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COVID-19 novel coronavirus disease (SARS-CoV-2)
EQLS European Quality of Life Survey
HESR(i) Health Equity Status Report (initiative)
NCDs noncommunicable diseases
NEET not in employment, education or training
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 inequities1.

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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.

**Fig. 0.4. Decomposition of the living conditions subfactor**

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 WHO Regional Office for Europe

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