Healthy, prosperous lives for all in Italy

Piloting the WHO model in three Italian regions during the COVID-19 pandemic
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Abbreviations

COVID-19  coronavirus disease
HBSC  Health Behaviour in School-aged Children (survey)
INVALSI  National Institute for the Educational Evaluation of Instruction and Training
Introduction

In 2020 the Italian Ministry of Health and the WHO Regional Office for Europe launched the Italian Health Equity Status Report initiative, Healthy Prosperous Lives for All in Italy (1), which led to the publication of this interregional report. The initiative is a collaborative project involving many different partner institutions within Italy with the main goal to support national and regional policy-makers in prioritizing investments to tackle current health and well-being gaps and create the conditions needed to enable all Italians to live healthy and prosperous lives.

The Report provides crucial insights to support decision-makers to understand what is driving health inequities within Italy and to review and prioritize policy options that can be tailored for implementation.

The COVID-19 crisis has highlighted the need to engage the whole of society in staying safe and being protected from the social, economic and health impacts and consequences of the pandemic. The Italian National Prevention Plan already had as an objective and requirement (i) the setting of health equity goals and (ii) including health equity audits in the implementation of all programmes within regional prevention plans (2). Therefore, pilot regions were already focused on identifying those at risk or falling behind prior to the COVID-19 crisis.

This work was undertaken both at national level and also at regional level in three participating Italian regions (Emilia-Romagna, Lombardy and Veneto) with the goal to remove inequities in health and well-being across the population.
Regional overview

Emilia-Romagna: impact of health system reorganization on health

Tackling the COVID-19 emergency required the rapid reorganization of the health system and the strategic reallocation of human and material resources, leading to the interruption of diagnostic and therapeutic services and the postponement of non-urgent hospital admissions. At the same time, access to general practitioner surgeries and other health-care centres was restricted to prevent the spread of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection in environments with a high exposure risk. Local health services already faced operational difficulties as well as historical issues related to non-hospital health care (poor infrastructure, few resources and insufficient skilled staff). During the COVID-19 pandemic, these services were forced to implement or test new solutions in order to respond to health needs that were triggered or exacerbated by the pandemic and by the consequences of physical and social distancing measures. The impact of these changes on health inequities has not yet been quantified, but an evaluation of these solutions might provide valuable insights for reorganization and creating a more resilient health system that is capable of countering inequities in access and promoting health equity.

Impact on the health system

- Before the COVID-19 pandemic, in Emilia-Romagna there were major inequities in the main indicators of hospitalization (although less so than elsewhere in Italy), with a higher rate of service use in groups experiencing the greatest social disadvantage in terms of education, migrant status and living in a deprived area.

- During the pandemic, in March–September 2020 there was a significant reduction in hospitalization rates compared with the same months in the previous 2 years (2018 and 2019). However, a number of indicators, including those related to urgent care, were significantly higher for groups with low education levels. The main cause of lower hospitalization rates was initially hypothesized to be a significant reduction in inappropriate admissions (which are traditionally higher among the most disadvantaged population groups) owing to the
fear of SARS-CoV-2 infection. However, demand also fell for care for urgent conditions (including emergency care) and planned surgical and oncology admissions. This may be explained by a marginal reduction in the number of patients with acute injuries and diseases owing to lockdown and social distancing measures (fewer accidents, fewer injuries, fewer acute respiratory illnesses). However, a major cause was a reduction in the health-care demands of the most disadvantaged groups caused by an inability to navigate emergency regulations, lack of awareness of the possible consequences of postponing treatment because of fear of SARS-CoV-2 infection in a health-care setting, loss of social support networks, and lack of local health services. However, the health system managed to maintain equity in providing inpatient services: once users had entered the health system, they were all treated the same way, regardless of social status.

- Critical consequences of the COVID-19 emergency regulations and health system reorganization included the isolation of elderly inpatients or of women receiving prenatal care, lack of access for children to child-care services, and a reduction in visits to general practitioners, especially for populations living in vulnerable conditions and migrants. At the same time, there was a rise in demand for health care from regional health services, which have had to cope with more applications for mental health support (especially for children living in vulnerable conditions) and more people returning to addiction services.

Policies

Policies implemented to facilitate access to health-care services
In response to increased health demands and difficulties caused by the COVID-19 pandemic, regional health systems attempted to implement a series of universal measures to facilitate access to health services by using innovative solutions or enhancing measures that had previously been piloted in some areas. Although they were not specifically targeted, groups living in vulnerable conditions have benefited the most from these measures because they have suffered the worst health consequences of the COVID-19 pandemic and of lockdown and social distancing measures. The following measures were implemented.

- Local health and social services have first and foremost attempted to guarantee the continuity of care, especially in response to needs triggered by the pandemic. Despite funding cuts and staff reductions, they have tried to maintain access to treatment centres for people with mental health and drug addiction problems, thanks in part to the dedication and overtime work of social and health workers.
• **Alliances with non-profit and voluntary sectors** were fundamental to all sociomedical services and to the home delivery of medicines, through which it was possible to prevent crowding at dispensaries in hospital and local health centres. Volunteers already working in hospitals, advice centres and the private social sector and as cultural mediators took part in this effort.

• **Digitalization and tele-medicine have been extensively used** to provide specialist and basic check-ups, maintain contact with psychiatric service users and elderly people, provide critical support for families with children and teenagers who are struggling with school closures, arrange childbirth classes, and promote violence-prevention videos.

• **Special continuity of care units** (*Unità speciali di continuità assistenziale*) that use the experiences of existing actors working on relevant projects, such as the Joint Consultative Committees (*Comitati consultivi misti*), were established to increase outpatient care and promote **home visits**. The units aim to guarantee care for people with COVID-19 or non-pandemic-related pathologies, especially those who normally face barriers to accessing the health system.

• **Help desks were set up to answer health queries and orient individuals with health issues** by simplifying links to appropriate services and facilitating direct communication with inpatients.

**Lessons learned from managing the COVID-19 pandemic and implications for the future**

The pandemic revealed weaknesses in the national health system and a need for structural reorganization, in particular of local health services, as highlighted in the National Recovery and Resilience Plan (3). The following points emerged from the Emilia-Romagna experience.

• Only some of the implemented measures were innovations – most had been discussed or proposed as part of the regional planning agenda and had been piloted in a few areas and many were undertaken to strengthen existing but poorly implemented policies. **Experiences and best practices derived from these measures need to be placed within a systemic framework and supported by regional and local governance.**

• **Digitalization of care and assistance** has been proven to overcome not only geographical barriers to access for groups living in remote areas but also cultural distances by helping to create trust with groups living in vulnerable conditions, such as migrant communities. Continuing investment is needed to **put in place the infrastructure required** by the health system and, in parallel, to **increase digital skills across the population to avert the risk of a digital divide.**
Regional health services must be reorganized to **promote personalized outpatient care by creating local multidisciplinary teams**. Reorganization must also address people’s specific needs by breaking down the physical and cultural barriers to access.

The pandemic has highlighted the **that social disadvantage has multiple interlinked dimensions**, including gender, socioeconomic status, citizen status and age. To provide comprehensive care to people facing social disadvantages, an inclusive health system that can interpret and respond to the needs of different groups living in vulnerable conditions must **foster intersectionality and multidisciplinarity** as essential resources.

It is essential to enhance and invest in human resources by creating appropriate roles and incorporating multidisciplinary processes within the health system. There is also a need to **enhance existing professional categories that are not being appropriately utilized**, such as community nurses.

### Lombardy: impact of the COVID-19 pandemic and school closures on child and adolescent health

Owing to a lack of evidence about the epidemiology of SARS-CoV-2 infection, **children and adolescents were among the first targets of worldwide responses to curb infection** because of their highly interactive lifestyles and known role in transmitting infectious diseases, including respiratory viruses. In addition to home isolation and a drastic limitation of social gatherings, **school closures** and **distance learning** affected more than 8.3 million students across Italy, including more than 1 million in Lombardy.

Prevention and risk mitigation measures, as well as increased vaccination coverage, allowed schools to reopen in 2021, but the establishment of strict contact-tracing protocols and arrival of more-contagious SARS-CoV-2 variants meant that most students **attended school intermittently**, especially those in secondary schools. However, the emergence of evidence on the real contribution of young people to the pandemic and, especially, the costs of social distancing in terms of learning and mental and physical health, especially when analysed through an equity lens, has increasingly questioned the appropriateness of distance learning and highlighted the importance of policies to mitigate the impact of the pandemic on the well-being of future generations.

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1. In the initial stages of the COVID-19 pandemic.
Health impacts and the role of children and adolescents in the COVID-19 pandemic

- Among children and adolescents, COVID-19 was a relatively mild disease. In Italy in April 2022, more than 3,300,000 infections were in people aged 0–19 years and rates of hospitalization, admission to intensive care and mortality in this age-group were 491.5, 11.0 and 1.6 per 100,000 diagnosed patients, respectively. Among children aged under 5 years, the same indicators were slightly more serious (at 1533.7, 23.5 and 3.4 per 100,000 diagnosed cases, respectively), but the disease resolved without complications in the vast majority of patients.

- Children and adolescents do not appear to be the main vectors of the pandemic, with susceptibility and transmissibility at least no higher in these groups than in the rest of the population and most likely lower among children under 10 years of age.

- Asymptomatic cases were more common in children than in other age groups, and the transmission rate seems lower in children. Nevertheless, these cases cannot be overlooked, especially in settings with high-transmission variants.

- Teachers were not at greater risk than the rest of the population in the first two pandemic waves, but data are not yet available on the most infectious waves.

- Although school closures may contribute to reducing the infection rate at community level, this is not a sufficient measure in itself to prevent or stop a pandemic wave. The trend of cases in the school population seems to reflect rather than anticipate the course of the pandemic in the community. In contrast, in Lombardy, the second and third waves seem to have been anticipated by about a week by an incidence peak in the younger age groups, also following the closure of schools.

- The vaccination campaign in Italy started on 27 December 2020. By 23 March 2022, 82.9% of 12–19-year-olds and 33.2% of 5–11-year-olds had completed the vaccinations course (with 4% of the latter group awaiting the second dose).

- Evidence for social inequities in SARS-CoV-2 infection in adults, strong intrafamily transmission and a social gradient in vaccine hesitancy supports the hypothesis that children from more deprived households are at greater risk of COVID-19.
Costs of distancing measures

Impact on learning

• The implementation of remote learning highlighted:
  
  ○ **the well-known but little-addressed issue that Italian schools lag behind in digitalization** – only 9% of primary schools, 11.2% of lower secondary schools and 23% of upper secondary schools had sufficient bandwidth to ensure adequate internet connections, with even lower percentages in remote, rural and the most deprived areas;

  ○ **difficulties related to having a teacher cohort that is older** (more than 50% of teachers are over 50 years old), **not digitally literate** (in 2019 only 47.1% of teachers had used digital technology in their teaching and more than 25% had done so less than once a year) and **not trained in digital literacy** (only 20% had attended a digital literacy training course);

  ○ **that families with lower education levels, in economic difficulty and/or with social disadvantage** cannot provide their children with the computer equipment, living environment and support necessary for the proper and effective use of distance learning; and

  ○ **low levels of and strong inequities in digitalization among Italian students.**

• In 2020 children and adolescents in Italy missed an average of about **65 school days** (compared with the European average of 27 days) and about 3 million students had difficulty accessing distance learning, thus increasing the risk of early school dropout and of being not in education, employment or training.

• The National Institute for the Educational Evaluation of Instruction and Training (INVALSI) results for 2021 show a **decline in the average exam scores for Italian and mathematics** (4), indicating an increased gap from European peers. This was particularly the case in high schools, where the number of days lost was greatest (equivalent to 5 months of schooling).

• The reductions in exam score were evenly distributed among all socioeconomic groups and did not increase the already significant inequities in learning that were present before the pandemic. However, even before the pandemic, INVALSI (4) and PISA Programme for International Student Assessment (5) data showed differences in the exam score based on parental socioeconomic status. Note that INVALSI indicators may not be suitable for measuring the impact of the pandemic on cognitive, relational and social skills.
Impact on physical and mental well-being

- School closures, stringent physical and social distancing measures, and the psychological impact of the pandemic have dramatically altered the daily lives of children and adolescents. This has jeopardized their physical and mental well-being and hindered their development, socialization, and acquisition of cultural, psychosocial and relational skills.

- **Anxiety, depression and emotional instability** have increased among adolescents and pre-adolescents. Among older boys and girls, the prevalence of these mental conditions (along with sleep and eating disorders) increased as the pandemic lengthened. **Languishing** (that is, a lack of well-being, purpose and joy) also became widespread, with serious implications for physical and mental health in the medium and long terms.

- Among children aged under 6 years, increased irritability and stress symptoms, restlessness and separation anxiety, regression episodes, and attachment disorders were reported, as well as difficulties in processing the meaning of the pandemic and, potentially, of family bereavement.

- Regarding lifestyle, **large increases in physical inactivity, time spent in front of screens**, number of daily meals consumed, use of fast-food home-delivery services, and consumption of fried and sugary foods were only partly offset by an increased consumption of fruit and vegetables, leading to an increase in obesity and overweight in children and adolescents. Tobacco and alcohol consumption among adolescents do not appear to have increased, although many studies hypothesized a decline in these behaviours (which did not occur) due to fewer opportunities for socializing and gathering outside the home and greater parental control at home.

Impact on inequities

- Impacts on physical and mental health were highest in the most disadvantaged families in terms of parental education level, material deprivation and migrant status, and occurred through a variety of mechanisms including:
  - a **reduced ability of parents** to support their children's emotional issues, meet their children's psychological needs and help them to process the situation;
  - **increased difficulty for families to find healthy ways to spend time** (from the lack of available space for physical activity to the absence of limits on screen use), partly due to low parental health literacy; and
• **greater financial hardship** – less job protection exposes more people to the effects of the pandemic on employment and income, leading to **impoverishment** in the quantity and quality of food and increased **familial stress and conflict**, which may lead to violence, mental health problems or increased compensatory behaviours (smoking and alcohol consumption).

• **Disruption of in-person lessons has decreased the ability of schools to reduce inequities.** School is the main context in which children from less fortunate backgrounds can undertake physical activity, eat a healthy meal, and acquire interpersonal and social skills.

• In this sense, **the interruption of the socializing and equalizing in school** was also relevant, since this may be the main place where children from less fortunate backgrounds can undertake physical activity, eat a healthy meal, or acquire relational and social skills. School is also an important entry points for health promotion and prevention programmes that are implemented in educational settings.

**Analysis of Health Behaviour in School-aged Children survey data to identify entry points for action**

An in-depth analysis of data from the latest Health Behaviour in School-aged Children (HBSC) survey in Lombardy showed that:

• even before the pandemic, more than four out of 10 children had at least one vulnerable condition (low purchasing power, single-parent family, parents born abroad), with no difference between genders;

• significant inequities in physical health and exposure to unhealthy lifestyles existed even before the pandemic – **attending a poorly ranked school, having a family with low purchasing power and, especially among girls, living in a single-parent family or having parents of foreign origin** are risk factors for poor diet; exposure to smoking, alcohol and bullying; physical inactivity and obesity; and the perception of having poorer health;

• while awaiting the new HBSC survey data to confirm or refute the hypothesis that the pandemic has exacerbated inequalities, other studies reported that **the pandemic has impacted several other protective factors that are linked with health outcomes**, including having a positive perception of the school environment and good relationships with schoolmates and peers, high levels of trust in neighbours and higher rates of health problems and symptoms such as feeling nervous, irritable or miserable or having difficulty falling asleep, which are also associated with behavioural risk factors;
• many of these pathologies have worsened (especially in the most disadvantaged groups) and may have created new inequities and exacerbated existing ones since, especially among girls, these variables are associated with migrant status, being from a single-parent family and having a socioeconomic status.

Policies

The COVID-19 pandemic has had strong repercussions on schooling. In order to fully understand its impact, the biopsychosocial dimension of health should be considered, in addition to the health aspects. Alongside preventing disease spread, the educational and social roles of schools must be enhanced to restore focus on issues such as inclusion and equity, which have been undermined by the pandemic. By remaining attentive to these dimensions, schools can be central players in promoting the mental health of all students and protecting the health of the entire population.

Policies to ensure that schools are equitable and can respond to the pandemic challenges

• Ensure that schools are open and are "last to close, first to open" through investments that enable the development of actions for the prevention, diagnosis and early tracking of cases and contacts, as well as implementation of a safe-school policy.

• During both the pandemic and the return to normality, strengthen the structured interaction between school communities and local social, educational and health services by enhancing the role in schools of existing networks and those with specific objectives and by improving the professional skills needed to operate the network of those who work in these services (in regional education pacts, this been fundamental to maintaining local programmes and preventive and health promotion actions).

• Promote the digitalization of schools by guaranteeing information technology infrastructure and fast bandwidth connections even in remote and less-accessible areas and by completing planning for the National Digital School Plan, starting with the creation of appropriate virtual learning environments.

• Invest in digital teacher training and promote distance learning and laboratory experiences that have proved capable of innovating, building and strengthening learning methods.
Policies to foster pupils’ participation in distance learning
- Launch incentives for larger and more disadvantaged families to purchase computers and devices and for school premises to be equipped with computers and other devices to be made available on loan.
- Promote forms of welfare and employment support to facilitate the home–work balance, especially in larger families with less access to smart working;
- Ensure learning continuity for students with learning difficulties by providing technical support in addition to cultural and community mediators to ensure stable internet access for families lacking digital skills or for migrant families, as well as families with children with special educational needs or disabilities.
- Increase digital education for children, especially those with learning disabilities and special educational needs.
- In the event of forced interruption of classroom teaching, it may be important to ensure that the children of essential workers have priority access to school, as is already the case for children with disabilities.

Policies to promote well-being and protect the physical and mental health of children
- Provide psycho-pedagogical support to students and teachers (and the entire school community, at both the individual and socio-organizational levels) to cope with problems experienced during the pandemic and tackle the negative impacts on mental health.
- Promote healthy habits such as exercise and healthy eating during the pandemic, and find ways to encourage physical activity even during the long months of lockdown and distance learning.
- Provide space and time for healthy behaviour (including the use of outdoor areas) by rescheduling the school day and adapting activities to the new living conditions.
- Support managers, teachers and students during school closures and other drastic changes that the school system has to face by considering each school not only as a physical place but, above all, as an arena for social relations.
- Extend life skills-based health promotion programmes to address issues related to forced isolation and ensure the maintenance and reinforcement of social relationships.
• To counter pre-existing inequities that are likely to be exacerbated by the pandemic, there is a need to:
  ° support the continuity of health promotion actions in both schools and the most deprived areas within the framework of the School that Promotes Health model (6);
  ° promote actions that foster parental participation and positive family relationships;
  ° adopt a gender approach that takes account of the different mechanisms through which social disadvantage impacts men and women; and
  ° abandon universalist approaches that promote quick-fix health prevention and promotion actions and instead invest in approaches that – based on targeted health profiles – can take into account the many facets of social disadvantage and work simultaneously on several risk factors by focusing on actions to promote healthy choices based on the needs of different population groups; and
  ° understand the determinants of the lower compliance with preventive norms and greater reluctance towards vaccination observed in disadvantaged families, enhance health literacy to promote self-protection, support active citizenship to recognize health as a collective right/duty, and strengthen the capacity to cope with change (by adapting existing health promotion programmes).

• In general, it seems appropriate to promote and strengthen actions to strengthen the role and skills of teachers and, more widely, of adults within the school community in collaboration with community members (educational co-responsibility) to reduce the impact of determinants of the early spread of substance use, physical inactivity and unhealthy eating habits. In the medium–long term, these impacts may result in a high incidence of overweight and obesity and of poor health among students, in particular among female students in vocational or technical schools.
Veneto: social inequities in exposure to lifestyle factors and the impact of the COVID-19 pandemic

The COVID-19 pandemic has led to fear of SARS-CoV-2 infection and of experiencing illness or the illness of loved ones and neighbours. Physical and social distancing measures such as home isolation and the closure of workplaces and main gathering points were rapidly put in place to try to flatten the pandemic curve. Such measures have led to loss of income and/or unemployment; increased stress, reduced social contact, and loneliness; home confinement and family conflicts, especially for families with children who are distance learning; and the perception of indefinite length of the emergency and pandemic fatigue. Thus, everyday life and living conditions have radically altered for most population groups, leading to a potential increase in exposure to behavioural risk factors. However, the severity and direction of such changes are likely to differ depending on interactions with the social determinants of health. Regional and national data are not yet available to determine trends in these potential changes, but the most disadvantaged social groups are likely to suffer most. Therefore, it is necessary to identify the mechanisms linking socioeconomic position with lifestyle factors and hypothesize how these may have changed during the pandemic in order to identify possible entry points for actions to enhance health equity, in accordance with the National Prevention Plan.

Social determinants of lifestyle inequities before the pandemic

- Social inequities have had a significant impact on health in the Veneto region, as also observed at national level and across northern Italy: between the ages of 30 and 74 years, 27.6% of male mortality and 16.6% of female mortality are attributable to education level. An estimated almost 2200 lives per year could be saved in the region if the mortality rate for the whole population were the same as for university graduates.

- None of the other big killers in public health account for such a high proportion of deaths. For example, it is estimated that each year in the Veneto region smoking accounts for 1848 deaths, physical inactivity for 1239 deaths, excess weight for 1090 deaths, excessive alcohol consumption for 689 deaths and inadequate consumption (less than three portions per day) of fruit and vegetables for 143 deaths.

- Inequities in exposure to both lifestyle and behavioural risk factors represent an important share of the contribution of all types of inequity to mortality, amounting to 41.0% among men and 24.3% among women. Therefore, such inequities are important targets of policies that aim to combat health inequities.
In the Veneto region, multivariate analysis of exposure to 14 behavioural risk factors (with indicators related to alcohol intake, smoking, physical inactivity and nutrition) and of exposure to overweight and obesity as a function of 10 different socioeconomic status indicators (including education level, economic status, employment status, social capital and housing conditions) revealed that:

- inequities are pervasive and common, especially among women – all indicators are significantly associated with at least one social determinant;

- for habitual alcohol consumption, associations were the same among all socioeconomic groups for women but were greater among the most advantaged groups for men; however, all other significant associations, including with binge drinking and at-risk alcohol consumption, were greatest for groups living in the most vulnerable conditions;

- some behavioural risk factors were associated with only one or a few social dimensions, for example, excessive consumption of meat among women or inadequate consumption of fruit and vegetables among men (both were associated with education level and the latter was also associated with economic status); however, in most cases, the multivariate analysis revealed interrelationships between multiple combinations of determinants, each of which explains a proportion of the social variability in exposure to a behavioural risk factor – this was particularly seen for physical inactivity and some unhealthy eating habits for both genders, for smoking in men and for excess weight in women;

- strengths of association followed the same pattern, with higher values for both genders for lack of physical activity, skipping the first meal of the day and consuming harmful fats, and for smoking in men and overweight and obesity in women;

- low education level (which is a proxy for poor health literacy in men and a determinant of poor economic resources, low professional qualifications and low social capital in women) was the main determinant of behavioural risk factors, followed by economic status and experiencing poverty in men and by unemployment and lack of satisfying relationships in women; and

- in contrast, living in a deprived environment was not associated with any of the behavioural risk factors considered.
Impact of the COVID-19 pandemic on lifestyle inequities

First and foremost, the pandemic has increased the number of socially disadvantaged people, as indicated by the increase in the absolute poverty rate (from 6.4% in 2019 to 7.7% in 2020) and in financial difficulty (which was only marginally mitigated by the special income support measures implemented by the Italian Government). These factors led to a reduction in material expenditure on healthy eating and to the adoption of unhealthy behaviour as a coping strategy. Among women, a major factor was also leaving the labour market, often with the purpose of balancing child care with increased family responsibilities. Physical and social distancing also increased the difficulties faced by groups living in vulnerable conditions (such as elderly people, migrants, families with children and single-parent households), who were already at a high risk of smoking and unhealthy eating habits before the pandemic.

A literature review of the main studies conducted in European countries found the following during the 2 years of the pandemic.

- At population level, there were reductions in physical activity and in the nutritional content of food, along with a tendency to eat more, particularly of foods that are high in calories, fat and salt. In turn, these factors led to an increased prevalence of overweight and, to a lesser extent, obesity. Increased fruit and vegetable consumption was also observed. Impacts on smoking and alcohol consumption were lower, with a slight downward trend for both.

- However, these average changes masked differing trends according to socioeconomic status: people with low education levels and low health literacy, with poor-quality or few social relationships, or who were unemployed or living in deprived areas had greater exposure to behavioural risk factors, whereas lifestyle factors improved for people at the opposite end of the socioeconomic scale.

- Habitual alcohol consumption decreased among young people but was unchanged among adults (who replaced alcohol consumption outside the home with consumption at home); however, the relapse rate increased for former alcoholics and more people had at-risk levels of alcohol consumption, especially those with a lower socioeconomic status.

- The impact on lifestyle was determined by impacts on mental health. Those most affected by anxiety, depression, restlessness and loneliness (emotional states that are more common in individuals with a low socioeconomic status and living in the most deprived areas) were more likely to engage in unhealthy behaviours and to have fewer hours of sleep and poorer quality sleep, especially women. The impact on mental health also depended on the prevalence of (and, therefore,
the level of alarm associated with) the pandemic and on the duration and severity of social distancing measures.

- Smart working helped to reduce exposure to SARS-CoV-2 and ensured work continuity, but less-skilled workers and those with less employment protection have been unable to work from home; many have lost their jobs or seen their income fall (thus increasing inequities in employment and income) and some have adopted unhealthy compensatory behaviours, such as alcohol and tobacco consumption.

- Essential workers (a higher proportion of whom have low education levels and low–medium levels of professional qualifications) whose average lifestyles worsened during the most acute phases of the pandemic were at the greatest risk of negative impacts on mental health (in particular, the onset of anxiety and depression).

**Suggestions for policies to combat inequities related to behavioural risk factors**

- Addressing these inequities requires action to reduce imbalances in the social determinants of health, including raising education levels, improving social protection for economically weaker populations (such as low-income and short-term workers) and improving working conditions and social capital. The public health sector cannot directly influence such policies: it can only continue to inform the sectors in charge about how their policy choices will impact population health.

- For this purpose, in support of the Regional Prevention Plan (Piano Regionale di Prevenzione) (7), the Veneto Region approved the “Veneto for Health” intersectoral working table (8) that establishes a collaboration between 20 sectors of the Veneto Region and 10 external regional institutional bodies with the aim of promoting the right to health through the adoption in their own policies of strategic lines consistent with the objectives of the Plan itself. The participating departments and bodies contribute with their own strategies for creating environments that are conducive to people’s health. All of the actors participating in this protocol undertake to collaborate in shared planning each within their respective field of expertise (social health, school sports, productive, environmental and agrifood). The development of synergies between public and private actors to support a new culture of prevention and health promotion will become a useful tool for empowering communities and individuals to make healthy lifestyle choices. The alignment of all services and players (health and non-health) guarantees networking and also equity throughout the region to strengthen and extend existing prevention programmes and plan any new interventions.
• The operational instrument of the protocol is the **Regional Intersectoral Working Table “Veneto for Health” (Veneto per la Salute)** (8), in which representatives who are identified by the signatory directorates and bodies participate. All members contribute with their strategies to the creation of health-promoting settings.

• Another instrument is the “Live Well” (“Vivo Bene”) Regional Communication Plan to support the Regional Prevention Plan (9) and Veneto for Health. It is a strategy adopted to promote messages of health and prevention for the population by all participants of the intersectoral working table (8).
Impact on regional programming

Emilia-Romagna

- The results of the analyses were presented and discussed in two focus groups comprising health equity representatives of the regional health authority. These discussions led to policy recommendations for creating more resilient health systems that can promote and protect equity.

- Furthermore, the contents of the report:
  
  - contributed to defining priorities for the programme to tackle inequities within the new 3-year strategic plans of local health authorities, which in turn led to the production of annual planning documents for activities to be implemented in each of the following 3 years;

  - will be used to develop the new Regional Social and Health Plan, which is currently being designed and will be the main document for shaping social health care in the region (10) – it will also guide the use of European Union funds for regional implementation of the National Recovery and Resilience Plan and form the basis of district area plans for health and social welfare; and

  - can promote the Metropolitan Longitudinal Studies Network (11) – other regional metropolitan longitudinal study centres that did not participate in the analyses would like to carry out the same analyses and join the network.
Lombardy

- The results of regional analyses and suggestions for orientation towards equity in public health policies will contribute to defining and fine-tuning the prevention and health promotion actions included in the Schools that Promote Health programme of the Regional Prevention Plan (12) and implementing them in the region. In this context, the results were also presented to and discussed with the 30 heads of the complex organizational units of the Lombardy Workplace Health Promotion Network.

- Following discussions, the HBSC Regional Scientific Insight Group and Okkio alla Salute (13) suggested which outcomes of potential pandemic impact should be the focus of the analysis of HBSC survey data (14). The results of the analysis contributed to extending the regional HBSC survey (to include new items to capture the possible impact of potential mechanisms for exacerbating inequities) and to the oversampling of pupils in order to have greater regional representativity and sufficient statistical power to test hypotheses on the impact of the pandemic on the physical and mental well-being of children.

Veneto

- The results of the analysis will contribute to the revision of interventions of the programmes of the ongoing Regional Prevention Plan 2020–2025 to mitigate the impact of inequities in lifestyle and behavioural risk factors of the population (7). The considerations that emerged will be highlighted at update meetings with local programme representatives to promote the alignment of strategic choices.

- The implications for both health and non-health policies will be discussed and debated by the Regional Intersectoral Working Table “Veneto for Health” (8), which includes representatives of the Veneto Region directorates and other regional institutional sectors, with the objective of promoting the well-being and health of the Veneto population through a people-centred and Health in All Policies approach (15).
**Overall added value of the project**

This project has:

- supported priority-setting in the formulation of regional prevention plans, in line with the aims and objectives of the National Prevention Plan to reduce health inequities (2);

- highlighted and facilitated the impact of regional intersectoral partnerships in engaging local communities in health;

- helped to promote key activities according to regional priorities in each context by tackling the wider social determinants of health; and

- promoted intersectoral action to prioritize the reduction of health inequities within new strategic plans, such as regional social and health plans, and to contextualize the National Recovery and Resilience Plan (3).

Applications of the results of this partnership include:

- facilitating discussion among local health authorities in Emilia Romagna;

- integrating the results into the Regional Social and Health Plan in Emilia-Romagna (10);

- promoting discussion between the HBSC Regional Scientific Insight Group and OKkio alla Salute;

- prioritizing prevention and health promotion activities; and

- contributing to the establishment in Veneto of the Regional Intersectoral Working Table “Veneto for Health”.
References


All references were accessed 21 September 2023.
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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