Influencing the Health Gap: Multi-country perspectives

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Strategic context and contribution

Wales was the first country to apply the milestone European Health Equity Status Report initiative (HESRi) (1), positioning itself as a global influencer and a live innovation site for health equity. Delivering through a Memorandum of Understanding (MoU) (2) between the WHO Regional Office for Europe and the Welsh Government, the Welsh Health Equity Status Report initiative (WHESRi) (3) was established to facilitate and support evidence-informed sustainable solutions and investment prioritisation, working towards closing the health gap in Wales and beyond.

WHESRi contributes to implementing the Well-being of Future Generations (Wales) Act (4), the Socioeconomic Duty (5) and A Healthier Wales long-term plan for health and social services (6). It builds on Public Health Wales' Making a Difference: Investing in Sustainable Health and Well-being for the People of Wales report (7), reinforcing the case for investment in prevention, well-being and equity towards achieving a healthier, more equal and prosperous Wales for current and future generations.

Additionally, this work supports Wales and other countries to progress the United Nations (UN) 2030 Agenda for Sustainable Development (8), and the WHO European Programme of Work United Action for Better Health (9).

Introduction

Health inequities are interconnected with wider social, economic and environmental factors. Action to tackle inequity in health therefore needs to take place at a structural level, acknowledging the constraints affecting an individual or a community's capability and opportunity to enable change.

Evidence of how social, economic and environmental factors determine health outcomes are well known; however, by using techniques to quantify the relative contribution of these different factors in explaining patterns and trends in health equity and well-being, policy makers and practitioners can make more effective decisions on the mix of policies and services in which they should invest, to close health gaps in their communities and nations.

Understanding the factors most closely associated with disparities in health is key in identifying policy levers to reduce health inequalities and improve health and well-being across populations.

This paper summarises a webinar on the Health Equity Status Report initiative (HESRi) decomposition analyses, with a multi-country discussion on methods and findings from Wales, Italy and Slovenia. The webinar built on previous work conducted in collaboration with the World Health Organization (WHO) European Office for Investment for Health and Development (Venice, Italy).

Scope

The webinar was a solutions-focused session which explored how the application of the innovative decomposition analysis methodology has generated insights into the drivers of health inequalities. In addition to local experiences interpreting and applying the methodology, the panel discussed how it can be used to inform further policy action and potential solutions to reduce health inequalities. The aims of the webinar were to:

- Share multi-country experiences on using the decomposition methodology and how it can be used as a tool to measure health equity;
- Help inform further policy action and potential solutions to reduce the health gap in Wales and beyond; and
- Gain insights into the potential next steps for action using the methodology amongst Health Equity Status Report initiative regions.

Decomposition Analysis and The Five Essential Conditions

The application of the Blinder-Oaxaca decomposition methodology is an innovative tool that can be applied to understand the factors which drive health inequities. The analysis is broken down by the Five Essential Conditions for Health (Box 1), which encompass policies that are considered key to ensuring health equity within a population. By using the Decomposition Analysis methodology, it is possible to estimate the relative contribution of each factor, or essential condition, to drivers of health inequities.

Box 1: The Five Essential Conditions for Healthy Prosperous Lives for All: WHO HESRi framework show-ing the different types of policies across sectors to address the wider determinants of health

1. Health and health services

Policies that aim to ensure availability, accessibility, affordability and quality of preventative and health care services and interventions.

For example, health protection, health promotion and improvement, primary, secondary and scheduled care.

2. Health and income security and social protection

Policies that aim to provide economic security and support to reduce the health and social consequences of poverty and low income throughout a person's life.

For example, financial support for parents, older people or unemployed.

3. Health and living conditions

Policies that aim to ensure opportunities for, and access and exposure to living conditions and environments that have a positive influence on people's health and well-being.

For example, planning, good quality and secure housing, clean air, green spaces.

4. Health and social and human capital

Policies that aim to develop and strengthen social relations and community assets, including education, skills, community resources and meaningful social interactions to promote learning, and protect and promote health and well-being throughout a person's life.

For example, improving training, apprenticeship, building community cohesion and resilience, trust, sense of belonging.

5. Health and employment and working conditions

Policies that aim to improve the health impact of employment, working conditions and workplace equality.

For example, availability of work, a living wage, physical and mental demands, ensuring health and safety at work.

Participants and presentations

Not all regions showcased as part of the webinar used the Decomposition Methodology in the same way, with local requirements driving the application and decision-making processes. A summary interpretation of the webinar is presented in this document and, the video recording can be accessed on the Welsh Health Equity Solutions Platform website.

Chairs:

Jo Peden, Consultant in Public Health, WHO Collaborating Centre on Investment for Health and Well-being, Public Health Wales

Bettina Menne, Coordinator, WHO Healthy Cities, WHO European Office for Investment and Development

Wales

- **James Allen**, Public Health Scientist, Public Health Wales

Italy

- **Elizabeth Tamang**, Regional Representative for Europe, Veneto region, Italy
- **Nadia Vimercati**, Lombardia Region, Italy
- **Luigi Palestini**, Emilia-Romagna Region, Italy
- **Luigi Bertinato**, Scientific Secretariat to the President of the National Institutes of Health of Italy

Slovenia

- **Andrej Srakar**, Scientific Associate, Institute for Economic Research, Ljubljana; Assistant Professor, School of Economics and Business, University of Ljubljana

Country: Wales

Influencing the Health Gap in Wales: Decomposition Analysis discussion paper

James Allen, Public Health Scientist, Public Health Wales

Introduction to the activity

- A Decomposition Analysis was carried out to obtain a snapshot of health inequalities experienced by different population groups in the years leading up to the Coronavirus (COVID-19) pandemic, using data from the National Survey for Wales.
- This analysis used three measures of self-reported health:

1. the prevalence of fair/poor health;
2. the prevalence of low mental well-being; and
3. the prevalence of low life satisfaction

- Comparisons of self-reported health were made between:
  - those who save at least £10/month and those who do not;
  - those who report being in material deprivation and those who do not; and
  - those who report a limiting longstanding illness, disability, or infirmity and those who do not.

Summary of findings

- Significant health gaps were found between different population groups in the years leading up to COVID-19.
- Social and Human Capital and Income Security and Social Protection accounted for most of the health gaps observed in the majority of health outcomes explored.
- Health Services contributed the least to observed differences in most of the health outcomes explored.
- Health gaps for those reporting a limiting long-standing illness, disability or infirmity remain least explained.

Key thoughts from the speaker:

- Application of the DA methodology could be used to targeting investment towards interventions and policies that address the essential conditions that account for most of the health inequalities observed.
- The triangulation of the DA results and public expenditure data has the potential to reveal alignment or mismatch in investment decisions. It could also provide a useful lever for informing and strengthening the case for investing in well-being and health equity.
- Policy implications:
  - Future policy and investment decisions should take into account and prioritise the mitigation of the drivers of health inequalities in Wales.
  - Interventions to reduce health inequalities should not be planned in isolation.
  - COVID-19 and the cost-of-living crisis need to be researched further .
  - Further exploration, research, data gathering and analysis are needed, engaging with and involving impacted groups and communities, to understand the health equity gap and its drivers.

Country: Italy

Contribution of Italian Surveillance System to the Health Equity Status Report initiative

Luigi Berinato, National report of the Italian Health Equity Status Report

Introduction to the activity

- The Italian Health Equity Status Report initiative (IHESRi) 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 main goal is to support national and regional policy makers to prioritise investments to tackle current health and well-being gaps and to create the conditions needed to enable all people living in Italy to lead healthy and prosperous lives.
- The speaker focused on the Italian Surveillance System's (ISS) input into IHESRi and the ISS methodological approach.

Summary of methodology

- The ISS uses five different surveillance systems that fed into IHESRi:

1. **Italian Surveillance System for Children (0–2 years):** monitors aspects relating to child health and key aspects across the maternity pathway.
2. **Surveillance System on Childhood Obesity (6-10 years):** a surveillance system for overweight, obesity and related risk factors in primary schoolchildren.
3. **Health Behaviour in School-aged Children (11-17 years):** a collection of five surveys that contribute to the continued monitoring of health behaviour in school aged children. These surveys ran in 2002, 2006, 2010, 2014 and 2018.
4. **Italian Obstetric Surveillance System:** collects and disseminates information on severe maternal morbidity and mortality.
5. **"PASSI" and "PASSI d'Argento" Surveillance Systems (18-69 years and over 65 years):** collect information on some conditions specific to people over 65 years to describe quality of life and treatment and care needs in this age group. They also "measure" the elderly's contribution to society through paid work or unpaid and voluntary activities to support their families and community ("the elderly as a resource"), which requires good physical health, independence, psychological well-being and social well-being.

Key thoughts from the speaker:

- In addition to tackling immediate negative impacts on health inequalities, equity-oriented action can mitigate the impact of social and economic shocks in the longer term.
- There is a need to identify priority areas for forward-looking post-COVID recovery planning to help rebuild Italy as a more equitable country.

Country: Italy

Findings from the Emilia-Romagna Region: Main learning, priorities, and implications

Luigi Palestini, Nicola Caranci, Innovazione nei servizi sanitari e sociali Regione Emilia-Romagna – Direzione Generale Cura della Persona, Salute e Welfare

Introduction to the activity

- This talk described the way data were collected during the COVID-19 pandemic to enable surveillance of service use across social gradients to, for example, determine the number of hospitalisations.
- The data collected had a particular focus on health equity and have been used to better inform service provision.

Outcomes of the work

- The speaker described several actions taken to improve service provision with a health equity lens. These included, but were not limited to:

1. Implementing local processes for health equity and re-thinking priorities and strategies through stakeholder engagement; this involved workshops for Local Health Units (LHUs) with general management and other parties.
2. Working with local authorities to define priorities, and feasible and measurable interventions to be carried out, such as equity action plans.
3. (Re)designing equity boards to better integrate them into organisational processes.
4. Strengthening the connection between epidemiology services and equity boards in LHUs.
5. Summarising evidence on the impact of the regional health system reorganisation on hospital access and care during the COVID-19 pandemic in Emilia-Romagna.
6. Sharing epidemiological findings on the indirect impact of the COVID-19 pandemic on inequality in hospital access and care in Emilia-Romagna.
7. Running focus groups with LHU equity representatives on effective strategies to tackle inequalities, such as the continuity and proximity of care, digitalisation of services, networking and third sector involvement.

Key thoughts from the speaker:

- Building strategic connections across global, regional and local levels was beneficial.
- Epidemiological research and support must be aligned with the governance of services with an equity lens to ensure solutions-based action and the effective targeting of resources.
- Ensure transparency of processes and coproduction, with a focus on equity not only for users, but also for health care workers.

Country: Italy

Italian Health Equity Status Report: Findings from the Veneto Region

Dr. Elizabeth Tamang, Dr.ssa Francesca Russo, Dr.ssa Federica Michieletto
Direzione Prevenzione Sicurezza Alimentare Veterinaria - Regione del Veneto

Introduction to the activity

- The speaker highlighted findings of the Italian Health Equity Status Report from the Veneto Region.
- Two pieces of work were carried out:

1. A literature review on the impact of the COVID-19 pandemic; and
2. A household survey that included 16 lifestyle variables (e.g. alcohol consumption, smoking and physical inactivity indicators) and nine socioeconomic indicators (e.g. education, economic conditions, employment conditions, social capital and residential setting).

Summary of findings

- Analysis of household surveys showed that inequalities are frequently experienced, and every indicator was significantly affected by at least one social determinant. For example:
  - Men and women with less education, worse financial situations or who were unemployed were found to have a higher prevalence of smoking.
  - Men and women with less education, worse financial situations and unsatisfactory relationships were found to have poorer eating habits.
  - Men with worse financial situations and working conditions were found to consume more alcohol.
- The literature search found that, as a result of the COVID-19 pandemic:
  - Unemployment mainly affected women.
  - Home working, despite its benefits, has posed important issues of equity due to employment types across social gradients.
  - Loneliness across certain sectors of the population has increased.
  - A general reduction in physical activity and a worsening of nutritional status has caused an increase in obesity rates.
  - Some sectors of the population were found to have increased their physical activity rates, particularly those who were already active. In contrast, rates dropped amongst those who previously reported doing little physical activity.
  - The habitual consumption of alcohol decreased among young people and remained unchanged among adults.

Outcomes of the work

- The Veneto Region chose to follow the Regional Prevention Plan 2020-2025 (RPP) with the following areas of focus:
  - Non-communicable chronic diseases;
  - Addiction and related problems;
  - Domestic and road accidents;
  - Accidents at work and occupational diseases;
  - Environment, climate and health;
  - Priority infectious diseases;
  - Workplaces that promote health;
  - Active municipalities; and
  - Child friendly communities.

- The main goal of this programme is to develop a strategic model of integrated prevention enabling Veneto to take care of the whole population, while also focusing on the most vulnerable groups.
- One of the main instruments to achieve this is the Veneto for Health Memorandum of Understanding created to support the RPP. It established a collaboration between 20 regional directorates and ten other external regional bodies that aims to promote well-being and the right to health through strategies and policies that are coherent with the objectives of the RPP.

Country: Slovenia

Blinder-Oaxaca Regression for Health Inequalities

Andrej Srakar, Institute for Economic Research (IER) and University of Ljubljana, Ljubljana, Slovenia

Introduction to the activity

- The speaker described three studies that used Blinder-Oaxaca regression DA to explore health inequalities:

1. A study that estimated the contributions of individual factors to inequalities in the relationship between long-term care (LTC) and health care for the elderly.
2. A study that assessed the contribution of individual factors to inequalities in receiving LTC for the elderly through a life course perspective.
3. A study that assessed the contribution of individual factors to inequalities in Slovenian health care utilisation due to the COVID-19 pandemic.

Summary of findings

1. **Inequalities in the relationship between LTC and health care for the elderly:** the results confirmed that there are positive outcomes to LTC provision on reducing health care utilisation, with significant direct and indirect effects across most criteria. The Blinder-Oaxaca DA confirmed the key role that income, education and gender plays within this association.
2. **Inequalities in receiving LTC through a life course perspective:**
    - The results of the analysis showed that gender and education are significant predictors in terms of DA for panel data.
    - For the unexplained component of the analysis, which is often found with the Blinder-Oaxaca method, income is a statistically significant predictor of the receipt of and type of informal care, including informal LTC within and outside households. Although different types of informal LTC care were not significantly different in terms of inequality aspects, they were found to be influenced by gender and education in the explained component of the analysis and income in the unexplained.
    - Finally, for formal care, age and income were important predictors for the explained part of the regression. This shows that inequality aspects for formal LTC provision are significantly influenced by most socioeconomic factors and receipt of formal LTC in Slovenia is conditional on those aspects.
3. **Inequalities in Slovenian health care due to COVID-19:** this study presented a conceptual framework to investigate the relative roles of policies and evidence on determining the spread of COVID-19 through their impact on people's behaviour.

Outcomes of the work

- **Inequalities in the relationship between LTC and health care for the elderly:** there are clear applications for policy action to support future reforms which, when using this methodology, could be translated to in-country analysis, driving solutions-based action.
  This model could generate an output which would determine the impact of individual diseases and how this may change due to LTC provision.
- **Inequalities in Slovenian health care due to COVID-19:** this causal framework could be useful to quantitatively analyse not only health outcomes, but also various economic outcomes.

Country: Italy

Healthy, Prosperous Lives for All in Italy: Learning from Lombardy Experience

Nadia Vimercati, Giusi Gelmi, Corrado Celata
Health promotion and prevention unit, Lombardy Region
Struttura Stili di vita per la Prevenzione, Promozione della Salute

Introduction to the activity and summary of regional approach

- This talk focused on the Lombardy Region's contribution to the Italian Health Equity Status Report initiative, with a focus on interventions targeted at children aged 1-13 years as part of the Healthy Schools Network.
- Half of the schools in the region participated in the Healthy Schools Network, 591 schools (out of 1134) of which were Health Promotion Programmes.
- Lombardy participates in a cross-national study, Health Behaviour in School-Aged Children (HBSC), that runs every four years. Data from the 2018 survey were used to explore the health and well-being of students in the context of socioeconomic status, school type, family type and migration status, correlated against factors including poor diet, cannabis use, bullying and cyberbullying, healthy conditions and tobacco use.

Summary of findings

- The type of school the child attended was found to link to multiple health behaviour and lifestyle risk factors.
- The reported social gradient in vaccine hesitancy found that children from more disadvantaged families were at higher risk of COVID-19, highlighting social inequalities and the importance of health literacy.
- Identification of indicators integrated in the data collection system could be used to monitor health inequalities trends.

Future work

- Outcomes of the findings have led to the commitment to future work, including but not limited to:
  - Updating the health profile of the Rete Healthy Schools Network and Schools Promoting Health based on new indicators;
  - Identifying areas with greater inequalities to enable the prioritisation of interventions; and
  - Evaluating the Rete Healthy Cities Model as a tool to reduce inequalities.

Opportunities and Solutions-Based Actions

Studies and activities highlighted in the webinar strengthen the case for investing in well-being and health equity in Wales and beyond.

Several policies and solution-based actions were identified throughout the webinar. For example:

- Future policy and investment decisions should take into account and prioritise the mitigation of the drivers of health inequalities in Wales.
- Interventions to reduce health inequalities should not be planned in isolation, instead linking with relevant stakeholders, such as policy makers, government and health stakeholders, incorporating the view that the building blocks for health are complex and multifaceted.
- The impacts of COVID-19 and the subsequent the cost-of-living crisis are entrenching existing differences in social, financial, health and well-being outcomes. More research is required to fully understand the long-term implications.
- Robust health equity data are of fundamental importance to successfully describe the health equity status of a region.
- Bringing together global, national and regional stakeholders aids in fostering solutions-based action.
- A whole-system, whole-society approach is beneficial in improving health equity outcomes.

Further reading

Influencing the Health Gap in Wales: Decomposition analysis discussion paper - World Health Organization Collaborating Centre On Investment for Health and Well-being (phwwhocc.co.uk)

A detailed explanation and graphical representation of the Blinder-Oaxaca decomposition method with its application in health inequalities | Emerging Themes in Epidemiology | Full Text (biomedcentral.com)

Health Equity Status Report initiative (who.int)

Health Equity Dataset (shinyapps.io)

Social determinants EURO (who.int)

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