Men and women with fewer years of education are more likely than other groups to smoke, and smoking levels have remained static in this group across the study period. Six times as many women with only compulsory education smoked during pregnancy as university-educated women. But university-educated men and women are most likely to engage in risky drinking behaviours, and more university-educated women consumed alcohol at least 1–2 times a month during their pregnancy than women with only compulsory education.

Gaps in overweight or obesity are wider for women and have widened over time, suggesting measures to reduce levels of overweight or obesity are not reaching women

- Inequities in overweight and obesity are evident from school age, and the gaps in prevalence of overweight or obesity between girls from the most and least affluent families are widening (Fig. 1.10).

- Similarly, gaps in prevalence of overweight or obesity between women with fewest and most years of education are also widening (17).

- Women and men of working age with only compulsory education are significantly more likely to be overweight or obese than those with more years of education. More than five out of 10 men and almost four out of 10 women of working age are overweight or obese and this trend has increased over time (18).

- These recent trends may be partially explained by evidence showing a change in food consumption habits since the financial crisis of

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2 Original analysis for the Italian HESR based on data for 2010 to 2018 from the Italian Health Behaviour in School-aged Children (HBSC) dataset.
2008, linked to economic factors. Households in which the head of household has fewer years of education and those experiencing income losses tended to follow consumption patterns characterized by low food spending, consisting of more energy-dense foods such as bread, pasta and grains consumed in the home. In contrast, more advantaged households tended to follow consumption patterns with a more balanced dietary approach, higher spending levels, and more frequently eating outside the home (19, 20).

**Fig. 1.10. Difference in percentage of adolescents (aged 11, 13 and 15 years) who are overweight or obese, comparing adolescents from low-affluence families to those from high-affluence families**

*Note.* The Family Affluence Scale is a composite indicator of the affluence of a family. It is based on a set of questions intended to discern the material conditions of the household in which a family lives, including car ownership, bedroom occupancy, holidays and home computers.

*Source:* original analysis for the Italian HESR based on data for 2010 to 2018 from the Italian HBSC dataset.

Gaps in physical activity have widened, particularly for girls and women, suggesting potential value in introducing programmes to encourage physical activity targeted specifically at women:

- The gap between the most- and least-active women is wider at all life stages than for men. For instance, among adolescent girls (aged 11, 13 and 15 years) there is a clear educational gradient, with girls whose parents have fewest years of education showing higher levels of sedentary behaviour across all time periods, compared to those whose parents have most years of education (Fig. 1.11).

- The gap in exercise levels between those with the highest and lowest educational backgrounds is present in children (aged 8–9 years) and adults (aged 18–64 years) of both sexes, but there is a statistically
significant narrowing of the gap for both men and women aged 65+ years in the years for which data were available (2016–2019).

- A greater proportion of both girls and boys from families with the lowest level of affluence watched TV or used electronic devices for more than two hours a day, with those from more affluent families less likely to do so.

**Fig. 1.11. Percentage of adolescents (aged 11, 13 and 15 years) not doing 60 mins a day of physical activity, by parental education level**

> Source: original analysis for the Italian HESR based on data for 2010 to 2018 from the Italian HBSC dataset.

**Risky behaviours such as smoking and risky alcohol consumption show a mixed picture, with very different behaviours in evidence for smoking and alcohol consumption**

- Prevalence of smoking is higher in working-age men than women, and higher in both women and men with only compulsory education than in those who have attained more years of education. Levels of smoking in working-age adults remained relatively static between 2009 and 2019 (Fig. 1.12).

- Among people aged 65 years and over, prevalence of smoking is lower overall, but university-educated women and men with medium-level education have the highest levels of smoking within this age range.

- University-educated women of working age (aged 18–64 years) are more likely than women with fewer years of education to be risky drinkers. This was also found to be true of university-educated working-age men in 2019, but the pattern was less well established in the period 2012–2015, when working-age men with the highest levels of risky drinking were those with only compulsory education.

- Among people aged 65 years and over there was a greater prevalence of high-risk alcohol consumption among women and men with a university education, and adolescents of both sexes from the most
affluent families were most likely to report binge-drinking on at least one day in the previous 12 months, with those in the least affluent families least likely to have done so.

Fig. 1.12. Percentage of adults (aged 18–64 years; age adjusted) who are current smokers, by education level

ANALYSIS: A WORSE PICTURE IN MULTIPLE AREAS FOR WOMEN
Multiple health and lifestyle indicators show a worse picture for women in Italy than for the population at large. The picture is particularly concerning regarding the worst-off women. For instance, since 2013 there has been a statistically significant widening of the gap between working-age women with the highest and lowest levels of education reporting one or more long-term conditions, but this is not the case for working-age men.

Gaps between the best-off and worst-off women in terms of overweight are wider than for men and continue to increase. Women are less likely to engage in physical activity than men at all life stages, and a greater proportion of women reported experiencing symptoms of depression across all education levels throughout the period 2009–2019.

Source: authors’ own compilation based on data gathered by the PASSI (17).
2. The essential conditions needed for health equity

KEY FINDINGS

Disparities in health service quality and access account for 9% of the total contribution from the five conditions to the health gap between the top and bottom income groups. Seven times as many women and men aged 25–64 years with only compulsory education reported unmet need in 2018 as those with university education. Unmet need was higher for women in every year studied up to 2017, when rates of unmet need for men in the top and bottom income groups overtook those of women.

Disparities in ability to make ends meet due to insecure income and social protection conditions account for 43% of the total contribution from the five conditions to the health gap. Income inequality widened between 2008 and 2019 and has remained at higher levels than before the 2008 financial crisis. The gap between the proportion of women with only compulsory education and the proportion of women with university education experiencing in-work poverty has also widened over the period studied. In 2018 three times as many women and men with only compulsory education experienced in-work poverty as those with university education.

Disparities in living conditions account for 22% of the total contribution from the five conditions to the health gap. Gaps in food and fuel insecurity have widened and persisted for both men and women since the great recession – these make up 28% and 16% of the portion of the health gap attributed to living conditions, respectively. This may have led to detrimental food consumption behaviours among disadvantaged households, with disproportionate reliance on low-cost, energy-dense foods influenced by marketing and product exposure techniques of commercial food organizations.

Disparities in social and human capital account for 15% of the total contribution from the five conditions to the health gap. Lack of trust contributes 43% of this portion of the gap attributed to social and human capital. In 2013 young people (aged 16–24 years) had the
highest levels of low trust, but from 2014 onward, those aged 65+ were most likely to report high levels of low trust. In Italy, low trust is high across all education levels, but more working-age adults with only compulsory education do not feel that most people are trustworthy compared to those with more years of education. This lack of trust increased among adults with only compulsory education between 2013 and 2018, but not among those with more years of education.

Disparities in employment and working conditions account for 11% of the total contribution from the five conditions to the health gap. Twice as many men with only compulsory education are unemployed as men with university education. Although youth unemployment decreased for both men and women between 2014 and 2019, rates of temporary employment among young people have increased over the same period, from 62% to 67% for women and from 54% to 57% for men. Precarious work can have negative health, social and economic consequences, as well as having a disproportionate impact on the risk of economic, psychological and physical stress and anxiety among vulnerable people.

Brief explanation of the methodology

- The five essential conditions identified in the HESRI that impact on health equity and are required for people to live a healthy and prosperous life are health services, income security and social protection, living conditions, social and human capital, and employment and working conditions. Insecurities in each of the areas contribute to the underlying causes of health inequities (Fig. 2.1).

Fig. 2.1. The five essential conditions that impact on health equity

Source: authors’ own compilation based on the European HESR (3).
• The five essential conditions can be defined as follows.

  ° Health services comprises indicators and interventions relating to the availability, accessibility, affordability and quality of prevention, treatment and health-care services and programmes.

  ° Income security and social protection encompasses indicators and interventions relating to basic income security and the reduction of health-related risks and consequences of poverty over the life-course.

  ° Living conditions includes indicators and interventions relating to differential opportunities, access and exposure to environmental and living conditions that each have an impact on health and well-being.

  ° Social and human capital covers indicators and interventions relating to human capital for health through education, learning and literacy, and relating to the social capital of individuals and communities in ways that protect and promote health and well-being.

  ° Employment and working conditions refers to indicators and interventions relating to the health impact of working, including availability, accessibility, security, wages, physical and mental demands and risks associated with working.

• Where statistical relationships between indicators in these areas and gaps in health can be seen, this suggests that these are issues that should be prioritized in terms of policy-making.

Understanding the decomposition analysis methodology

• Decomposition analysis uses an econometric regression technique, aiming to explain statistically the differences in health indicators that were observed between different socioeconomic groups in Section 1 by a set of contributing factors that differ systematically between these groups (the five determinants; as already mentioned).

• The analysis helps to understand the multisectoral conditions driving health inequities even when effective health systems are in place. For example, differences in health may be linked to differences in housing and/or working conditions, as well as differences in quality of health care. Even if countries are able to narrow inequities in relation to one factor, inequities may still remain in others, emphasizing the importance of taking a multisectoral approach to tackling health inequity.
The five conditions’ contributions to inequities in Italy

- Fig. 2.2 shows the extent to which disparities in each of the five conditions are associated with the gap in health status between the richest and poorest 40% in Italy. These results are based on decomposition analysis of EQLS data over the period 2003–2016.

- The chart shows that for the Italian population, among the five conditions, differences in income security and social protection are most strongly associated with inequity in self-reported health. This accounts for a little under half of the total contribution from the five conditions to the gap between the richest population group and the poorest.

- Overall, when decomposing the gap in health status between the richest and poorest 40% in Italy, the size of the relative contributions of each determinant is broadly similar to the picture across Europe as a whole. For instance, over the same period, an analysis of the impact of the five conditions for an aggregate of 35 European countries found that income security and social protection accounted for 39% of the difference between the best-off and worst-off 40% in those countries.

**Fig. 2.2. Decomposition of the impact of the five essential conditions on the gap in health status between the richest and poorest 40% in Italy**

Decomposing the health gap: health services

- The decomposition analysis shows that disparities in health service quality and access account for 9% of the total contribution from the five conditions to the health gap between the top and bottom income groups.

• The portion of the health gap attributed to inequities in health services can be decomposed a level further into its component subfactors (Fig. 2.3). This further level of analysis shows that, for Italy, these subfactors relate to quality of services and unmet need due to issues with access to services.

• Differences in the quality of health care services account for 78% of the portion of the health gap attributed to health services, when comparing the top and bottom income groups.

• The quality of health care services has an equity impact because health outcomes improve with better-quality care (21) and so equitable provision of good-quality care reduces gaps in health outcomes. Disparities in the quality of health services can arise from differences between providers catering to low- or high-income neighbourhoods, resulting in geographical inequities.

• Similarly, disparities in health care quality are also found between private and public providers, and can be affected by challenging working conditions and shortages of health workers that mirror geographical inequities in socioeconomic status and health outcomes. Improving working conditions in health settings may be beneficial for promoting a culture of health and sustaining the economies of local communities.

Fig. 2.3. Decomposition of the health services subfactor


• Existing evidence shows a high degree of regional variation in the quality of health care across Italy, reflecting differences in regional levels of income and economic activity (22). The results of the decomposition analysis show that this variation in the quality of health care in Italy translates into inequity in health status.
• Unmet need due to issues with accessing services accounts for the remaining 22% of the portion of the health gap attributed to health services. Of this, 16% is linked to long travel times or distance to services, while 6% is linked to long waiting times.

• Disparities in unmet need for health care impact on equity because the risk of foregoing necessary care differs according to socioeconomic characteristics. For example, Fig. 2.4 shows that unmet need for health care is consistently experienced more frequently among Italian women and men with fewer years of education.

• Unmet need may arise from a variety of barriers to accessing health-care services, including prohibitive cost, waiting times, travel times or distance, and work or care responsibilities. Rates of unmet need due to long waiting times, distances or transport problems are particularly unequal between income groups in Italy (23). The decomposition analysis shows that disparities in unmet need due to these barriers are indeed associated with inequities in health status.

Fig. 2.4. Percentage of adults (aged 25–64 years) reporting unmet need for health care, by education level

Source: authors’ own compilation based on data from the EU-SILC Italian survey (15).
• Disparities in unmet need due to cost do not appear as a statistically significant subfactor in the portion of the health gap attributed to health services. From this it can be inferred that no strong link exists between differences in unmet need due to cost and inequities in health status among the Italian population.

• The absence of this link is significant. The Italian National Health Service is financed by general taxation and is mostly free of charge at the point of use, granting universal access to hospital care to all residents throughout the country, irrespective of income. A compelling interpretation is that this financial protection against health-care costs built into the Italian health system is successful in offering protection against unmet need and poor health linked to low income.

**Trends: health services**

Highlighting key trends in these subfactors and related indicators can provide further insight into potential areas of effective policy action, given their demonstrated association to health inequity from the decomposition analysis.

**Widening disparities in unmet need for health care between socioeconomic groups highlight opportunities for policy to reduce gaps in service provision**

• The gap in unmet need for health care between adults with only compulsory education and those with university education widened significantly between 2008 and 2018 for adults aged 25–64 years (Fig. 2.4). In 2008 twice as many women and men with only compulsory education reported unmet need for health care as those with university education. In 2018 this number was seven times as high.

• There is a similar trend of a widening gap for adults aged over 65 years, but levels of unmet need are lower in this age group. A study by the PASSI found that during the pandemic, 44% of adults aged 65+ years reported a missed medical examination in the previous 12 months (28% owing to services being suspended and 16% due to fear of contagion) (24).

• Unmet need has generally decreased for adults with more years of education but not for those with only compulsory education, while for men with only compulsory education it has increased. Analysis by income shows the same trend but the gap in unmet need between the highest- and lowest-earning 20% of adults is even wider; 16 times as many women and 11 times as many men in the lowest-earning 20% reported unmet need in 2018.
Screening uptake is increasing

- Uptake of colorectal cancer screening among adults aged 50–69 years increased overall between 2010 and 2019, but in both 2010 and 2019 a higher proportion of men at all education levels accessed these screening services. For both breast cancer screening and cervical cancer screening, the proportion of eligible women accessing services increased overall between 2010 and 2019.

Decomposing the health gap: income security and social protection

- The decomposition analysis shows that disparities in income security and social protection account for 43% of the total contribution from the five conditions to the health gap between the top and bottom income groups.

- Income security and social protection are measured according to a single component in this analysis: degree of difficulty in making ends meet. This indicator captures financial insecurity irrespective of whether its source is inadequate earned income or inadequate social protection.

- The results of the analysis show that disparities in income insecurity and social protection in Italy translate into inequity in health status. All people in society require a basic level of income security and social protection to avoid the adverse health and social consequences of poverty throughout the life-course. Ensuring this involves preventing and protecting against poverty and income inequality, providing support to families – especially at early stages of child development – and supporting older people to ensure financial security in later life (Fig. 2.5).

**Fig. 2.5. Decomposition of the income security and social protection subfactor**

<table>
<thead>
<tr>
<th>Subfactors of the health gap explained by the essential condition income security and social protection (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficulty making ends meet</td>
</tr>
<tr>
<td>Poverty and inequality</td>
</tr>
<tr>
<td>Supporting families</td>
</tr>
<tr>
<td>Supporting older people</td>
</tr>
</tbody>
</table>

Trends: income security and social protection

Highlighting key trends in income inequality and insecurity can provide further insight into potential areas of effective policy action, given their demonstrated association with health inequity determined through the decomposition analysis.

Growing income inequality signals a point of policy intervention to reduce health gaps through a fairer distribution of income

- Income inequality widened between 2008 and 2019, as measured by the Gini coefficient of income inequality and the S80/S20 income quintile share ratio (Fig. 2.6) (15), and has remained at higher levels than before the 2008 financial crisis. In 2019 women and men in the highest-earning quintile of the population were earning over six times as much as their counterparts in the lowest-earning quintile. In 2008 this figure was just over five times as high.

- The COVID-19 pandemic may have had the effect of deepening this income inequality. According to the PASSI COVID-19 study, 34% of adults have reported a worsened financial position as a result of COVID-19. For the most economically vulnerable who reported having difficulty making ends meet, this figure was 52%. Those reporting no difficulty making ends meet amounted to only 22% (24).

- A total of 35% of those with only compulsory education have reported worsening financial resources as a result of COVID-19, compared to only 30% of those with university education. By contrast, only 12% of those aged 65+ years have reported a worsened financial position.

- While the focus of this analysis is on identifying and finding solutions to reduce inequities, it is also important not to forget the overarching aim of reducing rates of poor health in general. Here, overall levels of income security are also of critical importance. In particular, in view of the high reliance of people in Italy on informal loans from friends and family when in need of money, income insecurity due to arrears and defaults on informal loans is high (25) and there is scant support once people have debt problems (26). Strengthening social protection helps to prevent households from falling into formal and informal debt, as well as reducing poverty risk and its associated adverse health and social consequences.
Income insecurity does not necessarily arise solely from being out of work; increases in in-work poverty indicate that there is scope to strengthen wage and social protection policies.

- The gap between the proportion of women with only compulsory education and the proportion of women with university education experiencing in-work poverty widened over the period 2008–2018 (Fig. 2.7). In 2018 more than three times as many women and men with only compulsory education experienced in-work poverty as those with university education.

- While the proportion of adults with only compulsory education experiencing in-work poverty increased from 2008 to 2018, the proportion of those with more years of education experiencing in-work poverty has also increased.
• Analysis by macro-region shows that the highest rates of in-work poverty are found in South Italy and Insular Italy. There is a consistent gap over the years in in-poverty rates between the regions South/Insular Italy and Central/Northwest/Northeast Italy, of around 10% for women and 15% for men.

• According to the PASSI COVID-19 study, 28% of working adults are now doing the same job at a lower wage, as a result of the pandemic (24).

• This combination of longer-term and immediate trends supports the need for both short-term emergency income support and longer-term wage, social protection and active labour market policies to reduce these inequities, to enable all people in Italy to meet their basic needs and live a healthy life (27).

Fig. 2.7. Percentage of adults (aged 25–64 years) reporting in-work poverty, by education level

Source: authors’ own compilation based on data from the EU-SILC Italian survey (15).
Decomposing the health gap: living conditions

- The decomposition analysis shows that disparities in living conditions account for 22% of the total contribution from the five conditions to the health gap between the top and bottom income groups.

- The portion of the health gap attributed to inequities in living conditions can be decomposed further into its component subfactors (Fig. 2.8). This further level of analysis shows that, for Italy, these subfactors relate to access to decent homes, food and fuel, and neighbourhood green space.

- Differences in housing deprivation account for 45% of the portion of the health gap attributed to living conditions, when comparing the top and bottom income groups. Housing deprivation includes conditions of overcrowding, lack of a bath and indoor toilet, and damp or dark dwellings. Another 28% of this portion of the health gap is linked to fuel deprivation and homes that are inadequately heated. This does not take into account whether homes are inadequately cooled in hot weather, which would have an additional impact on the health gap through heat-related health effects (28).

- Poor housing and poor health are inextricably linked. People living in unaffordable, poor-quality or insecure housing are more likely to report poor health and to suffer from a variety of health problems, including both physical illness and mental distress. Decent shelter also provides safety, as well as a sense of belonging, peace and security.

- Considering the case of extreme housing exclusion, recent estimates show that at least 50,000 people are homeless in Italy, the majority of whom are foreigners (29).

![Fig. 2.8. Decomposition of the living conditions subfactor](image)

• The majority of people in Italy own their own homes, a fifth live in rented accommodation and 5% in public or social rented housing (30,31). Among households in the poorest income quintile, however, over half live in rented accommodation and 18% in public or social rented housing.

• Ensuring equal access to affordable, high-quality and secure housing therefore calls for an integrated approach, including, for example: improving the supply of good-quality social housing by developing *Edilizia Residenziale Sociale* (social housing); providing incentives to encourage affordable renting; and supporting the improvement of private and public housing stock through housing renewal, renovation and energy efficiency improvements.

• Disparities in food deprivation account for another 16% of the portion of the health gap attributed to living conditions, when comparing the top and bottom income groups. Food deprivation is measured in this analysis as inability to afford a protein-rich meal every other day.

• Food deprivation is not only an issue of having inadequate food; it also results from detrimental food consumption behaviours based on misunderstood nutritional requirements. Commercial food organizations influence food consumption behaviours through use of marketing and product exposure techniques in ways that affect the risks of NCDs and mortality. This has an impact on health equity because commercial influence varies with how well people are educated about the health risks of poor-quality diets, and whether their economic situation and social environment encourage or discourage them from detrimental consumption behaviours. This is linked to the widening inequities in overweight and obesity observed among women and girls (see Fig. 1.10).

• Disparities in access to green space accounts for the remaining 11% of the portion of the health gap attributed to living conditions, when comparing the top and bottom income groups.

• Differences in the quality of the local environment in which people live, including access to green space, has an impact on health equity because low-income households and neighbourhoods are less likely than wealthy neighbourhoods to have access to safe, health-promoting environments (32).

• Policies that shape the geographical planning, construction and management of green spaces can reduce health inequities linked to the local environment (33). Well-designed public and green spaces can have numerous health-related benefits, such as encouraging physical activity, improving air quality, providing nature as a means of relief from stress and anxiety, and enhancing safety and social integration.
**Trends: living conditions**

Highlighting key trends in living conditions can provide further insight into potential areas of effective policy action, given their demonstrated association with health inequity resulting from the decomposition analysis.

Persistent gaps in food insecurity point to opportunities to reduce health gaps by widening and improving Italy’s food safety net programmes, such as providing school lunches

- Seven times as many women and nine times as many men in the lowest-earning 20% were unable to afford a protein-rich meal every other day compared to those in the highest-earning 20% in 2018. Food insecurity increased across all income groups after 2009 and then decreased again after 2012 (Fig. 2.9). Fuel deprivation follows a similar trend (Fig. 2.10).

- Analysis by macro-region shows that the highest proportions of food insecurity are found in South Italy and Insular Italy. Analysis by education level shows that three times as many women and four times as many men with only compulsory education report food insecurity compared to those with university education (Fig. 2.9).

  - While differences in housing deprivation comprised the largest subfactor of living conditions linked to health inequity (Fig. 2.11), trends in the disaggregated indicators show that the gap in housing deprivation has not widened over this period. However, it is likely that prolonged exposure to housing deprivation from lockdowns due to COVID-19 will magnify the detrimental impact of such housing deprivation on health.
Fig. 2.9. Percentage of adults (aged 25–64 years) reporting a lack of a meal with protein every second day, by education level

Source: authors’ own compilation based on data from the EU-SILC Italian survey (15).
Fig. 2.10. Percentage of adults (aged 25–64 years) unable to keep their home adequately warm, by education level

![Graph showing percentage of adults unable to keep home adequately warm, by education level and gender.](image)

Source: authors’ own compilation based on data from the EU-SILC Italian survey (15).

Fig. 2.11. Percentage of adults (aged 16+ years) living in an overcrowded dwelling that also lacks a bath and indoor toilet, or is damp or too dark, by education level

![Graph showing percentage of adults living in overcrowded conditions, by education level and gender.](image)

Source: authors’ own compilation based on data from the EU-SILC Italian survey (15).
Decomposing the health gap: social and human capital

- The decomposition analysis shows that disparities in social and human capital account for 15% of the total contribution from the five conditions to the health gap.

- The portion of the health gap attributed to inequities in social and human capital can be decomposed further into its component subfactors (Fig. 2.12). These subfactors relate to human capital-building through participation in education, and to social capital-building through connections between people.

- Education and learning across the life-course (human capital) and promoting social capital enables people to stay healthy, connected with others and engaged in their communities, and helps to build trust, belonging, voice, a sense of future, and hope.

- Disparities in years of education account for 51% of the portion of the health gap attributed to social and human capital, when comparing the top and bottom income groups.

- Equal access to good-quality education from an early age has a strong impact on reducing inequities in opportunities and risks, which has both direct and indirect impacts on health.

- Continued provision of education and lifelong learning opportunities have a direct effect on promoting social and economic inclusion, as well as mental well-being (34). These also stimulate indirect effects linked to increased health and social literacy, such as awareness of health risks and behaviours, and mediating life chances and the effects of social and economic shocks (35).

- Disparities in levels of trust between people account for an additional 43% of the portion of the health gap attributed to social and human capital, when comparing the top and bottom income groups.

- Trust between people is a key element of social capital and a key contributor to sustaining societal well-being. Trust encourages more effective community integration, cooperative effort towards community development, and resilience against potential economic or environmental risks to health and well-being (36).

- The effect of trust on promoting health may be particularly important for low-resource communities, where social capital plays a more important role than financial and human capital in improving resilience and security (37).

- The remaining 6.4% of the portion of the health gap attributed to social and human capital was accounted for by disparities in participation.
in volunteering. Volunteering can act as a mechanism for social inclusion and solidarity, and promotes health equity by providing opportunities for social connections, relationships, informal learning, physical activity and civic engagement.

**Fig. 2.12. Decomposition of the social and human capital subfactor**

![Decomposition of the social and human capital subfactor](image)


**Trends: social and human capital**

Highlighting key trends in indicators of social and human capital can provide further insight into potential areas of policy action, given their demonstrated association with health inequity demonstrated through the decomposition analysis.

**Long-standing low levels of trust and gaps in trust indicate areas of potential for long-term improvement, to foster more inclusive civic engagement and collective decision-making**

- Higher proportions of adults aged 18–64 years with only compulsory education do not feel that most people are trustworthy (up to 86%) compared to those with more years of education (Fig. 2.13). Lack of trust increased among adults with only compulsory education from 2013 to 2018 but not among those with more years of education. Higher proportions of adults aged 65+ years report low trust than those in younger age groups.

- Higher proportions of women report low trust than men, across all education groups and years (Fig. 2.14). This time frame coincides with the period of widening inequities in chronic conditions among women.

- Analysis by macro-region shows that highest proportions of low trust are found in South Italy and Insular Italy.
• Social disadvantage and inequity affect a wide range of social conditions: more disadvantaged groups experience lower levels of trust, control, safety and social support than more advantaged groups.

• Social isolation, however, does not appear in the decomposition analysis as a significant contributor to the health gap, and levels and gaps in social isolation in Italy decreased from 2013 to 2018.

Fig. 2.13. Percentage of adults (aged 18–64 years) reporting low trust in others, by education level

Source: authors’ own compilation based on data from years 2013–2018 of the Italian Multipurpose survey on households: aspects of daily life (18).

Fig. 2.14. Percentage of adults (aged 16+ years) reporting low trust in others, by age group

Source: authors’ own compilation based on data from years 2013–2018 of the Italian Multipurpose survey on households: aspects of daily life (18).
ANALYSIS: TRUST, DEMOCRATIC ACCOUNTABILITY AND RECOVERY FROM COVID-19

The issue of trust, both in other people and in institutions, is particularly challenging in Italy, with higher levels of low trust in Italy than in many other countries of the WHO European Region. Low trust is associated with being worse off, and higher proportions of adults aged 18–64 years with only compulsory education reported that they do not feel that most people are trustworthy (up to 86%) compared to those with more years of education.

This divide is growing, with lack of trust increasing among adults with only compulsory education from between 2013 and 2018, but not among those with more years of education, and still higher proportions still of adults aged 65 years and over report low trust.

Lack of trust can arise if services are not created in a way that is people-centred. For instance, in the health-care sector, if medical doctors and other personnel do not receive training in providing person-centred care, this can result in a less trusting relationship with patients. A similar effect is possible in terms of the way laws are made, resulting in a lack of trust in the legal system.

As Italy begins its recovery from the acute stage of the COVID-19 pandemic, there is a risk that low levels of trust and a high degree of hesitancy to join the vaccination campaign may impede recovery. In particular, younger people facing a future of social distancing and a vastly changed sense of what their own individual futures will look like may experience a broadening of inequities around trust, belonging, voice, a sense of future, and hope.

Decomposing the health gap: employment and working conditions

- The decomposition analysis shows that disparities in employment and working conditions account for 11% of the total contribution from the five conditions to the health gap.

- Decent working conditions and job security, including reducing unemployment, are key elements of productive participation in the labour market. This has a health equity impact through its effects on day-to-day life and on life chances.

- The portion of the health gap attributed to inequities in employment and working conditions can be decomposed into its component subfactors (Fig. 2.15), which relate to quality of working conditions, represented by (excessive) working hours, and employment status.
Disparities in working excessive hours accounted for 93% of the portion of the health gap attributed to employment and working conditions, when comparing the top and bottom income groups. Given that the maximum weekly working time in Italy is established as 40 hours, and overtime cannot exceed an additional eight hours, the threshold for excessive hours was set at over 40 hours a week.

Differences in rates of overwork generate differential risks of stress-related health outcomes (both physical and mental). Although many of the other employment and work indicators follow a socioeconomic gradient, both high-earning employees and those on a low wage may be exposed to overwork and excessive hours, along with their associated health risks.

In Italy the occupations with the longest weekly working hours (averaging 40 hours or above), after managers, are skilled agricultural, forestry and fishery workers, workers in crafts and related trades, and plant and machine operators and assemblers (39). These latter occupations tend to rely heavily on manual work and tasks involving high physical loads.

Evidence from Italy shows that workers with a history of so-called blue-collar jobs experience poorer physical function in later life than workers in white-collar jobs. Unlike vigorous exercise in leisure time, which is associated with good physical function, strenuous physical activity at work increases the risk of poor physical function in later life (40,41). Given the socioeconomic divide between workers in blue- and white-collar occupations, this is likely to have an equity impact on health, as the decomposition analysis shows.

There is also evidence that stressful working conditions are particularly strongly associated with depression among working populations with low socioeconomic status, suggesting that there is
a differential effect of stressful work on poor mental health between socioeconomic groups (42).

- The indicator of excessive hours is a very rough proxy for quality of working conditions, used here in lieu of better data availability, and neglects many relevant aspects of working conditions.

- Since the onset of the pandemic, poor-quality and high-risk working conditions in formal and informal social care settings and for migrants have been brought further to the fore.

- A large proportion of formal and informal social care workers (many of whom are older women) are long-term care workers providing labour-intensive care services (43). Migrants are also over-represented in formal long-term care work, as well as in domestic work; this constitutes a large segment of this sector in Italy and is often undeclared work.

- The remaining 7% of the portion of the health gap attributed to employment and working conditions is accounted for by differences in employment status.

- Unemployment is directly associated with increased self-reported poor health and poor mental health (44). Long-term involuntary worklessness of three years or more is a predictor of more frequent heavy drinking and increased risk of cardiovascular disease (45).

- Since the 2008 financial crisis, young people and women in Italy have experienced particularly high barriers to securing employment and inequitable opportunities to participate in the labour market (46).

**Trends: employment and working conditions**

Highlighting key trends in employment and working conditions can provide further insight into potential areas of effective policy action, given their demonstrated association with health inequity, as demonstrated through the decomposition analysis.

High unemployment among young people and men with fewer years of education highlights the importance of prioritizing these population groups in active labour market policies

- Analysis of unemployment figures by education shows that twice as many men with only compulsory education are unemployed compared to men with university education.
- Higher proportions of young people (aged 18–24 years) are unemployed than adults aged 25–64 years, but this gap narrowed between 2014 and 2019. Youth unemployment decreased from 13% to 10% for women and 17% to 11% for men over this period.

- While youth unemployment has decreased, trends in temporary employment (Fig. 2.16) show that the jobs taken up by young people have not necessarily been secure or of good quality. Precarious work can have negative health, social and economic consequences, and has a disproportionate impact on the risk of economic, psychological, and physical stress and anxiety among vulnerable people (47).

Fig. 2.16. Percentage of employees with a temporary contract, by age group

<table>
<thead>
<tr>
<th>Year</th>
<th>18–24 years</th>
<th>25–64 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td>2018</td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td>2017</td>
<td>Female</td>
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<td>2016</td>
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<td>2015</td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td>2014</td>
<td>Female</td>
<td>Male</td>
</tr>
</tbody>
</table>

Source: original analysis for the Italian HESR based on data from ISTAT’s Italian Labour Force Survey.

High economic inactivity among young people not in employment, education, or training (NEET) and among women shows untapped potential for productive participation in the economy and society

- High economic inactivity is a cross-cutting issue in Italy, though levels of inactivity have fallen during the decade up to 2019. However, gender inequities and inequities across the life-course persist in labour market participation.

- Economically inactive individuals – who are out of work and not actively seeking work in the labour market – face similar or greater health risks than unemployed people. If their exit from the labour market was due to poor long-term employment prospects and discouragement, then they may also be more vulnerable to poor mental health and have reduced access to social protection systems, including health services and pensions.
In 2019 almost every second working-aged woman was unemployed or looking for a job, while this figure was 25% for men. Among older women in the South Italy region, this figure was almost 60% (Fig. 2.17).

There is a clear and persistent educational gradient in economic inactivity. In 2019 63.9% of women with only compulsory education were inactive compared to 18.9% of women with a university degree. For men, this figure was 35.2% among men with only compulsory education compared to 12.4% among men with university education.

While this inequity between educational groups has been decreasing among older people, it has been increasing among younger people; 19.9% of young men and 27.9% of young women (aged 15–34 years) are NEET, and rates of NEET are higher among young women and men with fewest years of education.

Policies supporting greater job security would benefit young people who are at higher risk of temporary and precarious employment

- Proportions of young people in temporary employment increased from 2014 to 2019, from 62% to 67% for young women and 54% to 57% for young men. Rates of temporary employment are four times higher among young people aged 18–24 years than among adults aged 25–64.

- This finding that decreased youth unemployment tends to be accompanied by increased job insecurity and precariousness is consistent with a more general finding in the European Union (EU),
showing that indicators such as low work intensity are converging across socioeconomic groups towards lower levels, while in-work poverty is converging towards higher levels (48).

**ANALYSIS: THE RISKS OF PRECARIOUS EMPLOYMENT**

The data suggest that precarious employment poses a particular risk for young people, women and migrants (49). A significant majority of young people in Italy are employed in temporary roles, with young women being particularly badly affected.

In-work poverty is high among people in precarious work situations – such as part-time or temporary work, seasonal work, and self-employed people – and this type of work is often undertaken by women, younger workers, and migrant workers. Women, young people and migrant workers are also overrepresented in many of the sectors that are likely to shrink in the medium term because of the impact of the COVID-19 pandemic, particularly the hospitality sector, leisure and tourism, retail, and caring roles.

When the data are analysed by level of educational attainment, men with only compulsory education are currently the group with the highest rates of temporary employment. With twice as many men with only compulsory education being unemployed as men with university education, there is a risk that a section of the population may find themselves in the position of being NEET.

This risk is also likely to be exacerbated by COVID-19, which has engendered a shift towards lower wages and less secure employment as the dual pressures of lockdowns and economic damage affect the job market. An urgent analysis is needed of polices to tackle the prospective reduction of working hours and unemployment leading to income insecurity and increased risk of poverty.

**CASE STUDY: SOCIOECONOMIC INEQUITIES EXPERIENCED BY ROMA PEOPLE IN ITALY**

Roma people living in Italy face entrenched inequities across multiple dimensions. Research carried out in 2011 (50) (the most recent data available) found that Roma people experienced poorer health, lower employment and higher rates of poverty than non-Roma people. In addition, more than 60% of participating Roma people aged 16 years and over said they had experienced discrimination because of their Roma background during the previous 12 months.

Almost 30% of Roma people aged 35–54 years reported having health problems that limited daily activities compared to under 10% for the non-Roma population. Only one in 10 Roma aged 20–64 years reported being in paid employment, compared to more than 60% of the non-Roma population, but around a quarter of Roma people reported being self-employed. Almost 30% said they were unemployed, compared to around 5% of non-Roma people. More than 95% of Roma
people surveyed were living in households at risk of poverty, compared to just over 40% of the non-Roma population.

More than 10% of Roma children aged 7–15 were not in school, compared to fewer than 5% of non-Roma children of the same age. Around half of Roma children attended a preschool or kindergarten, compared to more than nine in ten non-Roma children. Fewer than 20% of Roma adults aged 20–24 years had completed at least general or vocational upper-secondary education, compared to around 90% of non-Roma adults of the same age.

Roma people in Italy experienced significant poverty: the average number of people per room was more than 2.5 in Roma households compared to under one in non-Roma households. Around 30% of Roma people were living in households without at least one of: electricity, or an indoor kitchen, toilet, shower or bathroom – compared to close to zero non-Roma people. In addition, more than half of all Roma people surveyed reported that someone in their household had gone to bed hungry at least once within the past month, compared to fewer than 5% of non-Roma people. The decomposition analysis in Section 2 shows that disparities in living conditions including housing, food and fuel amounted to the second-largest single contribution to the health gap of the five essential conditions investigated.

A European Union Agency for Fundamental Rights report about the implications of the COVID-19 pandemic on Roma and Traveller communities in Italy describes unequal consequences for Roma communities in terms of poor access to health care, employment, schooling, social protection, and critical living conditions, with Roma people often living in overcrowded accommodation or informal encampments with no or scarce access to running water, preventing recommended distancing and hygiene measures (51).
3. What does the analysis mean for long-term recovery and rebuilding from COVID-19?

KEY FINDINGS
Italy entered the COVID-19 pandemic with multiple existing inequities, for instance in relation to the extent of NCDs, overweight/obesity, depressive illness and risky health behaviours.

Inequities in health were particularly apparent among women and young people, evaluated by education level, income quintile and region. Early evidence shows that COVID-19 and its containment measures may have exacerbated some of these existing inequities, creating multiple new vulnerabilities.

In particular, a social gradient has been observed in exposure to COVID-19, in the consequences of disease, and in the interruption of health-care pathways not related to COVID-19. This effect can also be seen in the impact of confinement on physical and mental health, and in exposure to increased poverty, unemployment and reduced income.

Severe illness from COVID-19 may be worse among disadvantaged groups because of the unequal distribution of underlying risk factors, such as having certain NCDs or working in riskier occupations.

There are early indicators that carefully targeted interventions have the potential to lessen the impact of the pandemic on some vulnerable groups.

By focusing on specific social and economic barriers, and pathways of impact, actionable policy options and measurable interventions can be identified and prioritized to have a positive impact in terms of longer-term development, including reducing inequities in health and risk factors for sustainable and inclusive recovery.
This section identifies three broad areas of intervention with the potential to drive progress in reducing inequities during the COVID-19 recovery phase:
1. reducing health inequity by ensuring the sustainability and resilience of the health-care system;
2. reducing poverty to improve health equity; and
3. harnessing health equity as a driver and outcome of economic rejuvenation.

Identifying opportunities for an equity-focused recovery

The previous sections of this report identified differences in health that already existed in Italy prior to the COVID-19 pandemic, analysed disparities in the essential social and economic conditions that are likely to have shaped them, and highlighted promising directions for solutions and interventions.

As governments plan for recovery from COVID-19, there is an opportunity to bridge the gaps that already existed before the onset of the pandemic between the best-off and worst-off among the population, at the same time as tackling further social, economic and health inequities that have arisen as a result of COVID-19. In addition to tackling the immediate negative impacts, equity-oriented actions in the medium term can be designed to address the common causes of vulnerability and prevent the compounding of inequities from subsequent phases of social and economic impact in the longer term, which have been observed from previous economic crises (Fig. 3.1).

Fig. 3.1. Phases of socioeconomic impact from COVID-19

![Fig. 3.1 Phases of socioeconomic impact from COVID-19](image)

Source: adapted from WHO Regional Office for Europe, 2020 (1).
Viewing findings from the previous analysis alongside emerging evidence about Italy’s experience of the COVID-19 pandemic, it is possible to identify priority areas for forward-looking recovery planning to help reconstruct Italy as a more equitable country. This entails going beyond short-term reactive policies and taking a longer-term perspective beyond the expiration of the unprecedented pandemic fiscal support and response packages. Prioritizing work in this way can help to ensure that gaps do not continue to widen as a result of the pandemic, and that they can be closed where possible.

**Summary of key pre-pandemic inequities within the Italian population**

This report shows that as Italy entered the period of the COVID-19 pandemic, distinct social and educational gradients existed within the population across multiple indicators.

Over the 15-year period prior to the onset of the pandemic, self-reported health had improved, and the gap between the proportion of working-age women and men reporting poor or fair health in the most affluent groups compared to the least affluent groups had been decreasing.

However, this narrowing of inequities is not apparent in younger and older age groups. In addition, those with lower levels of income or education are likely to experience higher levels of NCDs, more overweight and depressive illness, poorer diet, and higher smoking rates.

Although they have longer life expectancy than men, women experience poorer health status across multiple indicators. There is scant evidence that the size of the gap between women in the top and bottom income and education groups is narrowing in many domains, with inequities increasing in others.

Income inequality increased between 2008 and 2019, and has remained at higher levels than before the 2008 financial crisis. Gaps in food and fuel insecurity have widened and persisted for both men and women. There also appears to be an issue with lack of trust, particularly among older age groups and those who are financially worse-off.

Precarious employment poses a particular challenge for young people, women and migrants, with high levels of in-work poverty among those working in precarious employment situations.
Equity impact of COVID-19 in Italy: early evidence

Early evidence shows that COVID-19 and its containment measures may have exacerbated some of the existing inequities in Italy, creating multiple new vulnerabilities. In identifying and planning policy interventions, it is helpful to structure the evidence around two key mechanisms of impacts, which work to reinforce existing inequities or create new ones through a third reinforcing mechanism (Fig. 3.2).

**Fig. 3.2. Three mechanisms for COVID-19 socioeconomic impacts and their inequities**

Note. Green arrows, Mechanism 1; red arrows, Mechanism 2; blue arrows, Mechanism 3. 
Source: WHO Regional Office for Europe, 2020 (I).
Mechanism 1 works through the health and health inequity impacts of the pandemic itself. Health inequities follow from (i) exposure to and severe outcomes of infection, including Long COVID (52) and death, and from (ii) non-COVID health effects, including mental distress and other forms of health deterioration resulting from unmet health needs due to disruption and strain on the health system’s resources. These health effects may go on to generate or exacerbate pre-existing socioeconomic inequities and non-COVID health conditions.

People in less-advantaged social and economic situations are at a disproportionate risk of being exposed to infection, because of the conditions in which they live or the type of work they do: for example, they may be frontline workers, live in confined shared spaces, or have jobs that do not allow them to work from home. People exposed to these vulnerabilities are also more likely to suffer more serious health impacts if they become infected with coronavirus, because of their greater susceptibility to pre-existing health conditions or worse access to the health system (53).

Mechanism 2 works through the unequal socioeconomic impacts that COVID-19 containment measures may have on generating health inequities. Italy, like many countries, has taken a number of measures to contain COVID-19, including physical distancing, requiring people to stay inside and imposing lockdowns, closing workplaces and educational establishments (such as early years facilities, schools, colleges and universities), and interrupting or disrupting service provision. Containment measures can result in socioeconomic inequities through the way they are managed and implemented; for example, they can generate loss of employment and work opportunities, which subsequently affects health determinants and risks. Containment measures themselves – such as physical distancing, staying inside or being confined – may negatively affect physical, mental and emotional health and well-being.

Many of the people at higher risk of direct health effects through Mechanism 1 are also at a disproportionately high risk of suffering the social and economic impacts of containment measures (Mechanism 2). These social and economic impacts may in turn precipitate further adverse health impacts.

Mechanism 3 works through a reinforcing cycle between Mechanisms 1 and 2. Socioeconomic inequities can increase the risk of further health inequities that are not related to COVID-19. Conversely, the non-COVID health effects that are indirectly generated by containment measures or as a consequence of health problems caused by contracting COVID-19 may lead to further socioeconomic inequities. Without decisive policy intervention, this cyclical mechanism can reinforce and entrench long-term health and socioeconomic inequities.
**Mechanism 1. Unequal health impact of COVID-19 (contracting the virus and also non-COVID health effects)**

Emerging evidence about the impact of the pandemic on equity in Italy indicates that COVID-19 has mirrored and, in a few cases, exacerbated some existing gaps between the most and least advantaged, while also generating new ones. In particular, a social gradient has been observed in exposure to COVID-19 infection and in the consequences of the disease (Mechanism 1), as well as in the interruption or disruption of health-care pathways related to the treatment of non-COVID outcomes. This effect can also be seen in the impact of confinement and restriction measures on physical and mental health, and in exposure to increased poverty, unemployment and reduced income (Mechanism 2).

In terms of direct impact on health, socially disadvantaged geographical areas tend to be more at risk of COVID-19 infection. For example, in Lombardy, the first and most significantly affected region, an initial study in the Milan and Lodi provinces observed significantly higher risk of infection in neighbourhoods with a bigger area-level prevalence of educational disadvantage, unemployment and housing crowding (54). Analysis of disparities in mortality ratios between the poorest and the richest municipalities in Lombardy suggests a widening of the gap during the pandemic (55).

Similarly, analysis for Emilia Romagna shows a greater difference in age-standardized mortality rates between the least and most disadvantaged census blocks for COVID-19 mortality than for overall mortality, suggesting a steeper social gradient for health impacts due to the pandemic, with a stronger impact in the most deprived areas (56).

Results from the seroprevalence survey conducted by the ISTAT in summer of 2020 show that those with fewer years of education also seem to have faced higher rates of COVID-19 infection. A total of 3% of adults aged 35–64 years with only compulsory schooling tested positive, compared to 2.6% of those who have graduated from secondary school or have college degrees. Infection rates did not show any significant gender or age-related inequities (57). The educational inequities in infection may partially reflect differential occupational exposure to infection, with many frontline workers in food, retail, public transport and related industries (the health workforce notwithstanding) tending to have fewer years of education.

Men aged 70–89 years experienced the highest excess mortality rates overall, with the total number of deaths in this cohort increasing by more than 52 percentage points between 1 January and 30 April 2020 compared to the five-year average for the period 2015–2019. There was a clear educational gradient in the data, with those with the lowest education levels experiencing higher excess mortality rates (30% for
men and 20% for women) than those with most education (58). Data from the Piedmont region confirm that social disparities in mortality among the whole population increased during the first two COVID-19 pandemic waves, in particular among older men (59).

COVID-19 outcomes may be worse among disadvantaged groups because of the unequal distribution of underlying risk factors. Certain NCDs, such as cardiovascular disease, chronic kidney conditions and diabetes, as well as obesity and other behavioural risk factors (60,61) are associated with more severe illness from COVID-19 infection (62). Social and economic disadvantage is associated with higher prevalence of such chronic conditions and NCDs, resulting in inequities in COVID-19 outcomes. Preliminary findings in the Piedmont region attributed up to 30% of overall inequities in COVID-19 outcomes (risk of infection, hospitalization, admission to intensive care units and risk of death) to disparities in the prevalence of co-morbidities among older adults (aged 65+ years), and up to 50% among the working-age population (aged 18–64 years) (63).

The pandemic has also indirectly affected the availability of treatment for non-COVID conditions. Decreases in hospitalizations for acute myocardial infarction, scheduled surgery for tumours and orthopaedic problems, and in emergency room visits for less urgent reasons during the pandemic were observed in one study, although emergency room visits classed as more urgent increased, possibly related to suspected COVID cases (64).

**Mechanism 2. Unequal socioeconomic impacts of COVID-19 containment measures on health**

The economic impact of COVID-19 in Italy has been severe. The ISTAT research conducted during the first wave of the pandemic identified a significant increase in unemployment, absolute poverty and severe deprivation, impoverishment of social groups not affected previously by economic problems, and a substantial increase in inequities resulting from the widening of the income gap (65,66).

There has been a decrease in the number of jobs and in absolute numbers of people active in the workforce. A total of 945,000 jobs have been lost and 717,000 individuals have left the labour force. This reduction in labour market participation has affected all social groups, as well as both sexes. Economic inactivity increased from 25.0% to

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3 This is according to both the 2021 report Guarire dalla pandemia tornando ad una salute più uguale [Recovering from the pandemic – towards a fairer health] by the Italian Interministerial Working Group on Health Inequalities (unpublished at the time of writing) and a report in the same year by ISTAT (67).
26.5% among men and from 43.5% to 45.3% among women, and the gap between those with fewest and most years of education widened for both sexes.

The COVID-19 pandemic appears to have initially exacerbated income inequality, although swift and extensive income-based government interventions appear to have partially mitigated this trend. Early analysis of the economic impacts of the pandemic in Italy found that there was an initial rise in income inequality between January and May 2020, though this had fallen by September 2020 due to government compensation schemes (68). However, looking beyond income inequality to the most economically vulnerable, the number of cash-poor households increased to 44% between April and December 2020; that is, those who did not have sufficient cash or resources to maintain their essential consumption above the poverty line for at least three months, in the absence of other income. In particular, once emergency welfare measures are removed, the proportion of vulnerable households with debts may increase further (to 2% of the total; around 500 000 people) (69).

As well as their economic impact, restrictions implemented to slow the spread of COVID-19 may also have generated negative health impacts through their effect on living conditions and lifestyle factors, particularly through restricted physical activity due to confinement measures and lockdowns, and stress and anxiety-related health behaviours, such as poor diet and alcohol and tobacco consumption. Some early research into the dietary habits of a group of outpatients with obesity in Northern Italy during lockdown found participants had gained around 1.5 kg in weight on average after a month of lockdown (70). Another study of 7847 people living mainly in Northern Italy found that just under one in three smokers (29.5%) reported smoking more.

The Italian public seems to have benefited from high levels of resilience and cohesion during the early part of the pandemic, with an ISTAT survey in April 2020 finding a widespread awareness of its seriousness, strong cohesion, and a majority of respondents expressing strong confidence in major institutions (58). Subsequent research, however, has found a worsening of confidence, with almost 30% judging negatively the decisions and measures implemented against the pandemic by the region in which they live (71).

Bringing together the emerging evidence on the health-related socioeconomic impacts of COVID-19 and the findings of the previous two sections, the sections that follow outline forward-looking policy proposals aligning with priority issues identified in the earlier findings of this report and in alignment with the newly announced goals of the Italian Government. These aim to provide actionable measures to accelerate progress in Italy towards equity-oriented health and socioeconomic recovery centred on these priorities.
An equity-focused approach to health and socioeconomic recovery

The available evidence suggests that the COVID-19 pandemic may have mirrored or exacerbated inequities that already existed in Italy, particularly in terms of lifestyle and economic impacts, and potentially also in relation to access to health care, although it is too early to understand the full scope of this impact at present.

There are some early indications that properly targeted interventions may have the potential to lessen the impact of the pandemic on the most vulnerable population groups, as shown by the reversal in increasing inequity in household disposable income that occurred in mid-2020 as a result of government fiscal intervention (68).

By focusing on specific social and economic barriers and pathways of impact, it is possible to identify and prioritize actionable policy options and measurable interventions that can have a positive impact on healthy lifestyles and reducing inequities in health and health risk factors. Closely aligned with Prime Minister Draghi’s address to the Italian Parliament in February 2021 setting out the Government’s priorities (10), the analysis and discussion of potential interventions in this section focuses on three areas: ensuring the sustainability and resilience of the health-care system, reducing poverty, and rejuvenating the economy. The relationship between these three areas and health equity objectives is explored further in the remainder of this section.

Reducing health inequity by ensuring the sustainability and resilience of the health-care system

**KEY RECOMMENDATIONS**

- Equitable access to formal and informal care should be ensured (including mental health services and digital health care considerations), treating issues of access in conjunction with the multiple dimensions of the essential conditions needed for good health, such as trust in health institutions and flexibility of working hours to allow access to health services that are only open during office hours.
- People should be provided help with protecting against health-harming behaviours and risk factors, including community-based interventions for health promotion that strengthen local health services and those that aim to help women navigate the intersecting gender and socioeconomic factors that impact on harmful risk factors and behaviours.
- The role of schools in promoting health and well-being should be harnessed to mitigate inequities in nutrition, overweight and obesity,
physical activity, and risky health behaviours among children, as well as to support the well-being and life chances of young people through skills acquisition.

• Trust in health and other public institutions (along with trust between people) should be built through clear and transparent communication, facilitating health improvement initiatives through continuing public support and engagement.

In considering the role of the health system in reducing inequity, the analysis in this report demonstrates the importance of considering equity of access to health care, but also the role that different health-care functions can play in protecting people against behaviours and lifestyle factors that harm health. Health and well-being functions performed by public services outside the health field – such as local and community support networks – are crucial to achieving sustainable progress here, as is effective and coordinated public health messaging at national and regional levels.

i) Ensuring equitable access to care

The decomposition analysis in Section 2 showed that disparities in quality of and access to health services accounted for 9% of the total contribution from the five essential conditions to the health gap.

The COVID-19 pandemic has caused disruption and interruption of in-person health-care services, and evidence shows that during the pandemic activity has decreased across multiple areas of care. Furthermore, it is important to understand the extent to which COVID-19 has exacerbated inequities in access to health care; for example, people with reduced ability to co-pay due to income loss are being left behind in terms of access to services. Evidence from the EU shows that between March and July 2020 over one fifth of people who needed a medical examination or other medical treatment did not receive it and, when asked why, nine out 10 gave a reason related to COVID-19. Being unable to pay for health care frequently results in unmet need. Care-related or health insurance arrears are particularly common among unemployed people, and the proportion of the population with such arrears rose dramatically between March and July 2020 (72).

In addressing equitable access to health care, it is important to treat problems of access in conjunction with the multiple dimensions of the essential conditions analysed in Section 2. This involves addressing household, organizational and societal factors that affect the process of meeting health-care needs (73). For example, building trust in the safety and quality of available basic health services can reduce discrepancies in access that result from fear of poor-quality care or health care-associated infections during the pandemic and beyond, especially among
people without the financial means to pay for private health services. Another example is ensuring working conditions and standards allow enough flexibility in working hours or shifts so that workers can easily access primary care services, which are typically only available during office hours. This is of additional relevance to working parents and single parents who need to consider additional health-care needs of their children.

Inequities relating to digital health care are likely to increase in importance as health systems move to socially distanced tele-consultations and other digital interventions. Digital inequities contributing to poor health outcomes can include lack of access to digital health services, poor engagement with digital health, and barriers to digital health literacy (74). Reducing the digital divide will be an important priority for health systems, in particular focusing on providing older people with the connectivity, devices and skills to access digital health care.

To address the likely increased burden of mental ill health resulting from the pandemic, strengthening relationships with the voluntary sector may help boost health recovery and resilience. For example, a community well-being approach – achieved through scaling up and strengthening delivery of community support interventions, using outreach and peer-support mechanisms – can help build stronger community links and relieve social isolation, loneliness and depression. Inequities in existing access to mental health services should also be further examined to establish to what extent barriers to access are present and whether these are affecting men and women differentially according to their age.

Beyond the formal health sector, providing care support, including respite care, to supplement the role of informal and unpaid carers can help to alleviate pressure faced by these carers and unmet care needs as a result of COVID-19. This may include extending financial and administrative arrangements to provide third sector and community care support to those who have lost informal care or have developed new support needs as a result of the pandemic. Because informal and unpaid carers are overrepresented by women and migrants, these steps also contribute towards addressing the gender and social inclusion gaps that existed prior to the pandemic and which have since been placed under additional strain. One step already taken by the Italian Government is the inclusion of migrant workers providing personal care in entitlements to government support during the COVID-19 crisis, through regularization of previously undeclared employment relations and provision of work permits for irregular foreign workers.
ii) Helping to protect people against health-harming risk factors and behaviours

Prevalence of long-term conditions, such as cardiovascular disease and diabetes is greater among women and men who are worse-off, and has been associated with more serious illness from COVID-19. The earlier findings of the report show that, in particular, women with the fewest years of education are more likely to report having a chronic condition. Older working-age women also report higher levels of depressive symptoms than men. The link between poor mental health and engagement in behaviours that are detrimental to physical health, such as smoking and sedentary behaviour, generates the risk of reinforcing poor health and the development of long-term conditions, including those associated with serious illness from COVID-19.

Community-based interventions for health promotion, especially those catering to women, may be an effective strategy to tackle the intersecting gender and socioeconomic factors that impact on these health-harming risk factors and behaviours. Such interventions also provide an opportunity to strengthen and redesign local health services, helping to build a strong network of basic services at the local community level. Finally, a national survey conducted by the INMP into 5038 reception facilities for migrants highlighted the protective role the Italian reception system played in limiting the probability of developing and spreading COVID-19 infection (75).

iii) Harnessing the role of schools in promoting health and well-being

The analysis set out in Sections 1 and 2 documented inequities in nutrition, overweight and obesity, physical activity, and risky health behaviours. Where these combine with inequities in terms of disruption of schooling, meal provision and outdoor physical activity leading to inequities in health behaviours and lifestyles among children, school-based interventions can act to mitigate these inequities. Such interventions include active engagement with parents and connecting families in marginalized and vulnerable situations to community support services and wider society.

Schools can also play a role in enabling children and youth, in particular girls, to acquire dietary education and maintain social and physical activity. Allowing children access to their own peer groups protects and relieves pressure on children and youth, particularly in deprived, stressful, abusive, or violent home situations, as well as allowing parents (often predominantly women) to resume work and social activity.

Educational establishments can also play a much broader and longer-term role in supporting the well-being and life chances of younger
people. In line with government priorities, expansion of technical education to boost skills in the digital and environmental arenas will help to increase the range of roles open to young people in Italy. While addressing the supply of skills can provide one part of a solution to tackling the high levels of health-harming insecure employment among young people, the other part requires addressing the supply of available decent jobs. This part entails action to support job creation by the Government, major employers and institutions, and is discussed in more detail in the following subsections.

**iv) Building trust through clear and transparent communication**

Trust between people is a key contributor to sustaining societal well-being. The decomposition analysis in Section 2 found that disparities in levels of trust were a significant contributing factor to the health gap that existed prior to the COVID-19 pandemic.

For all health improvement initiatives, continuing public support and engagement is vital. Early in the pandemic, the Italian public demonstrated a high level of trust in the institutions involved in containing COVID-19 in Italy, combined with a strong sense of civic responsibility when following public health guidance. Trust in institutions is also important for ensuring people will access health care when needed. Many people were left with unmet health-care needs not only due to worker and resource shortages resulting from COVID-19, but also due to fear of infection. This partially reflects a lack of trust in the capability of health institutions, and other public services such as public transport, to protect them, enabling them to access these services safely.

Communicating with clarity and transparency will be important in maintaining adherence to social distancing requirements in the longer term, as well as in highlighting the importance of healthy behaviours in a way that does not appear to blame individuals for socioeconomic factors outside their immediate control. For instance, government programmes stimulating physical activity may be at odds with limited access to safe green spaces in disadvantaged inner-city neighbourhoods. Acknowledgement of this – alongside investment in creating health-enabling environments – would build the trust needed for such health improvement initiatives.

Coherent public health advice, community engagement and strategic communications can also help halt the spread of false rumours and disinformation that could otherwise hinder the uptake of public health advice. Ideally this clear communication approach should extend through all sectors of society and age ranges, so that the existing differentials in levels of trust can be addressed.
Reducing poverty to improve health equity

**KEY RECOMMENDATIONS**

- Sustainable income support should be redesigned for the longer term, including prioritizing cost-effective use of resources to act across the whole social gradient, while being implemented at a level and intensity that is proportionate to need, especially in light of increasing fiscal pressures due to the scale of COVID-19 support packages.

- Gender-related inequities and poverty should be tackled by creating new, gender-sensitive employment training and opportunities that reduce dependence on informal work, along with broadening access to child care, closing gender pay gaps, and reducing resource inequities within households.

The earlier analysis shows an educational gradient in unemployment levels in Italy, with twice as many unemployed men with only compulsory education compared to men with university education. While youth unemployment has decreased, trends in temporary employment suggest that young people have taken jobs that are not necessarily secure or of high quality. This has been compounded by the COVID-19 pandemic, with fewer jobs available during the pandemic, and fewer people active in the workforce.

Income inequality has worsened since the 2008 recession and, as previously noted, research into the impact of the pandemic suggests employment and poverty levels have been significantly affected, but policies already in place in Italy may be mitigating some of these effects. Considering how to extend and adapt such policies will be important for Italy in future, as will addressing gender inequities that could hinder the ability of women to avoid some of the worst economic impacts of the pandemic.

**i) Redesigning income support in the longer term**

As Italy moves out of the acute phase of the pandemic, longer-term and more sustainable welfare policies will be needed to support those whose livelihoods have been affected. The decomposition analysis in Section 2 shows that, even before the pandemic, disparities in ability to make ends meet due to insecure income and inadequate social protection already amounted to the largest single contribution to the health gap of the five essential conditions investigated. In addition, rates of in-work poverty had already increased between 2008 and 2018, with higher rates of in-work poverty found in South Italy and Insular Italy.

Policies that draw on the principles of universal basic income – as part of a tiered model operating in close complementarity with universal
services – can help support the building of welfare systems based on the principle of proportionate universalism. These can provide basic income stability that is both crisis-preventative and health-constitutive, acting across the whole gradient but implemented at a level and intensity that is proportionate to need (76). This proportionate approach is particularly important in light of increasing fiscal pressures resulting from the unprecedented scale of income support and compensation packages, necessitating cost-effective use and prioritization of resources.

ii) Tackling gender-related inequities and poverty

The decomposition analysis in Section 2 showed that, even before the pandemic, disparities in employment and working conditions accounted for 11% of the total contribution from the five essential conditions to the health gap.

Women were underrepresented in the formal economic sector in Italy prior to COVID-19 and the pandemic is likely to have exacerbated this trend through its impact on the tourism and care sectors, which traditionally employ a high proportion of women and rely heavily on informal forms of work.

Gender inequities in wages and employment can be tackled through a labour market recovery approach that creates new employment opportunities which reduce dependence on informal work for those in sectors that have disappeared or been retrenched, and by reducing informal work or providing incentives to formalize these jobs. Ensuring that these new jobs are gender sensitive and available to those in vulnerable and isolated situations, including those at risk of violence and abuse, will improve their long-term effectiveness in reducing gender and social inequities.

On the labour supply side, targeted efforts can make it easier for women to rejoin the workforce, for instance by broadening access to child care, closing gender pay gaps, and encouraging young women to train in disciplines in which there is growth. These interventions are likely to be beneficial in reducing the extent of gender-based income disparities.

Even in shared households in which income poverty is not apparent at the household level, if resources are not shared equally, inequities in material deprivation within households are more likely to disadvantage women (77). The work status of partners in a household and their relative contribution to the joint income are important determinants of the within-household gender deprivation gap. Reducing this type of inequity within households is an important component in reducing overall levels of inequity across Italy.
Harnessing health equity as a driver and outcome of economic rejuvenation

KEY RECOMMENDATIONS

- The power of institutions to rejuvenate local economies should be harnessed through support initiatives and community investment by anchor institutions, such as public hospitals, universities and other large non-profit-making employers.
- Community-led economic initiatives should be empowered through local organizations and support groups, to address non-medical health needs stemming from social isolation, debt and job loss, and support people to find routes back into the economy.
- The health system should be used as an engine of sustainable growth by enabling productive employment and human capital formation, as well as stabilizing and increasing household income.

As emphasized by the Italian Government priorities laid out in the Prime Minister’s first Parliamentary address (10), the likely enduring impact of social distancing restrictions on key sectors of the Italian economy (such as tourism and hospitality) will require continued activity to support job creation. This can be supported at all levels, with input from major employers and institutions to community organizations, as well as by harnessing the economic power of the health system itself (Fig. 3.3).

**Fig. 3.3. The advantages of examining economic and social impacts of health systems**

PROMOTING A CULTURE OF HEALTH: Health systems that work with new partners and local institutions are able to demonstrate their impact on local and national economies and their equity benefits.

DRIVING INCLUSIVE GROWTH: Health systems are significant contributors to sustainable and inclusive growth, helping to create benefits for the whole community – particularly those left behind.

IMPROVING IMPACT AT LOCAL LEVELS: Health systems can make deliberate choices in their employment and purchasing in order to support communities and address health equity at the local level.

Source: WHO Regional Office for Europe, 2019 (78).
i) Harnessing the power of institutions

Major employers and large institutions can be encouraged to play a strategic role in rejuvenating local economies. Harnessing the power of anchor institutions such as public hospitals, universities and other large non-profit-making employers can make a significant contribution to community wealth-building through local purchasing and hiring initiatives, and even community investment (79).

In the face of inequitable impacts from COVID-19, the important contributions of support initiatives for vulnerable groups and communities from existing non-profit-making and public institutions show that strengthening and reinforcing these structures and institutions can build society’s preparedness for future crises.

ii) Empowering community-led economic initiatives

Other community-level initiatives – such as social prescribing, using link workers4 at health centres to connect individuals with local organizations and support groups to address non-medical health needs stemming from social isolation, debt and job loss – could also contribute by supporting economically and socially excluded people to find routes back into the economy. There is evidence that counselling interventions and community-based debt advisory services, in particular those built on cooperation between professional and voluntary organizations and financial institutions, can help support people who have fallen into poverty to manage their debt (81).

iii) Using the health system as an engine of sustainable growth

Health can play its own role as an engine for fiscal stability and sustainable labour market recovery by enabling productive employment and human capital formation, as well as stabilizing and increasing household income (78). Moves to strengthen local health services, as signalled by the Italian Government, therefore have the potential to benefit the post-COVID economy in Italy, as well as improving the range of health services available to the country’s population.

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4 Link workers are non-health or social care professionals based in primary care who support people to develop and achieve a personalized set of health and social goals by engaging with community resources (80).
Supporting the development of an integrated approach to equity-improving policy design

This report supports recent advances in Italian national policy on health inequities, which have increased awareness in the country of the feasibility and impact of multisectoral strategies and actions on health and health inequities. While data available from national and European sources enabled the analysis in Section 2 of the associations between health inequities and the essential conditions needed for good health, development of an integrated approach to data monitoring that links health and non-health information and statistical systems would allow further causal assessment of the impacts of policies on health equity to inform policy design and prioritization in the future.

The COVID-19 crisis has highlighted the importance of being able to identify, mitigate and prevent health risks and to prioritize and allocate resources in a way that protects against widening inequities when urgent measures are necessary and funds are limited. Beyond the acute crisis period, health equity is central to achieving sustainable and inclusive recovery and development, not only immediately in response to the impacts of the COVID-19 pandemic but also in building more resilient health and social systems for Italy’s future.

As this report of the Italian HESRi has demonstrated, achieving progress towards health equity in Italy requires adopting a multisectoral approach to encourage collaboration between people working in different sectors. An approach that involves the health sector alone will not succeed in addressing health inequities fully. These findings and proposals provide support for decision-makers to take these steps to remove barriers and rebuild better and more equitable health and well-being, so that every person in Italy can prosper and flourish.


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5 All references were accessed on 5 October 2021.


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The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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