INEQUALITIES IN HEALTH
FUTURE CHALLENGES FOR INTERSECTORAL COOPERATION
(summary)

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CANCER REGISTRY REGISTER RAKA SLOVENIJA

UMAR

World Health Organization REGIONAL OFFICE FOR Europe

REPUBLIC OF SLOVENIA MINISTRY OF HEALTH

CONTENT

FOREWORD BY MINISTER OF HEALTH

This report on health inequalities comes at a time when we are faced with the challenges of the COVID-19 epidemic and its impact on all aspects of our lives. The epidemic, and the measures and restrictions introduced in response to it, represent a major challenge to all of us. They require us to make numerous adjustments, and are having a significant impact on the quality of life of every individual. The biggest burden in these unpredictable times is borne primarily by those who were already especially vulnerable before the epidemic or who have become so because of it, and who suffer from a chronic disease, mental health problems, poverty, social deprivation, exclusion or unemployment. Children (and young people generally) have been deprived of school and of the opportunity to socialise with their peers, older people have lived in fear of infection and of being isolated from their loved ones, patients have found it difficult to see their doctor in the way they were used to, and many people have encountered uncertainties in their employment and work. All these things can lead to an increase in health inequalities. Despite the superb efforts of medical, social and education workers, and the active involvement of civil society in addressing the epidemic-related and other needs of vulnerable groups, we are seeing a rise in the number of people in serious distress and who are unable to properly access healthcare and other services. It is vital that we continue to monitor the situation, draw comparisons with previous periods and other countries, and identify the new needs that have arisen among vulnerable groups. By responding promptly and with great sensitivity to those in distress, and by providing the necessary help and care, we can prevent further increases in health inequalities. This report on health inequalities provides a good insight into the complex area of inequalities, and is an important tool for planning measures that will enable us to be as successful as possible in eliminating health inequalities in the future.

The report is an exemple of intersectoral cooperation between key research institutions and ministries engaged in work and policies of reducing inequalities, and it is also the result of Slovenia's successful collaboration with the World Health Organization in this area. In 2019, Slovenia hosted the world's first high-level WHO conference on health inequalities. The Ljubljana Statement on Health Equity was adopted in response to the conference's findings, and called on policymakers to take more decisive action. It is an important milestone in efforts to eliminate health inequalities. Slovenia is very actively engaged in the problem of health inequalities, as the reports and other publications issued so far show.

'Health for All', 'Nobody Left Behind' and 'Together for a Healthy Society' – these have, for many years, been more than just slogans in Slovenia. We have already made progress in many areas, from public health efforts to promote health and prevent disease in all population groups; huge efforts were made by everyone working in primary healthcare to better address the needs of vulnerable groups through preventive programmes and comprehensive medical provision to chronic patients in cooperation with the local community and social services. cancer screening programmes and many achievements at the specialist healthcare level that are available to all. The COVID-19 epidemic should not derail efforts to further increase access to high-quality healthcare for all, and particularly for vulnerable groups, in the future.

This year, 2021, is also important for Slovenia in the international context, as it assumes the Presidency of the Council of the EU and it has the opportunity to show Europe its achievements. This report, 'Health Inequalities: Future Challenges for Intersectoral Cooperation', is an example of good practice and one that we can be proud of. It warns us that investments in health and a reduction in health inequalities, particularly among vulnerable groups, require an 'all-government' approach and the participation of all ministries and departments. They are a precondition for greater social justice and well-being for all, which are two key objectives of a strong social Europe, as well part of the United Nations' Sustainable Development Goals.

Janez Poklukar, Minister of Health

FOREWORD BY THE MINISTER OF LABOUR, FAMILY, SOCIAL AFFAIRS AND EQUAL OPPORTUNITIES

Equality is written in all fundamental international documents and is also the foundation for much of the relevant legislation. Social equality must be the guiding principle and objective of every society and every policy. However, we still (too) often encounter inequality in many walks of life. The task of the state is to identify these inequalities, take steps to reduce and eliminate them, and help to raise society's awareness of the issue of inequality.

Cooperation and the interconnection of policies across different areas is crucially important if we are to eliminate inequalities. Family policy, which pays particular attention to caring for and protecting children, is one example of good practice. While it is, an independent area, family policy is nevertheless inextricably linked to other policies, particularly those concerning education, healthcare, social security and spatial planning. If we want progress, it is vital that we connect with research institutions. Only the creative cooperation of everyone will increase child well-being and reduce child poverty and social exclusion.

The authors of this publication recognise the importance of cooperation and have therefore included all relevant stakeholders in order to address the issue of inequalities in a more comprehensive way. They have therefore carried out important work required to eliminate inequalities, for example by establishing cooperation between policymakers and institutions. They will also raise the awareness of the profession and the general public.

Reducing social inequality is one of the greatest challenges facing modern society. The starting point of any attempt to eliminate inequality is the belief that equality is good for everyone. This is proved by societies with a high degree of equality, where people are healthier, happier and have a better quality of life. Equality is therefore a value well worth fighting for.

Janez Cigler Kralj, Minister of Labour, Family, Social Affairs and Equal Opportunities

REFLECTIONS OF PARTICIPATING INSTITUTIONS

Ministry of Education, Science and Sport (MIZŠ)

Most of the departments and ministries have at least some expert institutions in their field that can provide analytical, methodological and developmental support for their policies. The pooling of these capacities, the participation of different experts and the interlinking of data can lead to innovative methods of integrating and implementing central government policies. Health inequalities are a matter not only of health policy, but are affected by many factors; moreover, they do not impact health policy alone, but are a part of the very fabric of society. Perhaps in future, the experiences gained from this cooperation will bear fruit in the preparation of other policies that do not (and should not) remain strictly within a single sector alone.

Aleš Ojsteršek, head of the department for educational quality

Slovenian Environment Agency (ARSO)

Pollution of the environment is one of the factors affecting health inequalities. According to the World Health Organization, the greatest risk to human health in the European Union is attributed to air pollution. Particularly population living in urban areas is exposed to higher concentration of air pollutants. However, it is not enough to try to simply eliminate health inequalities, which are affected by environmental pollution as well as by people's resilience, education and decisive action. Our aim should be to ensure that everyone is able to live in a healthy environment. Measures to improve the environment are fair to all, as they enable everyone to suffer less illness, facilitate personal development and encourage people to look after their own health. Interdisciplinary cooperation between stakeholders is a precondition for the achievement of these objectives. Such cooperation was successfully established during the process of producing this publication and, as such, provides a good basis for further work in this area.

Nataša Sovič, Director of the State of the Environment Office

National Institute of Public Health (NIJZ)

By adapting social subsystems and ensuring access to high-quality, timely healthcare and long-term care services, raising the awareness of and educating the population regarding the importance of lifestyle, and reducing risks to human health, we will also reduce the incidence of health inequalities. We must therefore realise, at the social as well as individual level, that health is not simply a value and an asset, but a right that should be available to everyone regardless of their socioeconomic status.

Milan Krek, director

Institute of Macroeconomic Analysis and Development (UMAR)

Studies confirm the exceptional importance of having an entire population healthy at all stages of life. The health of the individual is important if that individual is to be involved in society and if a higher level of economic development is to be achieved. This is key to securing the prosperity of every generation. Protecting and promoting health must therefore be incorporated into all policies and measures, with particular attention being paid to the socially more vulnerable sections of the population.

Marija Bednaš, director

Institute for Economic Research (IER)

Without appropriate measures, financial barriers to accessing long-term care and healthcare services for individual groups of the population will necessarily lead to an increase in health inequalities and, in tandem with this, to further increases in health expenditure as a result of unmet long-term care needs.

Boris Majcen, director

Social Protection Institute (IRSSV)

Health is a complex phenomenon and one that cannot be examined from a single perspective alone. However, it is usually the perspective of medicine itself that is made to dominate all others. It was therefore very important that specialist institutions from a variety of disciplines be involved in the preparation of this report, and we intend to continue with this approach. Only then will Slovenia be able to acquire a comprehensive insight into all the ways in which health inequalities can be reduced.

Barbara Kobal Tomc, director

Institute of Oncology

We have been aware for years that the burden of cancer to a large extent typically (but not exclusively) falls on the socioeconomically deprived. Every year, many cancer patients in Slovenia and elsewhere in Europe fall ill or die prematurely precisely because of the socioeconomic inequalities in our society. Eliminating these inequalities has therefore been the focus of attention for specialists, decision-makers and the general public for a number of years.

Vesna Zadnik, head of the National Cancer Register

HEALTH INEQUALITIES IN SLOVENIA – FROM REPORTING ON HEALTH INEQUALITIES TO STUDYING THE IMPACT OF POLICIES ON HEALTH INEQUALITIES

The public health challenges faced by specific population sub-groups are only noticed when data on state of health and the different circumstances that affect health are properly broken down, mainly by gender, age, region of residence and, in particular, by education and socioeconomic status. This enables us to establish which population groups have particularly unfavourable health outcomes because of their conditions of life and lifestyle, and are in an unequal position to that of the general population when it comes to their health. We are referring here to health inequalities and to the ways in which the state should work with all stakeholders to reduce unjust inequalities.

There was a boom in public health in Slovenia, with its social medicine aspects, after the First World War. In the period following the Second World War, healthcare, social and education systems were designed to enable wide access to the majority of the population. Slovenia largely retained this policy after 1991. Social and health inequalities are monitored in a variety of ways in Slovenia. The NIJZ monitors the unequal distribution of various health phenomena as a regular part of healthcare statistics. Following encouragement from the international community, and above all because of the increasingly more advanced methodological possibilities and availability of auxiliary data, we have thoroughly overhauled and updated these statistics in recent years.

In common with other countries, Slovenia has in recent decades transformed its national system for reporting health inequalities and well-being. We are also committed to do this by the World Health Organization's Political Declaration on Social Determinants of Health, which was adopted in Rio in 2011. It highlights the importance of Member States measuring the situation in five areas of the social determinants of health that depend on policy measures, which it did for the European region in the WHO Health Equity Status Report[1], which was based on a tool for tracking policies that have an impact on equality.

In comparison with other countries, Slovenia today has a sophisticated three-level system of obligatory reporting that also contains elements or indicators of health inequalities, or is designed for exclusive reporting on health inequalities: (1) since 2007, the Institute for Macroeconomic Analysis and Development (UMAR) has published an annual Development Report, which includes the objective of achieving a healthy and active life for all, as part of the process of monitoring implementation of the Slovenian Development Strategy; (2) since 2014, the Social Protection Institute of the Republic of Slovenia (IRSSV) has, under a decision taken by the National Assembly's Assembly Committee for Social Affairs, been responsible for regular annual reporting on poverty (and wider social status) in Slovenia; and (3) the NIJZ is responsible for compiling periodic reports (every four to five years) on health inequalities in Slovenia, as laid down in the Resolution on the National Healthcare Programme 2016–2025 ('Together for a Healthy Society') (for more on this, see below).

[1] Healthy, prosperous lives for all: the European Health Equity Status Report [Internet]. Copenhagen: WHO Regional Office for Europe; 2019. Licence: CC BY-NC-SA 3.0 IGO. Available from: https://www.euro.who.int/en/health-topics/health-determinants/social-determinants/health-equity-status-report-initiative/health-equity-status-report-2019

The first two NIJZ reports on health inequalities were mainly focused on collecting, analysing and presenting data on the differences in health between different groups of the population. The first report was published in 2011[2] and included an analytical presentation of access to healthcare and conceptual proposals for reducing health inequalities. The second report on health inequalities in Slovenia[3] was published in 2018. It outlined changes in the health inequality indicators during the financial crisis and, in line with the WHO guidelines, the first steps were also taken towards describing the impact of intersectoral measures on the way health inequalities are expressed. For the third report on health inequalities, the NIJZ sought an approach that would shift the emphasis from reporting data on inequalities to programmes and measures that affect the incidence of inequalities. In collaboration with partners from the IER and IRSSV, we selected inequalities in child well-being, long-term care and lifestyle connected to harmful alcohol use for review.

A steering committee was established in the process of preparation of the third publication on health inequalities in Slovenia. It comprised representatives of several sectors and participating organisations. Cooperation with senior sectoral representatives proved to be of considerable added value, as researchers were able to explain the results of their research work in direct dialogue, while sectoral representatives were able to guide the work from the policy perspective. It was also evident that, while the implementation of a 'health in all policies' approach enables public health experts, with the support of the healthcare sector, to present their results and content independently to the representatives of other sectors, those experts do not necessarily have sufficient multidisciplinary competencies and, above all, that they lack knowledge of how the various elements interact and of the history of the development of specific areas in other sectors, that the number of established networks is too small and that the required mutual trust is frequently lacking. In the case of the preparations for this report, good mutual cooperation between several of the leading sectoral institutions was key to the successful preparation of the review and of the policy recommendations.

The shift from reporting on inequalities in Slovenia based on data to reporting on the basis of policies affecting inequalities also required a shift in the area of mutual cooperation and the development of a range of different types of capacity. Work on the preparation of the publication was only part of the short-term objectives of the cooperation between partner institutions. As a medium-term objective, we envisage the establishment of a joint pilot interdisciplinary research platform of sectoral institutions that will support measures to reduce inequalities in health and well-being, while the long-term objective is to place this platform within the organisational structure of the government so as to enable the system-wide formulation of policies to reduce health inequalities. The platform is defined as one of the measures for enabling Slovenia's recovery and swifter exit from the crisis caused by the COVID-19 syndemic.

[2] Buzeti T, Djomba JK, Gabrijelčič Blenkuš M, Ivanuša M, Jeriček Klanšček H, Kelšin N, et al. Health inequalities in Slovenia [Internet]. Ljubljana: National Institute of Public Health; 2011. Available from: https://www.nijz.si/sl/publikacije/health-inequalities-in-slovenia

[3] Lesnik T, Gabrijelčič Blenkuš M, Hočevar-Grom A, Kofol-Bric T, Zaletel M, editors. Neenakosti v zdravju v Sloveniji v času ekonomske krize [Internet]. Ljubljana: Nacionalni inštitut za javno zdravje; 2018. p. 152. Available from: http://nijz.si/sites/www.nijz.si/files/publikacije-datoteke/neenakosti_v_zdravju_2018.pdf

HEALTH INEQUALITIES

Using indicators to show health inequalities in Slovenia

Unless we uncover, monitor and show health inequalities between groups in all societies and geographical areas, we tend to deny their existence. We traditionally observe them according to gender, age and geographical area, while many of the differences in health that are unjust and that need to be reduced are caused by individuals' socioeconomic status and the characteristics of the environments in which they live. The adequate indicator-based evaluation and monitoring of differences in health underpins all strategies for reducing health inequalities at local, national and international level. We have addressed inequalities in Slovenian society with the help of health indicators, lifestyle determinants, socioeconomic health factors and indicators of inequalities in access to healthcare and long-term care.

We begin by highlighting health inequalities in Slovenia using quantitative indicators. We put them into an international (EU) context, where Slovenia is often close to the average for health indicators. In relation to socioeconomic health inequalities, and in common with other countries, Slovenia performs well or very well in some indicators (prevalence of chronic diseases, obesity among men, smoking among women, unmet treatment needs on account of waiting lists) and fairly poorly in others (obesity among women, self-assessed health, visits to specialists and dentists, unmet treatment needs on account of geographical distance).

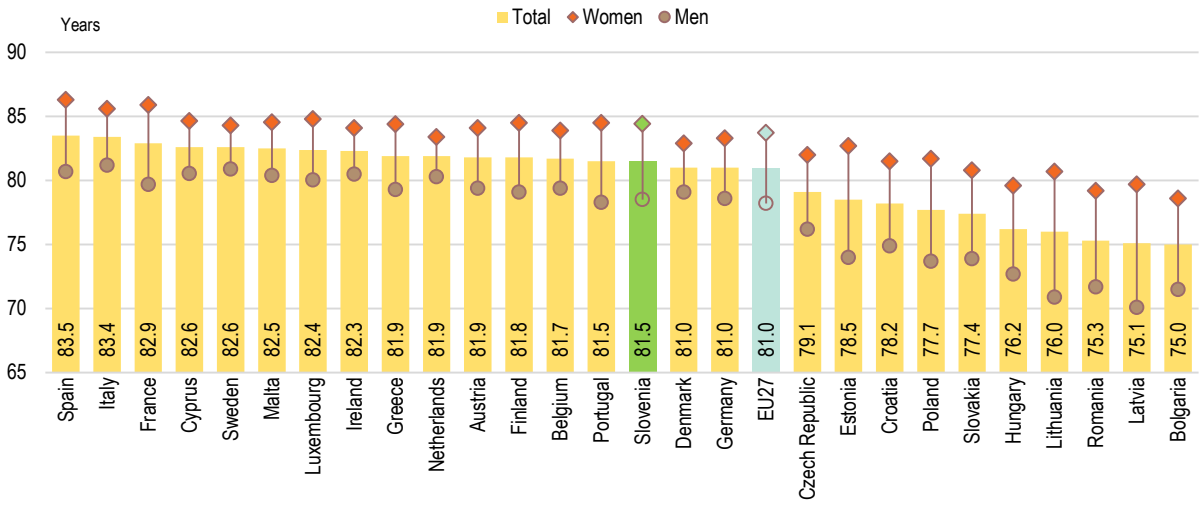


Fig. 1: Life expectancy in EU countries, 2016–2018 average

Source of data: Eurostat Database, OECD calculations.

There are differences within every country, as well as differences between countries. The monitoring of socioeconomic health inequalities over several years enables us to examine, in relation to the selected indicators, whether those inequalities between the lower and higher social classes are rising or falling.

improvement during the period observed
deterioration during the period observed
no statistically significant changes or an indefinable trend resulting from a fluctuation in the value or a reversal of the educational gap in the period observed

It is encouraging to find that the gaps between the socioeconomic groups are narrowing in Slovenia and, at the same time, that people are, on average, assessing their own health as better, living longer, suffering less mortality as a result of accidents and are quicker to seek help for mental health problems.

Indicators in which the trend in the gap between lower and higher levels of educational attainment is improving (difference between socio-economic groups is narrowing)

	Time trend for Slovenia in total	Low level educational attainment group time trend	High level educational attainment group time trend	Time trend in the gap low/high
Self-assessed good or very good health				
Life expectancy at age 30 – men				
Obesity - men				
Neck chronic disorder				
Backk chronic disorder				
Seeking help from mental health professionals – women				
Adult mortality from injuries caused by accidents				

Fig. 2: Indicators in which the trend in the gap between low and high levels of educational attainment is improving – the difference between socioeconomic groups is narrowing

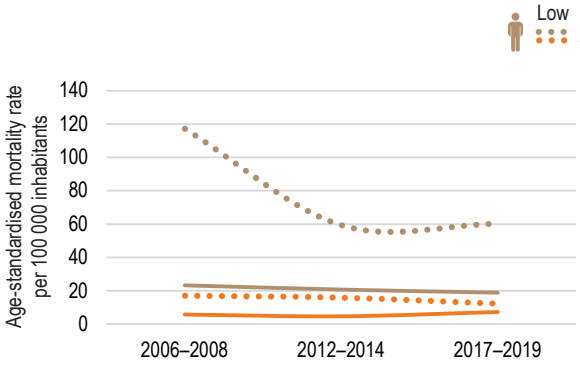


Fig. 3: Age-standardised mortality rate of adults aged between 25 and 74 caused by accidents, by gender and educational attainment, Slovenia, 2006–2019

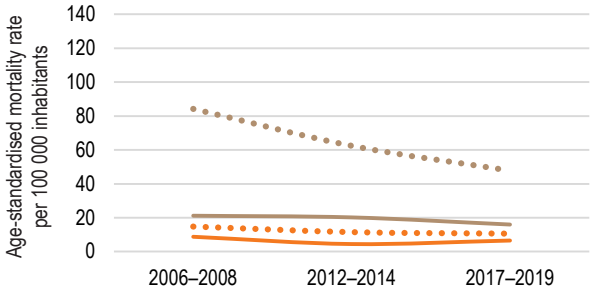


Fig. 4: Age-standardised suicide mortality rate per 100,000 inhabitants, by educational attainment and gender across three time periods

There are unfavourable trends concerning the gaps between socioeconomic groups and in the Slovenian average when it comes to the utilisation of healthcare services during pregnancy, the harmful use and consequences of alcohol, and the prevalence of diabetes, hypertension and depressive disorders.

Indicators in which the trend in the gap between lower and higher levels of educational attainment is worsening (difference between socio-economic groups is widening)

	Time trend for Slovenia in total	Low level educational attainment group time trend	High level educational attainment group time trend	Time trend in the gap low/high
Pregnant women (first pregnancy) not attending a maternity course				
Alcohol – heavy episodic drinking				
Prescribed antihypertensives – men				
Prescribed antihypertensives – women				
Prescribed diabetes medication – men				
Prescribed diabetes medication – women				
Symptoms of depressive disorders – men				
Symptoms of depressive disorders – women				
Seeking help from mental health professionals – men				
Lung cancer mortality – women				
Mortality directly attributable to alcohol – men				

Fig. 5: Indicators in which the trend in the gap between low and high levels of educational attainment is deteriorating – the difference between socioeconomic groups is widening

For the first time, we show new cases of cancer by level of educational attainment; this highlights the socioeconomic gradient in cancers linked to lifestyle factors. However, there are also no noticeable changes here in the gap between those with lower and those with higher levels of educational attainment. There has been improvement at national level in the premature mortality and suicide indicators, although the gap caused by socioeconomic status is not narrowing.

Indicators in which the trend in the gap between lower and higher levels of educational attainment is not statistically significant or fluctuates from period to period

	Time trend for Slovenia in total	Low level educational attainment group time trend	High level educational attainment group time trend	Time trend in the gap low/high
Life expectancy at age 30 – women				
Smoking during pregnancy				
Proportion of women with BMI >= 25 before pregnancy				
First examination after 12th week of pregnancy				
Pregnant woman not undergoing foetal chromosomopathies screening				
Preterm birth				
Low birth weight				
Perinatal mortality of singletons				
Prevalence of tobacco smoking				
Physical activity				
Consumption of fruit and vegetables				
Obesity - women				
Incidence of all cancers (total) – men				
Incidence of all cancers (total) – women				
Incidence of lung cancer – men				
Incidence of lung cancer – women				
Incidence of gastric cancer – men				
Incidence of gastric cancer – women				
Incidence of breast cancer				
Incidence of melanoma skin cancer – men				
Incidence of melanoma skin cancer – women				
Incidence of head and neck cancers – men				
Incidence of head and neck cancers – women				
Premature mortality before the age of 75				
Lung cancer mortality – men				
Mortality directly attributable to alcohol – women				
Mortality of elderly people from falls				
Suicide mortality – men				
Suicide mortality – women				

Fig. 5: Indicators in which the gap between low and high levels of educational attainment is not statistically significantly changed in the observed time period or educational gap fluctuates from period to period

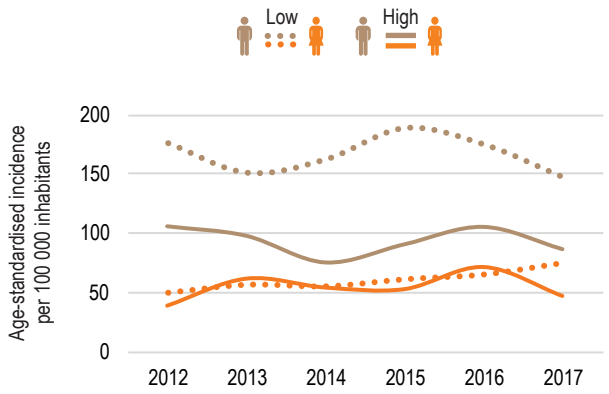


Fig. 7: ASR of lung cancer incidence (C33–C34) in low and highlevels of educational attainment by gender (25+ years), three-year moving average

Inter-institutional cooperation has enabled sectoral viewpoints and expertise to be incorporated into the interpretation and data processes. The indicators of inequalities in access to healthcare and long-term care are addressed more extensively than in the two previous reports, while the indicators of unmet needs for healthcare and expenditure on health show minor inequalities by socioeconomic group. Health inequalities are increasing on account of the lengthening of waiting lists, as only the more affluent can afford direct out-of-pocket expenditure. The lengthening of waiting lists makes access to healthcare more difficult for all socioeconomic groups to roughly the same extent.

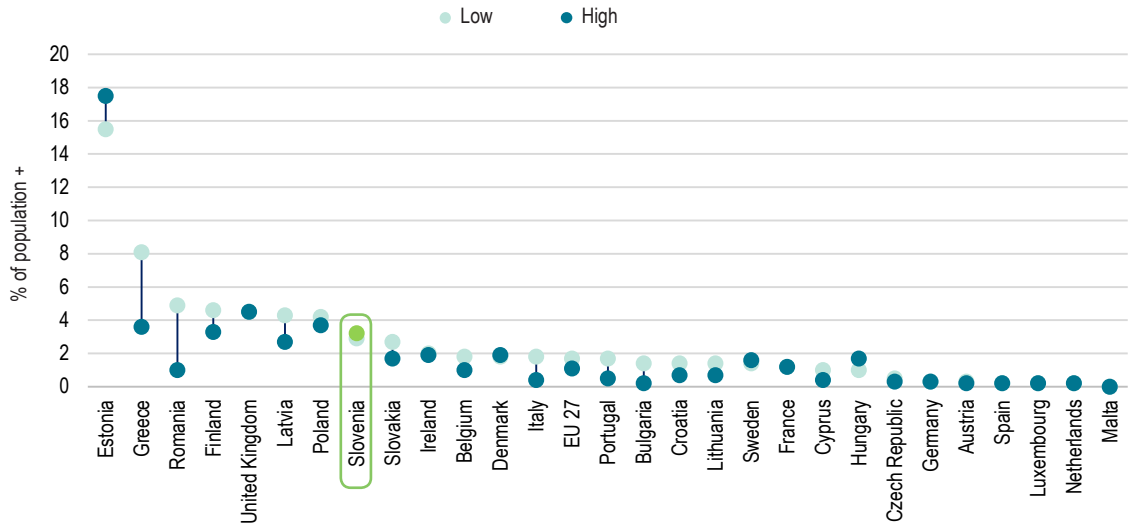


Fig. 8: Unmet needs for medical examinations due to waiting times, financial reasonse or geographical distance, and the income gap, Slovenia and the EU, 2019

Source: Eurostat, 2020.

Direct personal expenditure on long-term care is increasing markedly.

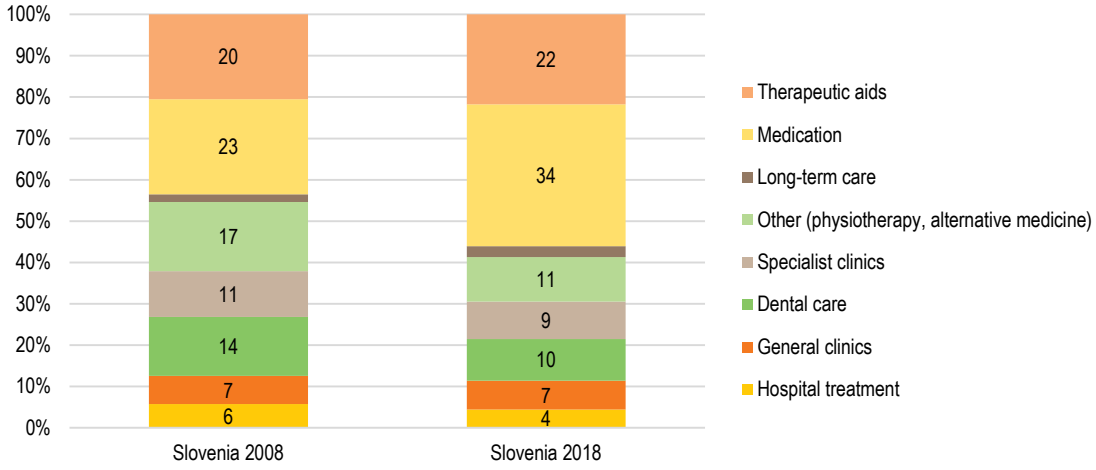


Fig. 9: Structure of out-of-pocket payment for healthcare, 2008 and 2018

Source: SURS and OECD Stat, 2021, calculations UMAR. Note: by SHA.

An overview of the socioeconomic determinants of health has also been added to this report. Of the indicators of social status, we highlight the at-risk-of-poverty rate for children, which is explicitly linked to the work intensity of the household in which they live.

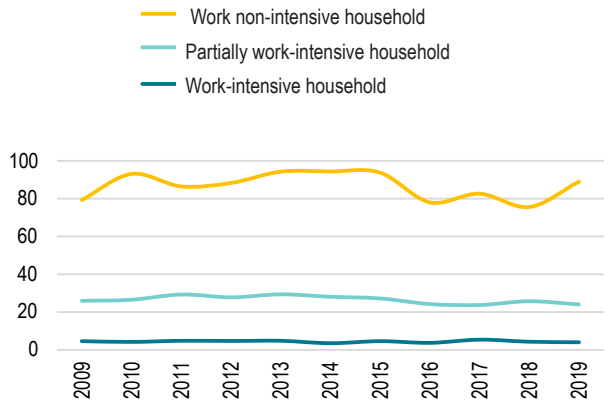


Fig. 10: At-risk-of-poverty rate of children (0–17 years), by household work intensity 2009–2019

Source: SURS, SI-STAT.

We shed light on the regional aspects of inequalities by showing the factors of lifestyle, the at-risk-of-social-exclusion rate and life expectancy. Our general conclusion is that the eastern half of Slovenia remains in poorer health than the rest of the country.

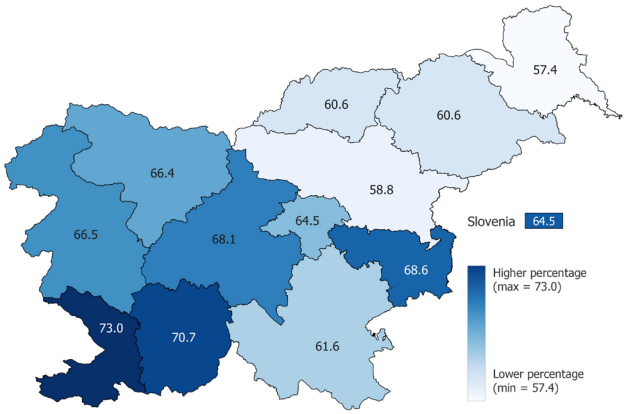


Fig. 11: Self-assessed good health
Source: EHIS 2019.

We regard the set of indicators presented as a step forward towards the formulation of a standard set of selected indicators that will enable us to monitor health inequalities in Slovenia periodically over the long term. Using health indicators, lifestyle determinants, socioeconomic determinants of health and access to healthcare and long-term care, we outline the results and important factors affecting the main causes of disease and death, the various options for the use of system-wide services, and well-being. The information helps organisations, communities and governments to focus their resources and efforts on activities that improve the health and well-being of everyone. The adequate indicator-based evaluation and monitoring of differences in health underpins all strategies for reducing health inequalities at local, national and international level.

Key messages

The gaps between different social groups are narrowing in Slovenia. People assess their own health as better, live longer, suffer less mortality as a result of accidents and are quicker to seek help for mental health problems than was the case in previous measurement exercises. There are unfavourable trends in the utilisation of healthcare services during pregnancy, the harmful use and consequences of alcohol, and the prevalence of diabetes, hypertension and depressive disorders. Health inequalities are increasing on account of the lengthening of waiting lists, as only the more affluent can afford direct out-of-pocket expenditure. Direct personal expenditure on long-term care is increasing markedly, while a not-inconsiderable proportion of needs for long-term care remains unmet. Children's at-risk-of-poverty rate, which is explicitly linked to the work intensity of the household in which they live, is highlighted, and shows, particularly when such situations are long term in nature, the danger inherent in the social exclusion of children and the intergenerational transmission of poverty.

Groups with vulnerabilities

For the first time in that reports, we add a qualitative paper to the presentation of quantitative indicators; this arose as part of the MoST qualitative research project based on the interviews with people with vulnerabilities and with the stakeholders that encounter and deal with them. The interconnectedness and complexity of the concept of vulnerability, as well as the interconnectedness and multi-faceted nature of the barriers that individuals can face to accessing healthcare and other forms of assistance and services, are shown as key in the 'Groups with vulnerabilities in Slovenia' presentation. There can also be major differences within a single vulnerable group. One barrier may be common to several groups, and one group may be faced with several barriers at the same time. The qualitative research approach has enabled us not only to observe these various vulnerabilities and the numerous groups with vulnerabilities, but also the specificities of the environments examined. Despite the fact that not all variation can be specified in detail, a major gap has been filled in our understanding of inequalities and vulnerabilities in the health of vulnerable groups in Slovenia.

We defined 20 groups with vulnerabilities and further subdivided them into numerous subgroups, with particular reference to the barriers they encounter in accessing health and other forms of care, institutions and resources. The following were most commonly regarded as vulnerable: the elderly; immigrants; people who do not speak Slovenian; people with various forms of disability; individuals and families in a socioeconomically vulnerable position; children and adolescents with various vulnerabilities; the unemployed; people without health insurance cover (without compulsory health insurance and/or supplementary health insurance); the Roma; people experiencing mental health problems.

Alongside the numerous barriers that groups or persons with vulnerabilities encounter when attempting to access healthcare or other forms of assistance, the many ways in which these barriers are overcome are also outlined. These are as varied as the vulnerable groups themselves. The main practices observed for overcoming barriers to accessing healthcare and other forms of assistance are: (1) systemic practices that have been developed only in certain local environments; (2) the social nature of local environments and institutions, and their formal (and informal) cooperation; (3) programmes and projects (funded from international, national or local sources) that address the vulnerabilities and needs of specific groups within the local community; (4) informal assistance; (5) services on the market, which have been studied the least because they remain financially out of reach for the most vulnerable; (6) project-based practices in medical centres, e.g. 'Improving Health for All', as part of the activities at health promotion centres within the local community.

A qualitative view provides a large amount of additional information on the otherwise hidden, overlooked, elusive and often stigmatised problems faced by vulnerable individuals, problems that we quickly overlook if we rely merely on 'counting the numbers' and if their occurrence is too rare to show up in the quantitative statistics. For several years, the IRSSV has, when monitoring the Slovenian population's social status, been compiling regular reports on poverty in the country with the help of mixed quantitative and qualitative methods.

Because of the variety and multi-faceted nature of vulnerabilities and inequalities, information on specific vulnerable groups can get lost when the situation is presented using numbers alone. Vulnerable individuals and groups must be addressed using a qualitative approach. It is therefore recommended that presentations of inequalities using indicators be complemented as a matter of course by the results of one-to-one interviews with the representatives of vulnerable groups and those that work with these groups. Combining quantitative and qualitative research is of considerable benefit. It is an approach we recommend for the monitoring of and reporting on health inequalities going forward.

Key message

When studying vulnerabilities and inequalities, it is vital that their interactions and complexity be acknowledged, as well as their multi-faceted nature and the complexity of and intersection between barriers. There can be major differences within a single vulnerable group. At the same time, one barrier can be common to several groups, or one group can encounter several barriers at the same time. There are also many forms or practices for overcoming barriers that are also diverse in nature.

Combining quantitative and qualitative research into vulnerabilities and inequalities is of considerable benefit and an approach we recommend.

POLICY MEASURES AND GAPS IN INEQUALITIES

Five basic conditions for health equity – an assessment of the factors that contribute to the gap in self-assessed health

An examination of the factors and measures that give rise to health inequalities is an important part of the search for solutions and for enacting measures to reduce inequalities. Following the model of the WHO European Health Equity Status Report and in collaboration with its authors, we provide an analysis of inequalities in self-assessed health in Slovenia between the most affluent 40% and least affluent 40% of the population. We break down the gap in health according to the relative contribution made by five important areas of life: healthcare, income and social security, housing and the environment, social and human capital, and employment and working conditions. The analysis used the answers given by adult inhabitants of Slovenia to the European Quality of Life Survey.

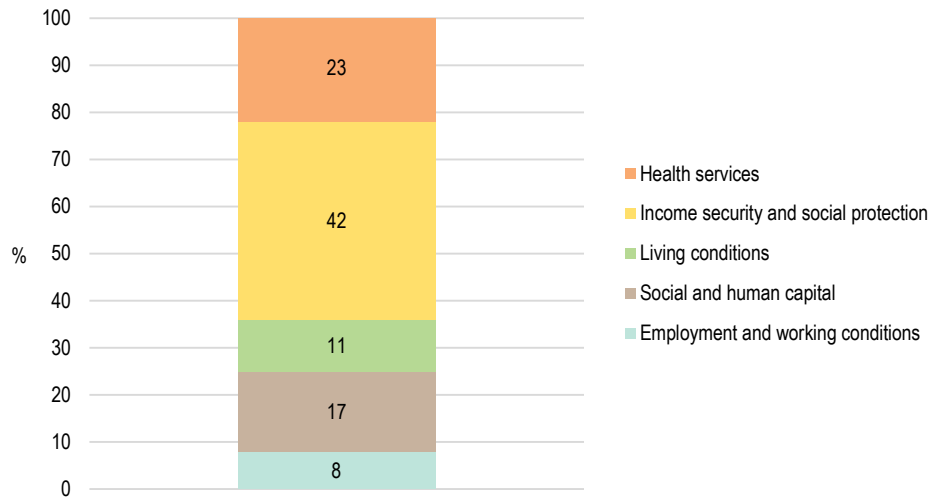


Fig. 12: Contribution of five essential areas of life to gap in self-reported health in Slovenia

The difference in income uncertainty between the more affluent and less affluent population groups makes the biggest contribution to the gap in self-assessed health in Slovenia, with the area of income and social security accounting for 42% of the gap. As expected, income inequalities are the most important generators of health inequalities in Slovenia and as an average across the EU countries, despite the fact that Slovenia is known for its lower income inequalities and greater social security, which have historical roots. Differences in the quality, availability and accessibility of healthcare services contribute 23% to the gap in health in Slovenia. This is higher than the EU average of 8%. Differences in survey participants' responses to questions on waiting for a GP appointment and waiting in the GP waiting room, on the self-assessed quality of the services provided and on the costs associated with a visit to a doctor, all of which contribute a very similar share to the gap, are the healthcare factors taken into account. The results reflect an awareness of the availability of high-quality health services to all inhabitants of Slovenia regardless of income, which differs from the EU average. Information on the waiting time at GP surgeries reveals the inequalities that the less affluent feel in contact with the healthcare system, but society does not, as yet, highlight this as important. Differences in social and human capital contribute 17% to the gap in health in Slovenia, with level of educational attainment and

lack of trust in others making similar contributions to this figure, in line with the EU average. A greater proportion of those with lower levels of educational attainment have low levels of trust in others, which presents an obstacle to involvement in social life. Differences in living and environmental factors contribute 11% to the gap in health in Slovenia. A more detailed breakdown shows housing deprivation as the most strongly represented factor, followed by food deprivation. A lack of green space and poor air quality make only minor contributions to the gap. Green space is accessible in Slovenia regardless of income. Differences in employment and working conditions account for 8% of the gap in health in Slovenia, with unemployment being the predominant component of this figure.

A systematic analysis of the factors that have the greatest impact on equality in health between the less and more affluent shows their complex multisectoral interdependence. The measures taken by different sectors give rise to health inequalities between population groups on account of the creation of the unequal conditions in which people live and work. This is something we cannot improve despite the efficient healthcare system in place.

Measurements using the WHO HESRi[4] tool are useful for measuring health inequalities with the help of different policy baskets at regular intervals of several years within the national context. The knowledge required for such measurements and assessments can be found in domestic institutions, where human resource and knowledge capacity must be systematically built and made to connect with each other.

Key message

Income contributes 42% to the health inequalities between the 40% most affluent and 40% least affluent members of Slovenian society, followed by healthcare (23%), education and trust in others (17%), housing and the environment (11%) and employment (8%). This demonstrates the multisectoral interdependence of the large differences in health even though there is an efficient healthcare system in place.

[4] WHO HEALTH EQUITY POLICY TOOL [Internet]. Copenhagen: WHO Regional Office for Europe; 2019.
Licence: CC BY-NC-SA 3.0 IGO. Available from: https://www.euro.who.int/__data/assets/pdf_file/0003/403608/20190527-h1005-policy-tool-en.pdf

Poor air quality as an element of health inequalities

The environmental benefits and risk factors for human health in the European region of the WHO are not spread evenly across that region. In very many cases, environmental factors weigh more heavily on the majority of society's deprived groups. According to WHO figures, these deprived groups are at least five times more exposed. Of all the environmental risk factors, polluted ambient air, which the WHO estimates kills around half a million people every year in the European region, is the greatest threat to health. Independently of the differences in exposure, groups with a lower socioeconomic status are nevertheless more sensitive to the harmful effects of ambient air pollution because of their poorer health, which is the result of other factors.

The assessment of poor air quality was selected from among the living environment factors and the differences in the assessment of poor air quality examined. In Slovenia these differences are as important a factor in the gap in self-assessed health between the more and less affluent as the EU average. Poor air quality contributed very little (less than 2%) to the gap in self-assessed health in relation to living and environmental factors.

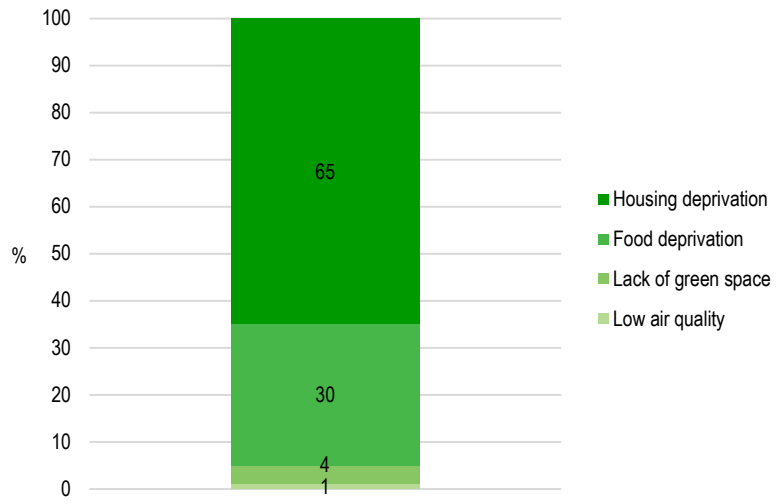


Fig. 13: Contribution of Living Conditions subfactors to the gap in self-reported health

Although an analysis of the data relating to this indicator does not show a clear gap by level of education, the data does show primarily that perception of air quality can change a great deal in groups according to level of educational attainment. Conditions in the environment and the importance attributed to the topic by the media have the most significant impact on this. **In order to formulate evidence-based conclusions on perceptions of poor air quality and correlations with health inequalities, further research is required that incorporates representative samples of the population at national level.**

In order to protect vulnerable groups in society and achieve environmental justice, targeted environmental and intersectoral measures must be adopted, social and environmental policies coordinated, and measures at local level improved (e.g. better spatial planning and a move towards sustainable mobility, a ban on the use of solid fuels for heating, a definition of pollution sources), thereby reducing their disproportionate exposure compared to less vulnerable groups in society.

Key message

Poor air quality contributed very little (less than 2%) to the gap in self-assessed health in Slovenia in relation to living and environmental factors. This is the same as the EU average. Perceptions of air quality can change significantly between educational attainment groups, with conditions in the environment and the importance attributed to the topic by the media having the most significant impact on this.

Applied research into child well-being

The formulation of composite indicators or indices is becoming an ever more established approach to the study of complex social phenomena. With the creation of the international and regional child well-being indices, we have facilitated the measurement and monitoring, based on data and the latest theoretical findings in this field, of well-being outcomes within a variety of social areas important to children. An international comparison of the child well-being index shows that Slovenia's highest rankings come in the domains of family and peer relationships and of education (sixth place), and its lowest in the domains of housing and the environment (12th place) and of behaviour and risk (17th). Child well-being in Slovenia as measured by the regional child well-being index is highest in Goriška, followed by the Osrednjeslovenska and Gorenjska regions. These three regions comprise the top 25% when it comes to the best-ranked statistical regions. The Zasavska statistical region has the lowest regional index score, with children there having the worst living conditions of all counterparts in other regions. It is joined in the bottom 25% by the Obalno-Kraška and Koroška regions.

The results of the index indicate the considerable differences in child well-being, differences between the well-being of boys and girls, and the uneven regional development of some areas that affect the well-being of children. This requires future thorough analyses of the possible reasons for and consequences of these results, and the formulation of appropriate measures.

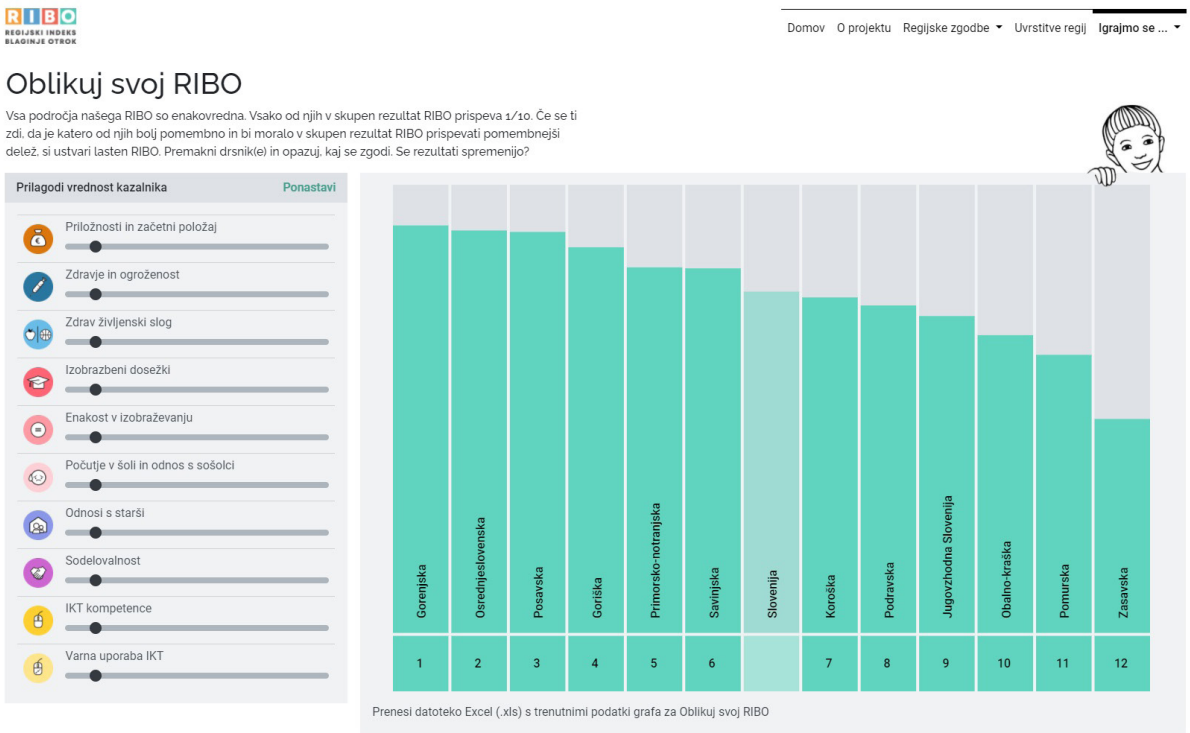
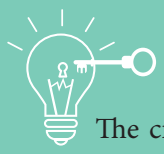


Fig. 14: Re-designed RIBO[5] with weighted domains of well-being and new classifications of Slovenian statistical regions

[5] Child Well-Being Index (CWI). [Internet]. Available from: https://ibo.irssv.si/#/

Both well-being indices show how important it is to reduce the gulf between political decision-makers and researchers if we wish to ensure that research results are used in the process of creating public policies. Measuring complex social phenomena by formulating composite indicators is, in this context, an important tool for the well-informed creation of public policies, one that complements existing findings on child well-being and regional differences and can help to reduce regional inequalities in child well-being.

Measuring complex social phenomena through the formulation of composite indicators can be an important tool for the well-informed creation of public policies. The composite indicators cannot wholly replace more in-depth analyses (as indices are, for methodological reasons, always an approximation or estimate), but they do complement more detailed analyses of the topic being discussed.



Key message

The creation of the child well-being and regional child well-being indices complements the system for monitoring child well-being in Slovenia and beyond. They constitute a tool for monitoring areas important to children, and the well-being outcomes within those areas, by means of condensed data, in a conceptually and theoretically legitimate way and on a continuous basis. The complexity of child well-being is shown by a single value, which facilitates assessment of the child's status, enables time-based, regional and international comparisons to be drawn, offers a more effective identification of the issues pertaining to individual social areas of relevance to children, and leads to the easier and more adequate formulation of public policies.

Alcohol in Slovenia: How big is the problem and how successful have we been?

There is an increasing acknowledgement that the consequences of alcohol consumption have a bearing on health inequalities; it is therefore important for alcohol policy activities to be incorporated into policies and programmes aimed at reducing health inequalities. Alcohol use is a major public health issue in Slovenia. In terms of per capita consumption of pure alcohol and deaths directly attributable to alcohol, Slovenia is above the average for the European region of the WHO. On average, three people die every day from causes directly attributable to alcohol in Slovenia (more men than women).

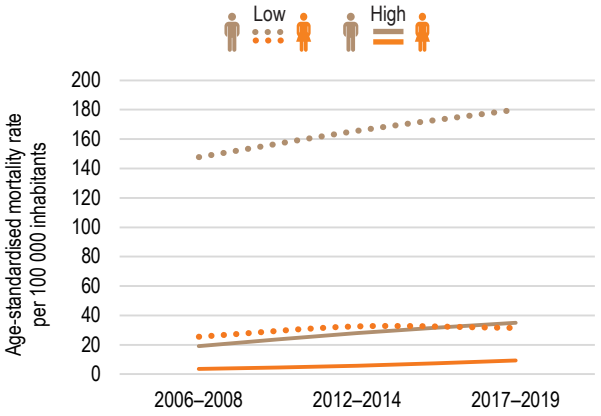


Fig. 15: Age-standardised mortality rate directly attributable to alcohol, by educational attainment and gender across three time periods

Almost half the adult population engage in highly risky alcohol consumption. Among adolescents, boys are most prone to engaging in risky alcohol consumption, particularly those with below-average school achievement and those attending vocational schools. The healthcare costs occasioned by alcohol consumption account for between three and five per cent of all health expenditure every year.

The last 20 years have seen quite a few legislative changes in relation to issues surrounding alcohol in Slovenia. International comparisons of the success of alcohol policy show that Slovenia has had greatest success in drink-driving countermeasures, restricting the availability of alcohol, and dealing with risky and harmful drinking and addiction. The country has had less success in restricting the marketing of alcoholic beverages, reducing the impact of the illicit provision and sale of alcohol and informally produced alcohol, and reducing the affordability of alcohol.

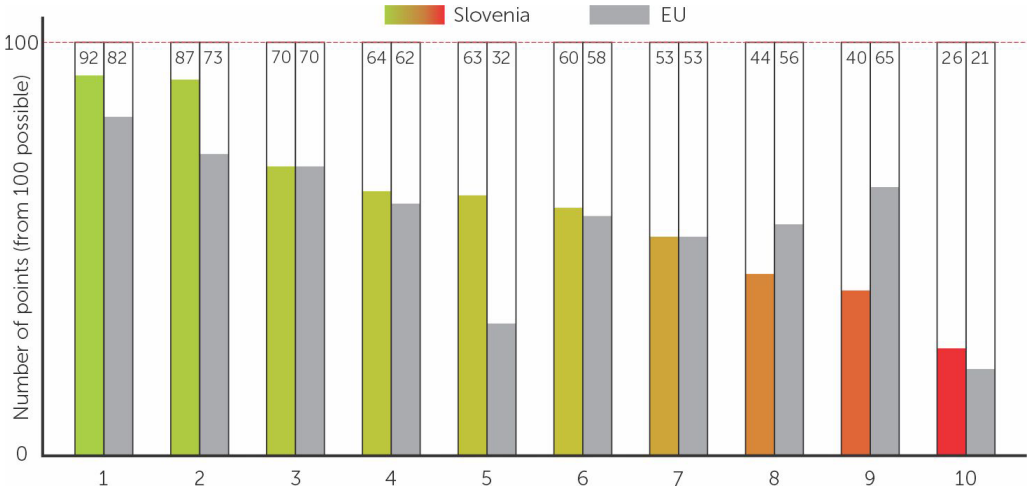


Fig.16: Comparison between Slovenia and the average for 30 European countries regarding the success of implementation of comprehensive alcohol policy measures in ten areas

Ten action areas: (1) Drink-driving policies and countermeasures, (2) Leadership, awareness and commitment, (3) Monitoring and surveillance of alcohol-related issues, (4) Limiting the availability of alcohol, (5) Reducing the negative consequences of drinking and alcohol intoxication, (6) Treatment of hazardous and harmful alcohol consumption and addiction in healthcare settings, (7) Community and workplace action, (8) Restricting the marketing communication for alcoholic beverages, (9) Reducing the public health impact of the illicit provision and sale of alcohol and informally produced alcohol, (10) Affordability of alcohol (pricing policies).

Slovenia's breakthrough year was 2003, which is when the Restrictions on the Use of Alcohol Act (ZOPA) was adopted. It lays down measures and methods for restricting alcohol consumption, and measures to reduce its harmful effects. ZOPA supports measures that have been proven to be effective and that are aimed at restricting alcohol consumption, specifically through the use of age-, time- and space-related measures to reduce the availability of alcohol, particularly to young people. According to Health-Related Behavioural Style studies, the proportion of people drinking alcohol to excess in Slovenia has fallen since the adoption of the ZOPA. The fall has been more pronounced in groups with lower levels of educational attainment when set against those with higher levels of educational attainment. As the Restrictions on the Use of Alcohol Act was not primarily aimed at reducing health inequalities between people in Slovenia, other factors can have an impact on these inequalities.

We believe that the findings collected in this report will guide future research into the impact of legislation on inequalities in the harmful use of alcohol in Slovenia and lead to even more effective measures. At the same time, Slovenia has seen a growth in the last 15 years in activities and programmes that are already filling in the gaps in activities and successfully providing talking points regarding long-term systemic approaches to reducing alcohol use and related inequalities.

Key message

According to the figures from the study, the percentage of excessive drinkers fell in the years following adoption of the ZOPA, mainly among those with lower levels of educational attainment. Given that the law was not primarily aimed at reducing health inequalities among people in Slovenia, we cannot exclude the impact of other factors on reducing the differences in the share of excessive drinkers between those with different levels of educational attainment.

Inequalities in the relationship between long-term care and healthcare of the older adults, and inequalities in the receipt of long-term care in relation to life cycle

There is also a link between long-term care and the use of healthcare services in relation to the socioeconomic status of the individual concerned. An analysis of health inequalities with the help of an analysis of the relationship between long-term care and healthcare over the observed lifetime of an individual shows the contribution made by individual socioeconomic factors to inequalities in the receipt of long-term care.

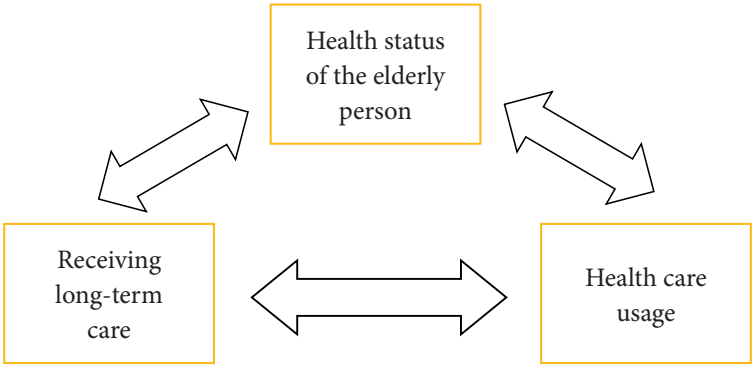


Fig. 17: Causal scheme of the basic mediation model

Increasing the volume of long-term care services can improve the efficiency of the healthcare system by reducing the number of hospitalisations and smoothing the path towards the implementation of plans to coordinate healthcare and social care. The results confirm the positive effects of long-term care provision on reducing the use of healthcare, with visible direct and indirect effects in the majority of indicators. The important role played by income, education and gender in the relationship between long-term care and healthcare was confirmed. A detailed study of the need for long-term care through an individual's life cycle showed that gender and educational status are the typical predictors of need, while income is a strong predictor of both the receipt and type of informal care. The majority of socioeconomic factors, and age and income most strongly, have an important impact on inequalities in the formal provision of long-term care.

Slovenia has been trying for around two decades to adopt a law to regulate the current arrangement, where long-term care is fragmented across different social protection systems. This area has been included in European Semester processes for a number of years by means of specific recommendations; therefore, the paper can provide additional support for the provision of the necessary public resources for long-term care and the adoption of new legislation in this area in Slovenia.

The analysis showed the close mutual substantive and financial interdependence of the systems of social care, the labour market and education. The measures and reforms of an individual system are generally embarked upon separately, meaning that we often overlook these connections. The impact of socioeconomic differences between different population groups on the relationship between long-term care and healthcare services is an additional dimension in support of a universal approach and additional proportionate measures.

Key message

The positive effects of long-term care provision on reducing the use of healthcare are confirmed, with visible direct and indirect effects in the majority of indicators, and with important roles played by income, education and gender. Gender, education and income are major factors of inequalities when it comes to the receipt of long-term care when we observe an individual from childhood onwards.

The systems of social care, the labour market and education are substantively and financially closely interconnected, a fact that should be taken into consideration when measures and reforms are being drawn up and linked together. It is also important to monitor, assess and anticipate the consequences of measures in the area by paying due regard to the interconnection of these systems.

HEALTH INEQUALITIES RESULTING FROM COVID-19 IN SLOVENIA

In 2020 and 2021 the syndemic triggered by COVID-19 had a marked impact on the trend in health and social inequalities.

Regional inequalities in child vulnerability during the COVID-19 epidemic

A study of children's everyday lives was conducted during the first wave of the epidemic. It was grounded in the measurement of the effects of the epidemic on the well-being of children and their attitude over time to the measures to suppress the effects of the epidemic, with the focus mainly placed on an analysis of the changes to child vulnerability at regional level. Identifying the factors that affect the index of the change to child vulnerability and the vulnerable groups of children can serve as the basis for adopting public policy measures tailored to the needs of children during the epidemic.

The key finding from the results of the index of the change to child vulnerability is that, on average, the vulnerability of the children surveyed worsened only slightly, which is understandable given that this was an emergency situation that lasted a relatively short period of time (two months). During the first wave of the epidemic, most of the children (just under 60%) remained as vulnerable as they had been before (most clearly in the Jugovzhodna region), while the vulnerability of a fifth of children increased (most clearly in children in the Zasavska region). At the same time, we also highlight the increase in vulnerability among other groups of children: those living in regions with an above-average increase in vulnerability (Pomurska, Podravska, Obalno-Kraška, Koroška). These are the regions in which child well-being is already among the lowest in Slovenia. In just over a fifth of children, vulnerability fell in the period in question (most of all in the Osrednjeslovenska region).

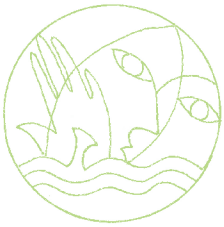
We note that groups of children who were already vulnerable before the epidemic proved to be the most vulnerable during the first wave. This means, therefore, that these groups saw the greatest increase in vulnerability, but were, at the same time, vulnerable even before the epidemic. This widened the gap between vulnerable groups of children and the degree of their vulnerability. The reasons for the increased vulnerability of these groups of children can be sought in a combination of socioeconomic characteristics and lifestyle, which are inseparably linked. Child well-being deteriorated to the greatest degree in the area of information and communications technology, in terms of the negative aspects of ICT use or an increase in activities that lead to dependence or alienation.

One of the areas of child well-being we can further highlight is that of mental health or psychological stress, where vulnerability also increased. It is worth pointing this aspect out when designing measures to mitigate the consequences of the epidemic on child well-being and quality of life, as the preservation of children's well-being and psychosocial health in Slovenia is exceptionally important, especially given that Slovenia is not among the best-performing countries according to the relevant international scale.

When adopting measures to suppress the negative effects of the coronavirus epidemic, political decision-makers should pay particular attention to maintaining child well-being, with an emphasis on protecting children's mental health and reducing activities that lead to passivity and alienation (as a result of increased use of information and communications technology) and to strengthening protective factors (good family relations and the promotion of outdoor leisure activities and sport).

Key message

During the first wave of the epidemic, just over 50% of children remained as vulnerable as they had been before (there were most of such children in the Jugovzhodna region). The vulnerability of a fifth of children increased (most clearly in children in the Zasavska region). Vulnerability has also increased among other groups of children: those living in regions with an above-average increase in vulnerability (Pomurska, Podravska, Obalno-Kraška, Koroška). These are the regions in which child well-being is already among the lowest in Slovenia. Groups of children who were already vulnerable before the epidemic proved to be the most vulnerable during the first wave.



Health inequalities resulting from COVID-19 in the general population in Slovenia

Based on an analysis of the spread of COVID-19 and its main characteristics in Slovenia, and of an assessment of its impact on inequalities in healthcare indicators, we also looked at the contribution of specific socioeconomic indicators to health inequalities resulting from the first COVID-19 pandemic wave.

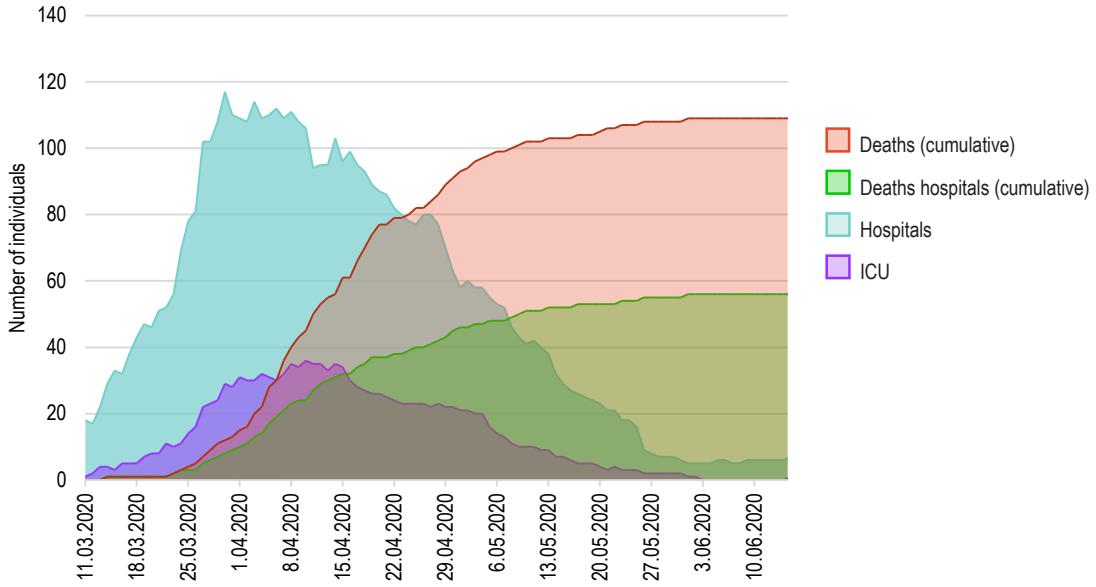


Fig. 18: Number of patients in hospitals and ICUs on a certain day, total number of deaths and number of deaths in Slovenian hospitals (all due to COVID-19), 4 March to 3 June 2020.

Source: Manevski et al., 2020, re-drawing based on Covid-19 tracker data.

The first national lockdown led to a reduction in the number of positive cases in every local community in Slovenia. The causal effects of the lockdown as a political measure are measured as the number of positive cases based on the individual's behaviour in the face of changing protective measures. The impact differed according to age, income and educational status. These calculations are valuable to political decision-makers in assessing the adequacy and proportionality of measures, in this case to reduce the spread of SARS-CoV-2 infection.

Scientific research work can be of great help to decision-makers, particularly in crisis situations such as the COVID-19 epidemic, if it has already been inserted into the system by the time strategic preparations are being made for possible outbreaks, is planned in a multidisciplinary way, is conducted in a timely manner, and is applied adequately and proportionately, and if the capacities are in place in all areas (institutional, human resources, knowledge and financial resources, and the expert management of processes).

Key message

On average, the first national lockdown led to a statistically significant reduction in the number of positive cases of COVID-19 in every local community in Slovenia, from which we can make precise causal estimates of the reduction in all key indicators of the epidemic resulting from the first lockdown. A comparison in terms of age, income and educational status shows the statistically significant impacts of these factors.

Will the COVID-19 pandemic deepen health inequalities in the Slovenian population? Results of the SI-PANDA survey

The survey results outlined here show that signs of pandemic fatigue are already appearing in Slovenia as well. The COVID-19 pandemic is already having an impact on individuals' financial situation, contact with doctors, lifestyle and mental health, particularly among some of the most vulnerable population groups. In the first phase, the infectious disease epidemic affected the older population most of all, with the long-term impact of the measures designed to contain it having the greatest impact on the young, as reflected in the worsening of their financial situation (Fig. 19), lifestyles and levels of obesity, as well as their mental health. People suffering from chronic disease and those with mental health problems are a particularly vulnerable group, with the COVID-19 pandemic having had a particularly negative effect on them.

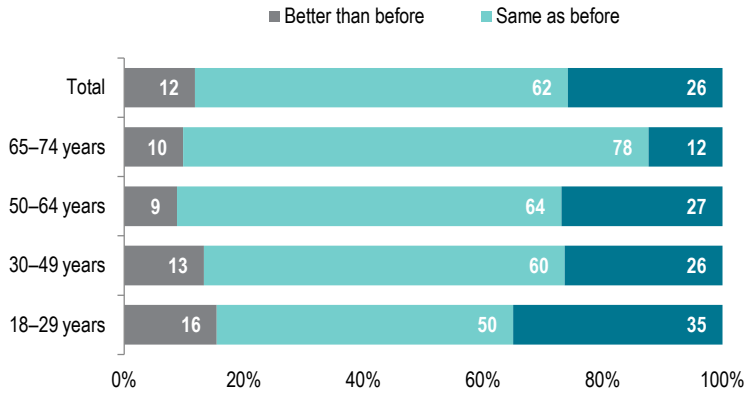


Fig. 19: Perception of financial situation in the last three months, as a total and by age group
Source: NIJZ.

People who assessed their financial situation as having worsened in the three months prior to the survey accounted for the highest single percentage (26%) of those who stated that their household found it difficult to provide high-quality protein-based food in their diet (Fig. 20). Around one fifth of those who reported mental health difficulties or signs of a depressive disorder gave the same response (18.2% and 20.6% respectively).

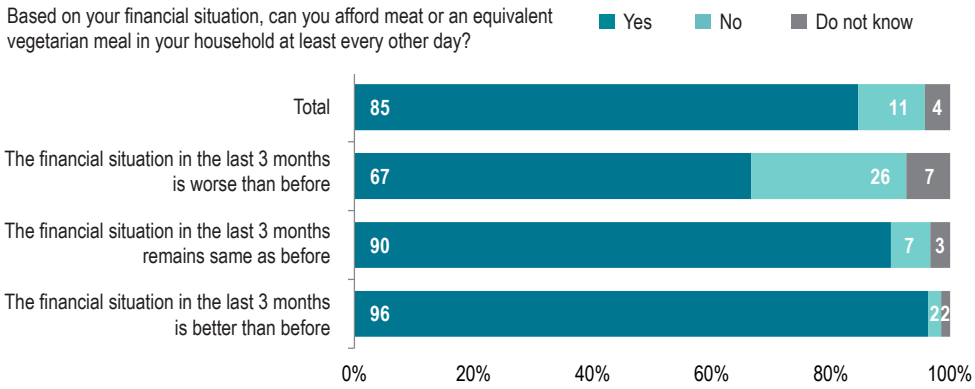


Fig. 20: Ability to afford a meat-based meal or vegetarian equivalent at least every other day, as a total and in relation to assessment of financial situation

Source: NIJZ.

It is crucially important that the situation is monitored on a regular basis and priorities established for the measures to be taken, and that policy measures in the areas of healthcare and social protection, as well as other areas, are taken in time in order to prevent an increase in health inequalities among future generations.

Key message

The COVID-19 pandemic is having an impact on individuals' financial situation, contact with doctors, lifestyle and mental health. The COVID-19 infectious disease epidemic has affected the older population most of all, while the impact of the measures designed to contain it have most affected the young, as reflected in the worsening of their financial situation, lifestyles and levels of obesity, as well as their mental health. People suffering from chronic disease, and particularly those with mental health problems, are a particularly vulnerable group.

The COVID-19 pandemic will have long-term consequences for the lives, lifestyles and health of the people in Slovenia. We can expect a rise in chronic non-communicable diseases and mental health problems and, with it, an increased burden on the healthcare system, and an increase in differences between population groups, leading to widening social inequalities that will require well-considered policy responses. The recovery and resilience plan also brings a wealth of opportunities for successful emergence from the crisis, although it is essential that public health aspects are taken into account when the plan is being drawn up and implemented.

MULTIDISCIPLINARY VIEW OF THE WORK PERFORMED, WITH RECOMMENDATIONS FOR POLITICAL DECISION-MAKERS AIMED AT IMPROVING THE SITUATION

Fig. 21: Schematic presentation of a interdisciplinary research platform of sectoral institutions and links with the sector

Source: Own drawing NIJZ.

Intersectoral cooperation can proceed more smoothly if competent specialist national sectoral institutions work together to produce well-argued reasoning for policies or measures. Inequalities are a complex field of enquiry and can only be interpreted to a certain extent within the boundaries of a single discipline, while institutions that work together can achieve more by pooling their knowledge and experience.

For the most part, proposals for measures come from a specific sector and are then intersectorally coordinated, with arguments for measures arising within the competent national institution in that same sector. We have shown in our work how individual measures can be researched in cooperation with several competent sectoral institutions, which establishes multidisciplinary competence for the coordinated argumentation of measures. Bases prepared in a multidisciplinary way can then serve as an incentive for intersectoral coordination at the political decision-making level. Coordination and cooperation during the phase of formulation of measures will be important for the harmonious operation of political, research and other relevant institutions.

Systems must therefore be addressed as a whole and intersectoral coordination carried out at individual phases of the preparation of proposals for a specific measure as this is the only way to improve the quality of proposals and accelerate the process of intersectoral coordination. The involvement of national expert institutions covering individual areas in the preparation of an analysis of the situation, proposals for measures, assessments of the consequences of those measures and their coordination is more than welcome and necessary. The previous successful work of the platform of institutions in preparing expert foundations for the Strategy for a Long-Lived Society, defining long-term care and preparing this report only confirms this. We should be aware that we also currently have tasks involving activities of an infrastructural nature, which therefore require constant interdisciplinary research work in relation to maintaining adequate databases and maintaining and developing adequate methodologies. This approach removes otherwise common and recurrent problems: the time pressures that attend the preparation of analyses, a lack of data and the relevant tools, or data and tools that require adaptation, problems in coordinating the work of researchers within single institutions, and the impossibility of setting up regular groups of researchers, as their engagement is only periodic and partial. Continuation of the platform's work for the selected substantive areas will therefore be a direct indicator of changes to an understanding of the operation of these systems, as well as of the need for the permanent engagement of an adequate interdisciplinary platform.

RECOMMENDATIONS FOR FUTURE WORK

I. Monitoring and analysis of the situation, and the development of methods and knowledge

1. **Regular monitoring of the situation regarding unjust health inequalities for the preparation of foundations for measures**

   Using health indicators, lifestyle determinants, socioeconomic determinants of health and indicators of inequalities in access to healthcare and long-term care, we outline the results and important factors affecting the main causes of disease and death, the various options for use of system-wide services, and well-being. The information helps organisations, communities and governments to focus their resources and efforts on improving the health and well-being of everyone. The adequate indicator-based evaluation and monitoring of differences in health underpins all strategies for reducing health inequalities at local, national and international level.

   In doing so, it is vital for knowledge and resources to be interlinked horizontally (between sectors and organisations) and vertically (locally, nationally, internationally) and, at the same time, for the situation to be monitored on a continual basis at all levels.

2. **Further detailed quantitative and qualitative research**

   Further research into health inequalities is required, particularly in light of the impact of the COVID-19 syndemic. That research will be conducted using mixed quantitative and qualitative methods and will include representative samples of the population at national level. Further detailed analyses of the possible causes and consequences of the results of unjust inequalities are required if we are to formulate more adequate public policy responses. The findings will guide research into the impact of legislation on inequalities.

3. **Development of methodologies for measuring health inequalities resulting from policy measures and for assessing the impact of policy measures on health inequalities**

   Monitoring the health inequalities situation with the help of the WHO methodology of policy baskets at regular intervals of several years facilitates well-argued and well-considered measures, with public health being taken into account during preparation and implementation. Measuring inequalities resulting from policy measures is a methodologically complex and demanding process and one that employs a variety of tools. Indices help us to assess the situation, and are important for the formulation of public policies. Other more complex empirical tools and models are also important for assessing policy impacts. Longitudinal research and data are required for systematic monitoring. The use of mix methods (i.e. qualitative and quantitative research) is a major step forward, and one that we recommend for the future monitoring of and reporting on health inequalities.

4. **Development, flow and dissemination of knowledge**

   The knowledge required for monitoring health inequalities and the associated policy measures can be found in domestic institutions, where capacity must be systematically built and the institutions made to connect with each other. It is also important to ensure that knowledge flows to and from the international community.

II. Investment in activities and programmes

1. **Investment in activities and programmes for reducing unjust health inequalities**

   It is necessary to continue the coordinated intersectoral investment in activities and programmes to enable more robust systemic and adequately evaluated approaches for reducing unjust health inequalities between different groups in society. Indeed, this process should be intensified as a result of the needs that have arisen in the course of the syndemic. The establishment of all the necessary intersectoral capacities for implementing activities and programmes (infrastructural, human, financial, as well as the capacities of multidisciplinary competence, leadership and cooperation) is a priority.

2. **Greater support for environmental justice**

   In order to protect vulnerable groups, reduce inequalities in health and well-being and achieve environmental justice, targeted environmental and intersectoral measures must be adopted, social and environmental policies coordinated and local measures improved.

III. Establishment of a multidisciplinary platform for assessing the impact of policy measures on health inequalities

1. **Multidisciplinary and integrated handling of proposals for measures**

   Intersectoral cooperation can proceed more smoothly if competent specialist national sectoral institutions work together to produce well-argued reasoning for policies or measures. Foundations prepared through multidisciplinary cooperation can provide an incentive for intersectoral coordination at the political decision-making level. Coordination and cooperation at all stages, and especially when the policies are at the formulation stage, will be important in the future for the coordinated operation of the policy-making sphere and research and other relevant institutions.

2. **Establishment of a multidisciplinary platform of sectoral institutions with all the required implementational capacities for assessing the impact of policy measures on health inequalities**

   Sectoral systems must be addressed together, with intersectoral cooperation starting with the joint definition of priorities and research questions and a joint research process as support to the preparation of proposals for measures or reforms at specific phases. Only in this way can we improve the quality of individual proposals and accelerate the process of intersectoral coordination. Continuation of the platform's work for the selected substantive areas will therefore be a direct indicator of changes to an understanding of the operation of these systems, as well as of the need for the permanent engagement of an adequate interdisciplinary platform.

   These are activities of an infrastructural nature that require continuous multidisciplinary research work to maintain the relevant databases and maintain and develop the relevant methodologies if up-to-date support is to be given to policy measures. This approach ensures the stable availability of staff and of regular research groups, and the accessibility of data, knowledge and the appropriate tools. It also removes the time constraints involved in preparing analyses and the problems associated with coordinating the work of researchers at individual institutions.

REVIEWERS' OPINIONS

The process of reducing health inequalities can be tackled at various dimensions of the issue. The measures taken so far in Slovenia have tended to focus mainly on mitigating the consequences and less on eliminating the causes. The report defines itself as the first step on the path towards support for evidence-based political decision-making, which will be followed by a joint interdisciplinary research platform for bolstering measures to increase well-being and reduce health inequalities, and insert them into the government's decision-making practices. Strong efforts will be required to overcome the current political power games going on between parties and groups, and to raise the common interest above that of a particular government – or at least, to bring those interests together.

Professor Majda Pahor

The report makes a valuable contribution to the analysis of health inequalities in Slovenia. We hope that those charged with planning public policies and those that decide on them treat it as a vital pillar of their decision-making. In addition to analysing the numerous indicators of differences in health, the report draws attention to the structural inequalities that need to be addressed by health and social protection policies. It is distinguished by its interdisciplinary nature and its interpretations of inequality, which implicitly and explicitly, and from different perspectives, point out the problematic nature of policies in the areas concerned.

Assistant Professor Dr Metka Mencin Čeplak

The report makes it clear that we must bring an awareness and the ethics of interdependence into the complex and dynamic social relations as the guiding principle of our decisions. This report further convinces us that we need more systemic solidarity if, as a community, we wish to achieve better health and take advantage of the benefits that come with well-being and prosperity.

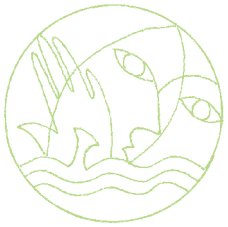
Assistant Professor Dr Marjan Premik

When faced with health inequalities, we will always ask ourselves what degree of health is achievable in any given circumstance and still be fair despite the differences. Our more socioeconomically deprived fellow citizens have needs, but also the ability to meet them. They need greater support to do that. I therefore hope that the Slovenian population will also be brought into the promised process of intersectoral integration and active cooperation.

Assistant Professor Dr Božidar Voljč

Health inequalities often appears as unintended consequences of policies with other purposes than health. If the consequences for health equity are not visualized, we lack the starting point for taking action. The responsible sector needs to be aware of the equity consequences of their sector policies and own both the problem and the solutions in order to reduce health inequalities. This report measures the problem, identifies the basic conditions for equality in health, engages stakeholders and creates the platform for intersectoral collaboration for tackling the root causes of health inequalities.

Ms Tone Poulsson Torgersen



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