EPIDEMIOLOGIA PIEMONTE

The European and Italian agenda on health inequalities: priorities for Health Equity Audit

Giuseppe Costa

AIE Catania
Oct 25, 2019

giuseppe.costa@unito.it

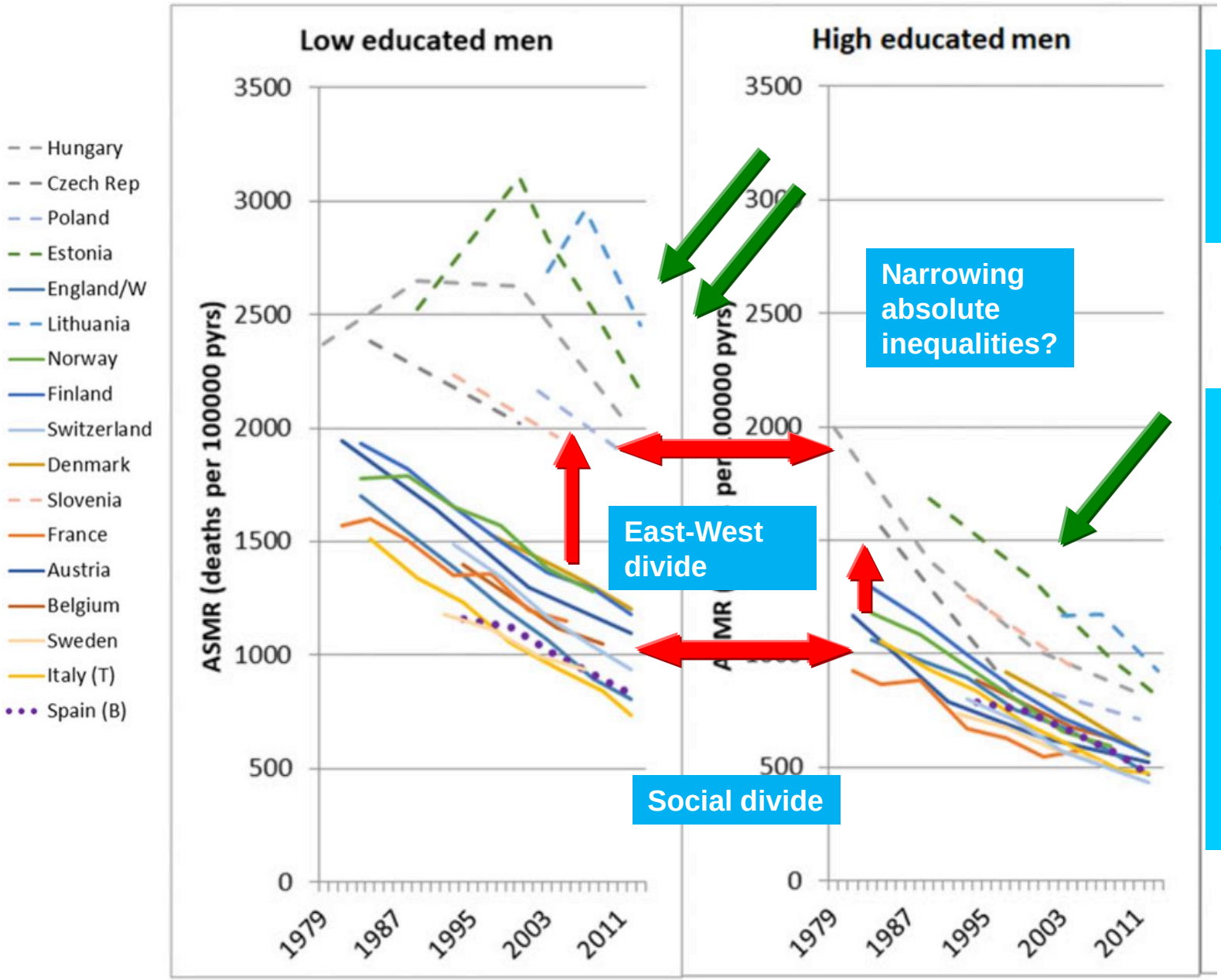
Health Equity in the agenda

- Facts: health inequalities in Europe, Italy and local level
- Explanations: causality issues behind health inequalities (FEAM/ALLEA)
- Entry points for policies (WHO Europe)
- Policy response: the new European joint action (JAHEE)
- The Italian agenda

Health Equity in the agenda

- Facts: health inequalities in Europe, Italy and local level
- Explanations: causality issues behind health inequalities (FEAM/ALLEA)
- Entry points for policies (WHO Europe)
- Policy response: the new European joint action (JAHEE)
- The Italian agenda

EDUCATIONAL INEQUALITIES IN MORTALITY ACROSS 17 EU POPULATIONS, MEN 1980-2014 (Mackenbach, Pnas 2018)



Social inequalities in health are still there

Going the right way: favourable trends also in Eastern Europe and among lower educated, despite the recession

LIFE EXPECTANCY BY EDUCATION, ITALY 2011-2014

LIFE EXPECTANCY BY EDUCATION, ITALY 2011-2014

www.epiprev.it

4

SPERANZA DI VITA ALLA NASCITA PER LIVELLO DI ISTRUZIONE, AREA GEOGRAFICA DI RESIDENZA E SESSO

LIFE EXPECTANCY AT BIRTH BY EDUCATION LEVEL, GEOGRAPHICAL AREA OF RESIDENCE, AND SEX

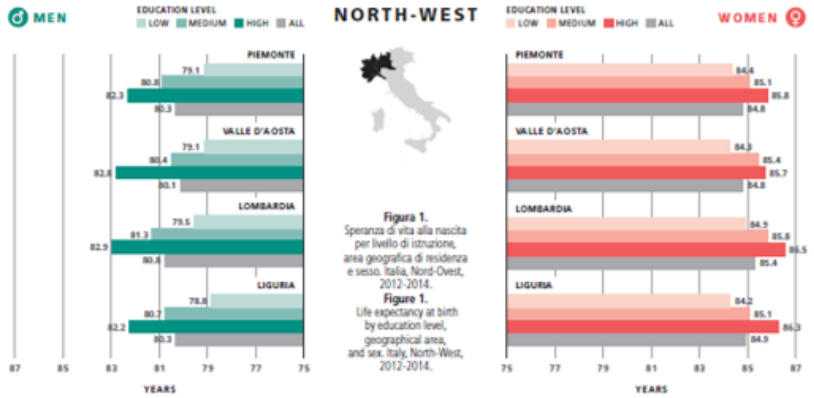


Figura 1. Speranza di vita alla nascita per livello di istruzione, area geografica di residenza e sesso. Italia, Nord-Ovest, 2012-2014.
Figure 1. Life expectancy at birth by education level, geographical area, and sex. Italy, North-West, 2012-2014.

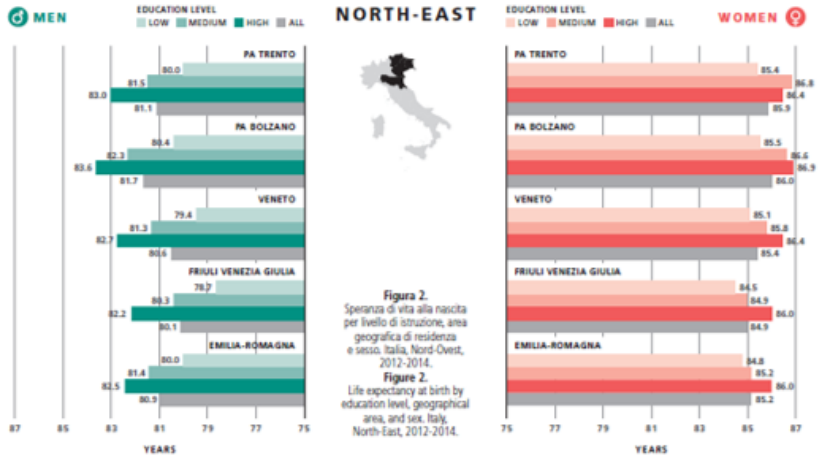


Figura 2. Speranza di vita alla nascita per livello di istruzione, area geografica di residenza e sesso. Italia, Nord-Ovest, 2012-2014.
Figure 2. Life expectancy at birth by education level, geographical area, and sex. Italy, North-East, 2012-2014.

www.epiprev.it

SPERANZA DI VITA ALLA NASCITA / LIFE EXPECTANCY AT BIRTH

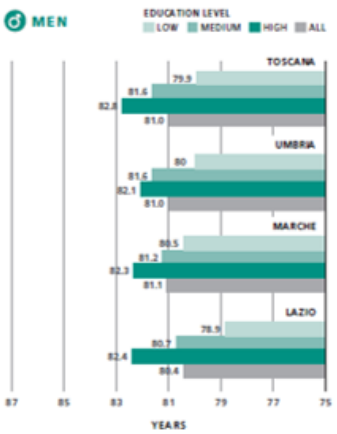


Figura 3. Speranza di vita alla nascita per livello di istruzione, area geografica di residenza e sesso. Italia, Centro, 2012-2014.
Figure 3. Life expectancy at birth by education level, geographical area, and sex. Italy, Centre, 2012-2014.

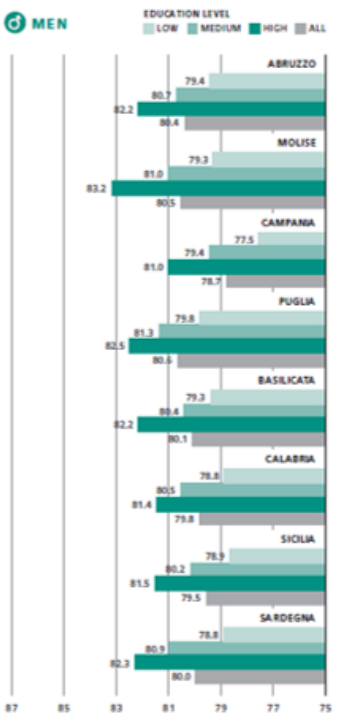
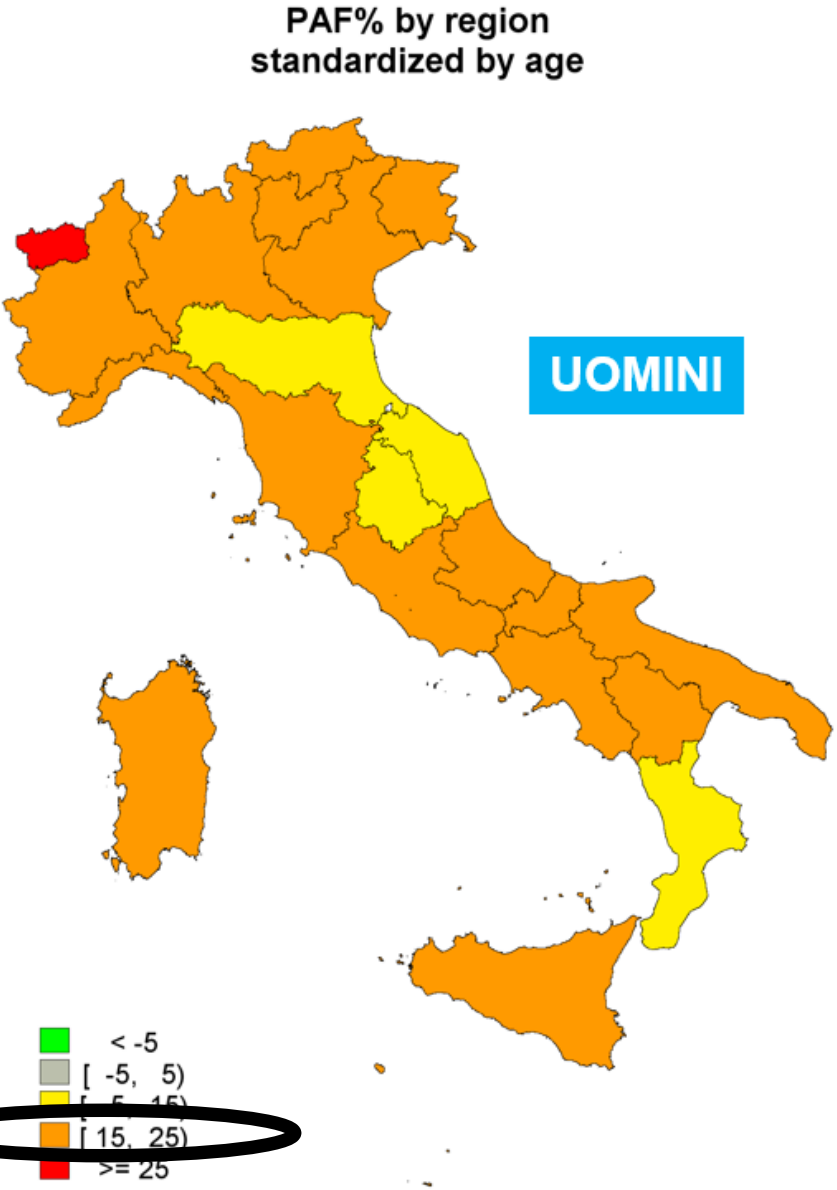
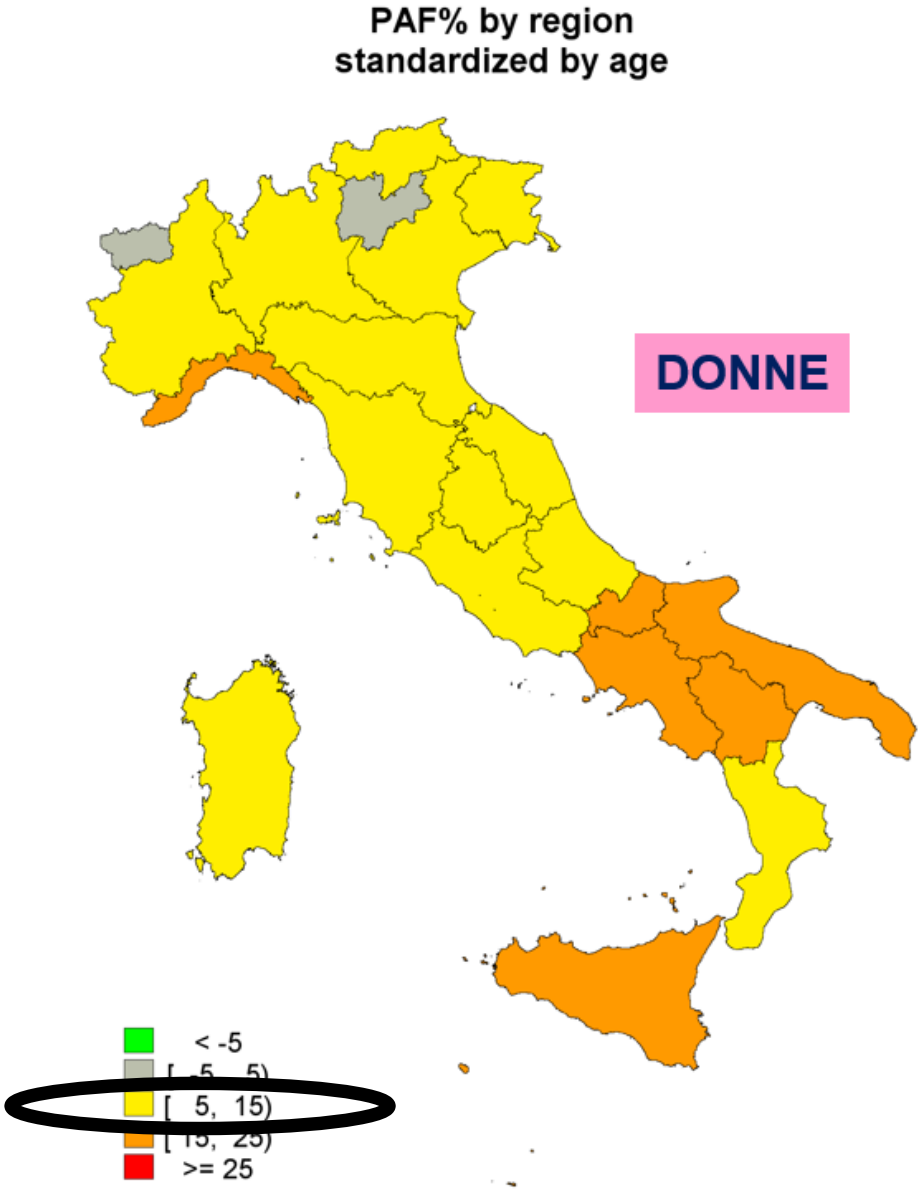


Figura 4. Speranza di vita alla nascita per livello di istruzione, area geografica di residenza e sesso. Italia, Sud e Isole, 2012-2014.
Figure 4. Life expectancy at birth by education level, geographical area, and sex. Italy, South and Islands, 2012-2014.

OF DEATHS «ATTRIBUTABLE» TO LOW EDUCATION, ITALY 2011-2014

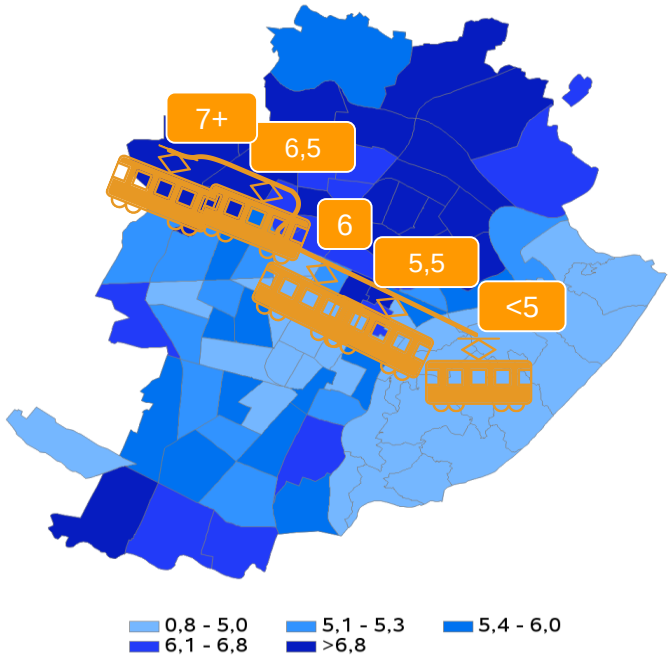




Petrelli et al., 2019

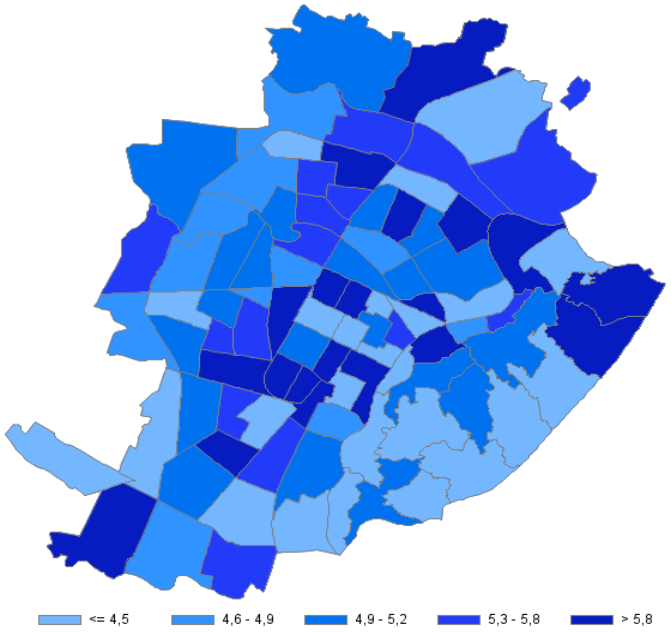
Education	
High	4,5
Middle	6,5
low	13

Prevalence % of diabetes in Turin in 2017, age adjusted



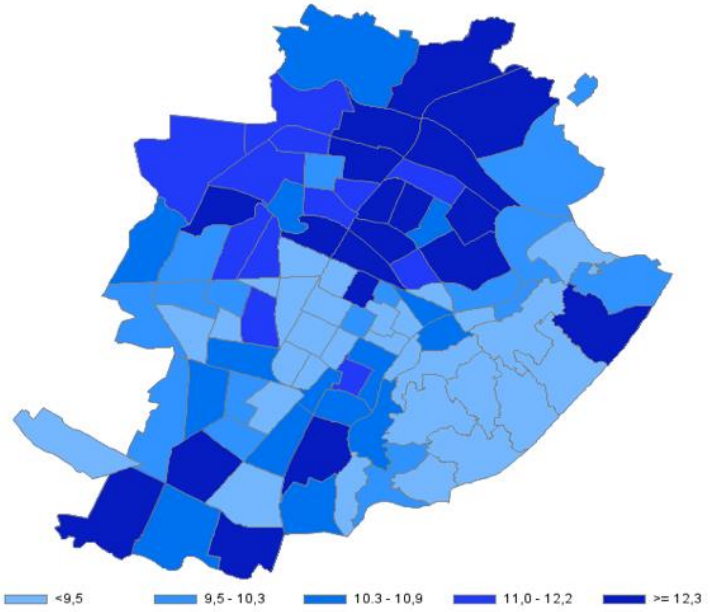
Health equity rationale for the «Piano Nazionale Cronicità»

Mortality % among diabetes patients 2016-2018 in Turin, age adjusted



Education	
High	5,1
Middle	5,1
Low	5,6

Incidence ‰ of diabetes in Turin in periodo 2016-2018, age adjusted



Education	
High	8,8
Middle	11,9
Low	15,6

Health Equity in the agenda

- Facts: health inequalities in Europe, Italy and local level
- Explanations: causality issues behind health inequalities (FEAM/ALLEA)
- Entry points for policies (WHO Europe)
- Policy response: the new European joint action (JAHEE)
- The Italian agenda

The more recent effort of assessment of evidence of causality behind health inequalities

KONINKLIJKE NEDERLANDSE
AKADEMIE VAN WETENSCHAPPEN

DISCUSSION PAPER

HEALTH INEQUALITIES
an Interdisciplinary Exploration of
Socioeconomic Position, Health and Causality

Health Inequalities

AN INTERDISCIPLINARY EXPLORATION OF SOCIOECONOMIC POSITION, HEALTH AND CAUSALITY

SYMPOSIUM REPORT
November 2018

ALLEA All European Academies
FEAM
KONINKLIJKE NEDERLANDSE AKADEMIE VAN WETENSCHAPPEN

Amsterdam, November 2018
FEAM/ALLEA Committee on Health Inequalities
Reporters: Johan Mackenbach and Jean Philippe de Jong (KNAW)

Annex 1: FEAM/ALLEA Committee on Health Inequalities

Professor Johan Mackenbach, *chair*

- Professor of Public Health, Erasmus Medical Center, Rotterdam, The Netherlands
- Royal Netherlands Academy of Arts and Sciences

Professor Giuseppe Costa

- Professor of Public health, Dept. Clinical and Biological Sciences, University of Turin, Italy

Professor Johannes Siegrist

- Senior Professor Work Stress Research, Institut für Medizinische Soziologie, Heinrich-Heine-Universität Düsseldorf, Germany

Dr. Domantas Jasilionis

- Max Planck Institute for Demographic Research, Rostock, Germany
- Center for Demographic Research, Vytautas Magnus University, Kaunas, Lithuania

Professor Alfred Spira

- Professor of Public Health and Epidemiology, Université Paris Sud, France
- French Academy of Medicine

Professor Denny Vagero

- CHESS, Centre for Health Equity Studies, Stockholm University/ Karolinska Institutet, Sweden
- Royal Swedish Academy of Sciences

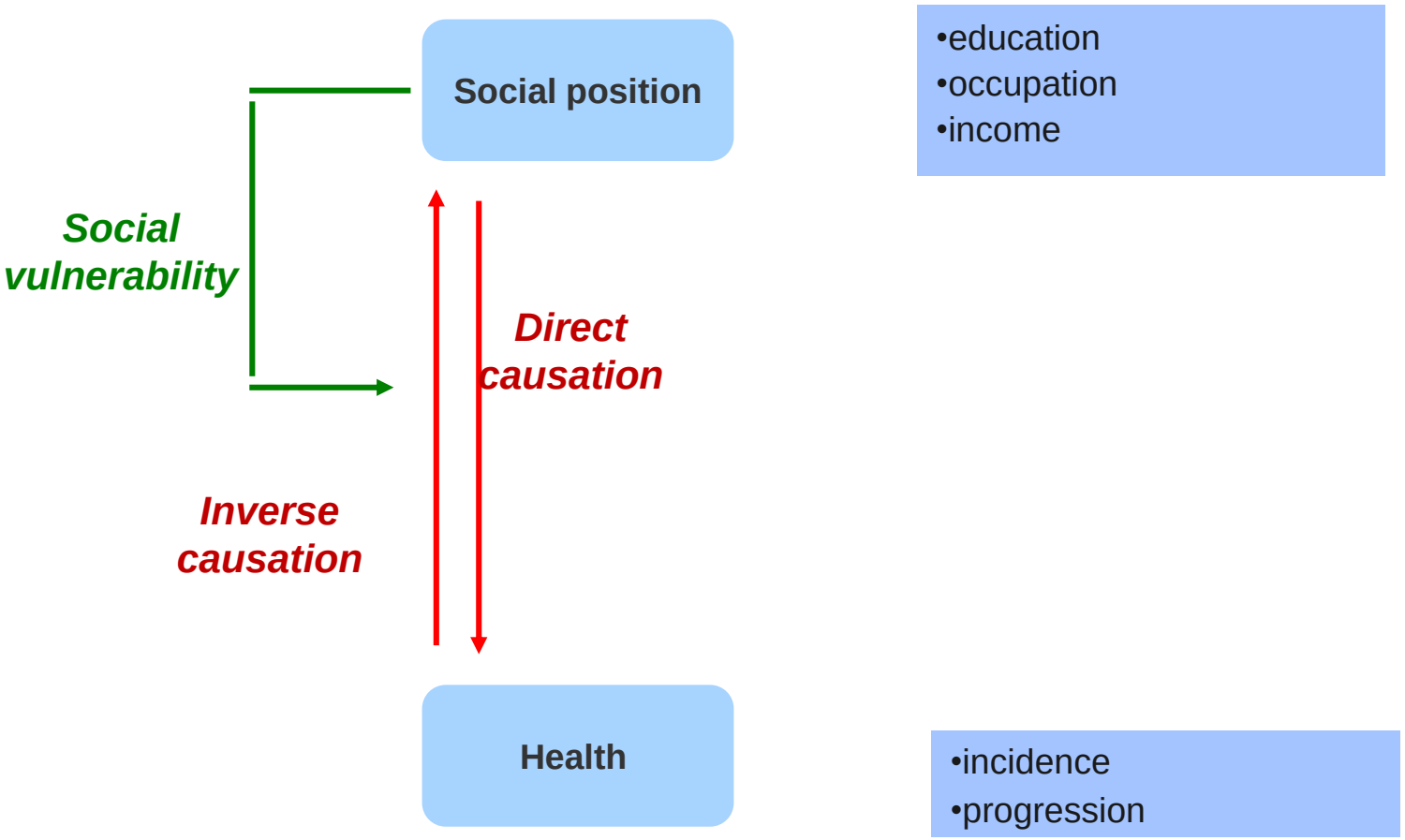
Professor Brian Nolan

- Professor of Social Policy, Institute for New Economic Thinking, Nuffield College, University of Oxford
- Royal Irish Academy

Dr. Jean Philippe de Jong, *secretary*

- Royal Netherlands Academy of Arts and Sciences

Explanatory framework: good poor evidence



- Does health inequality affect income inequality (reverse causality)? Yes.
- Does income inequality affect adult health inequality? Not proven, but there may be a stronger relationship longer-term.
- Does income inequality affect population health? No.
- Early life conditions, including parental income, do matter for child health.
- The health of the poor is more vulnerable to income shocks.
- There are stronger effects in low- and middle-income countries.

Does higher income/wealth cause better health? The answer expected from economic theory on investment and consumption benefits is yes (because the rich demand more health and can afford market prices, although they can also afford harmful behaviour), but the empirical evidence is not so clear. Because there is little scope for experimentation, quasi-experimental methods are invoked (using "natural experiments" such as German unification), together with the search for impacts of exogenous variation in wealth (e.g. lottery wins).

The economic sciences point of view
Eddy Van Doorslaer Review on income and health 2015

A major study provides additional insight since the time of the 2015 review: using Swedish data on players of the national lottery (the majority of the population in Sweden) to estimate the impact of random income shocks on adult health and child development. The results of this study of relatively permanent income shift show:

- No significant effect of wealth on mortality.
- No measurable effect on child health or development (except for increased risk of hospitalisation and decreased risk of obesity).
- A small reduction in adult use of mental health drugs.
- No signs of an effect growing with time or of stronger effect at lower initial levels of wealth.

The researchers concluded that, in affluent countries with extensive social security safety nets, causal effects of wealth are not the main source for wealth-mortality gradients nor of variations in child development. Prof van Doorslaer reinforced this with his own overall conclusion that there is no strong evidence for impact of income on health in high income countries and that the expectation of greater effects at the bottom end of income distribution was not confirmed. Thus, any contribution of wealth on health may be minor.

A natural policy experiment
Cesarini 2016

The public health point of view: M. Whitehead (Liverpool Univ.)

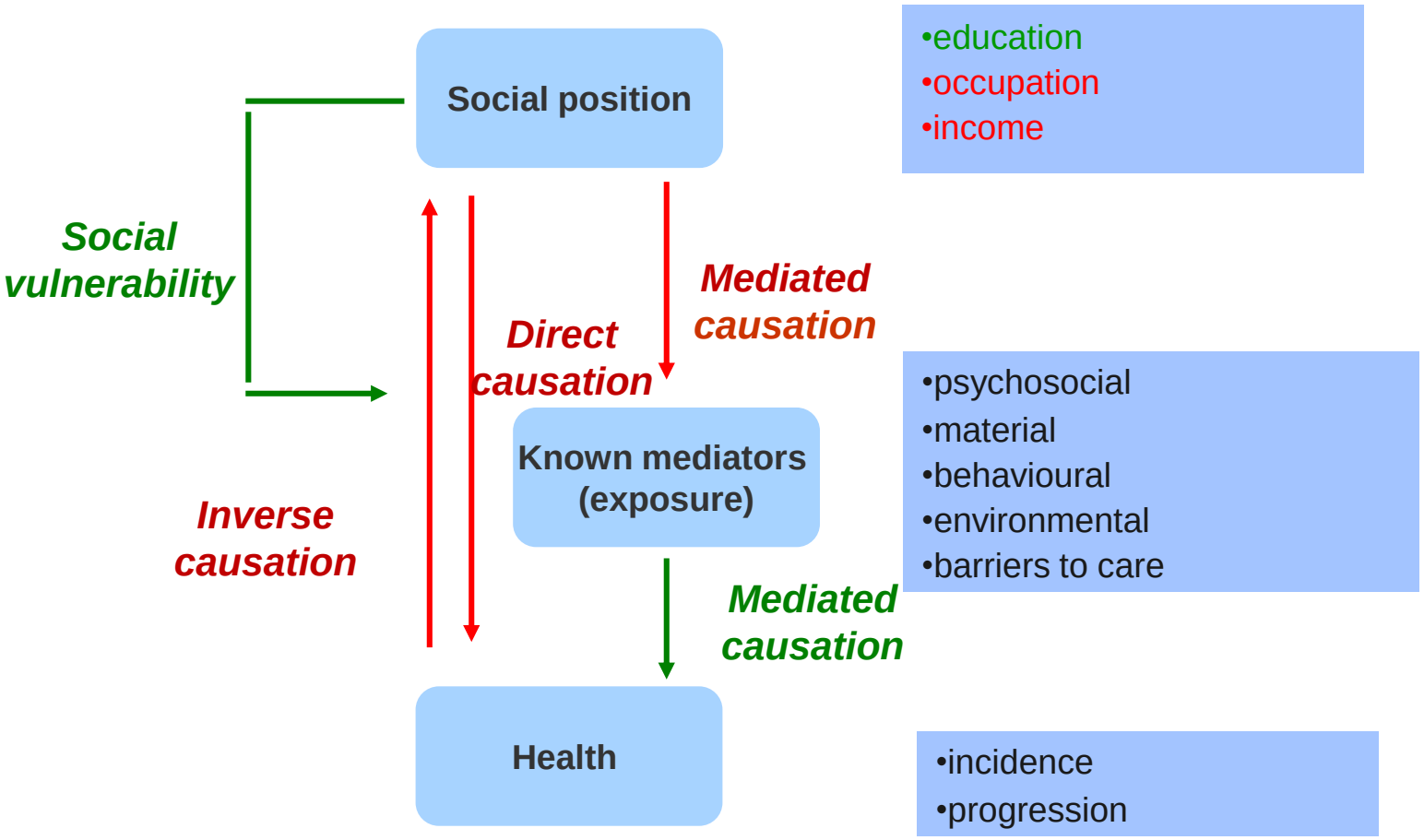
» *Child health* A systematic review in 2017 "does money affect children's outcomes?" draws on randomised clinical trials, quasi-experimental and longitudinal studies. This review concludes that income has causal effects on a wide range of outcomes including child physical health and development, cognitive and social achievement. Low income was not found to be a proxy for other factors such as education. Two potential mechanisms were proffered for the impact: (i) Investment model – via parents' ability to invest in goods and services that promote a child's healthy development; and (ii) Family stress model – low income affects parents' mental health and influences their behaviour. Recent evidence from the UK Millennium Cohort Study (2017)[7], analysing the time of first transition into income poverty, discloses increased child and maternal mental health risk (the latter influencing the former). Other work finds a dose-response relationship of poverty with child mental health risk, and longitudinal studies show that children from less advantaged backgrounds had higher risk of premature death in adulthood.

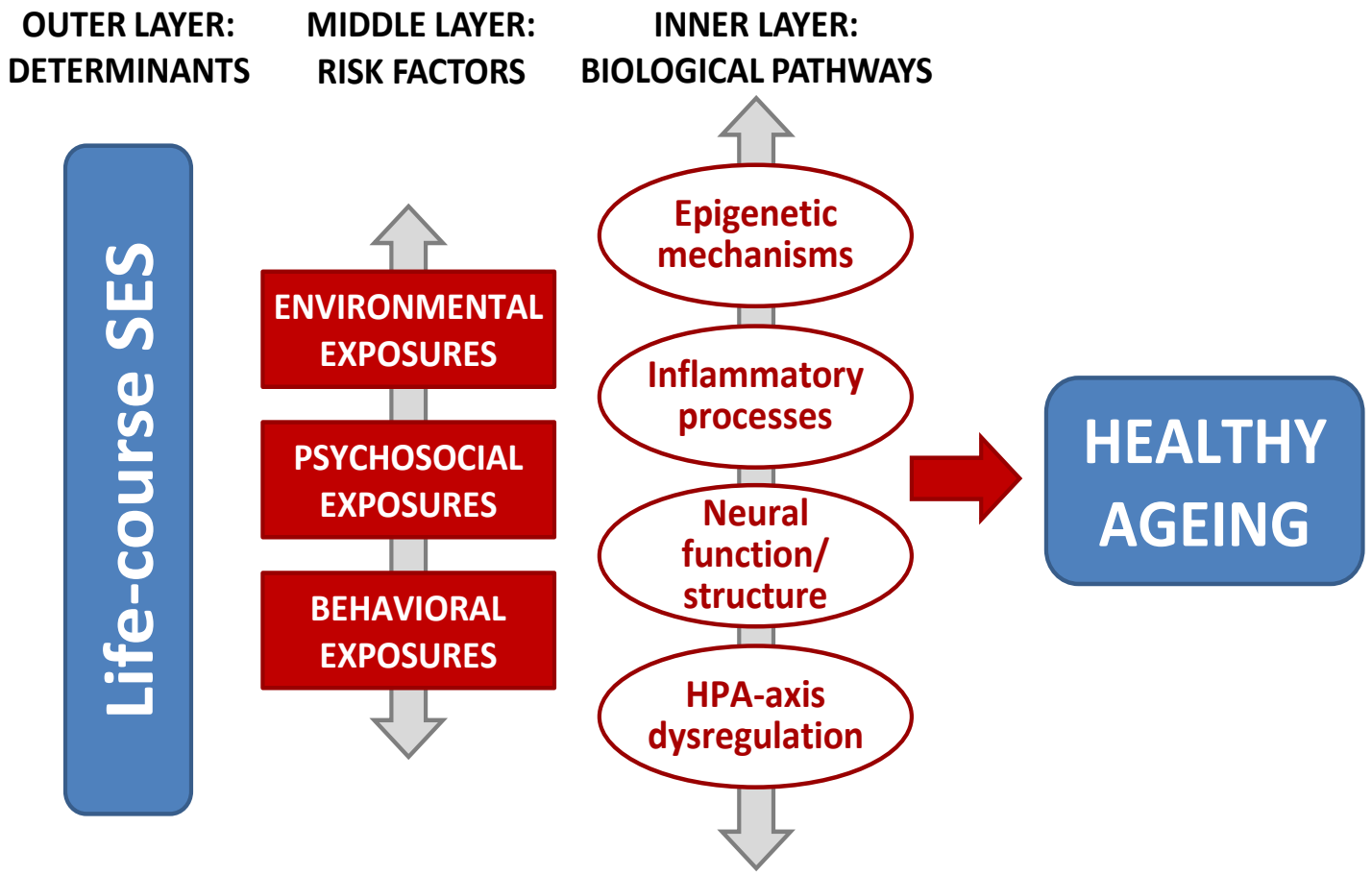
Adult health A systematic review in 2015 on "does money in adulthood affect adult outcomes?" provides strong evidence that additional resources reduce mental health problems, with the effect pronounced in lower socioeconomic groups. A recent US study on negative wealth shocks in middle-aged and older adults finds significant mental health toll and increased all-cause mortality over 20-years follow-up.

HEALTH EQUITY RATIONALE FOR THE «REDDITO DI CITTADINANZA»?

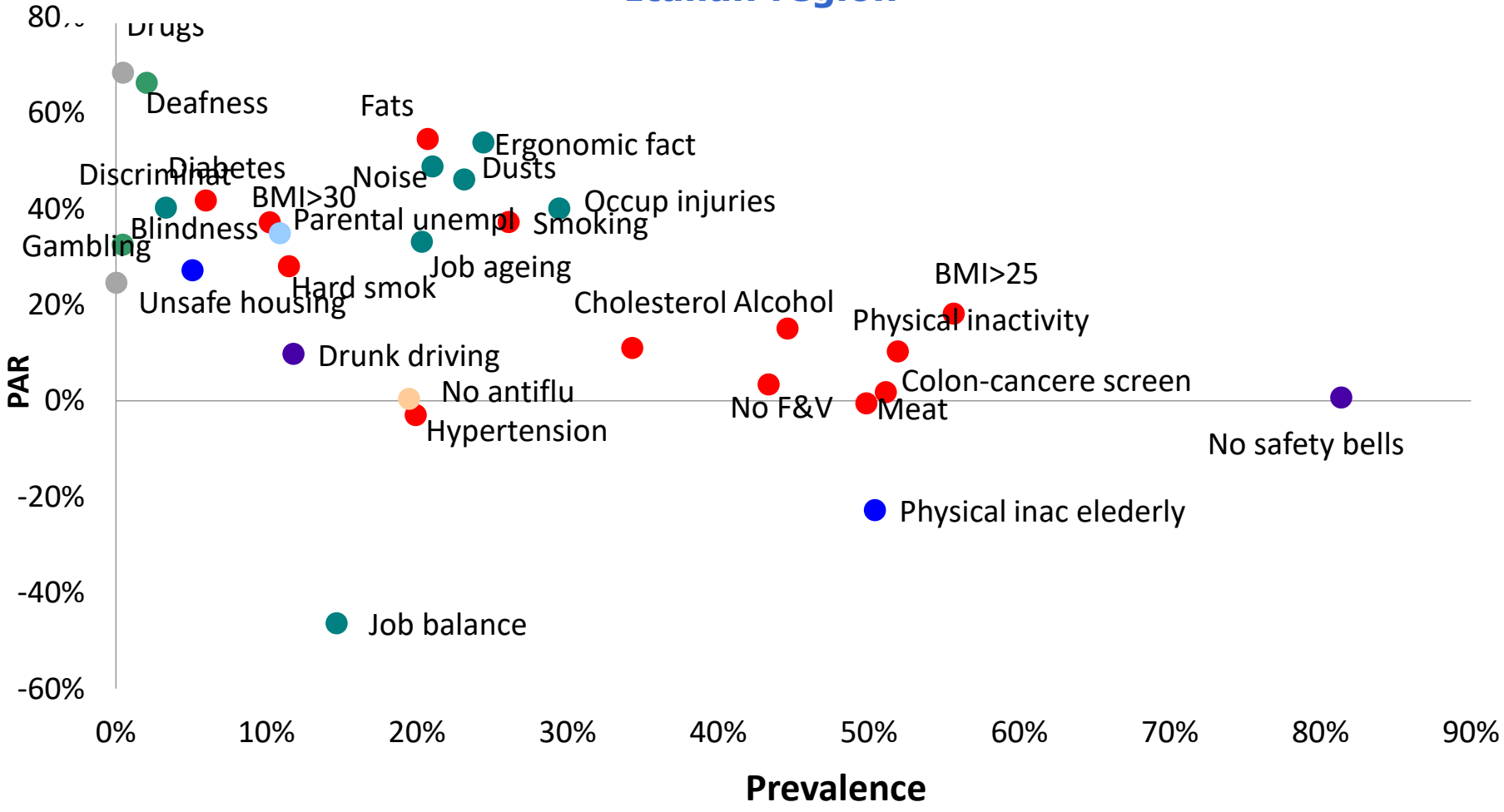
(reverse causation)? People with disability are at greater risk of living in or near poverty. But there are large differences between countries and the effect is context/policy dependent. Meta-analysis in 2015 shows that poor health in adolescence is associated with poorer education and employment in adulthood, with the evidence stronger for mental health conditions. Thus, public investment in health may improve life chances. Having to pay for health care is particularly impoverishing but there is a lack of EU evidence on this point.

Explanatory framework: good poor evidence




OUTER LAYER:
DETERMINANTS
MIDDLE LAYER:
RISK FACTORS
INNER LAYER:
BIOLOGICAL PATHWAYS
Life-course SES
ENVIRONMENTAL EXPOSURES
PSYCHOSOCIAL EXPOSURES
BEHAVIORAL EXPOSURES
Epigenetic mechanisms
Inflammatory processes
Neural function/ structure
HPA-axis dysregulation
HEALTHY AGEING

Prevalence of 38 risk factors targeted by the National Preventive Plan and fraction exposure «attributable» to low education in one Italian region



Silvestrini 2016

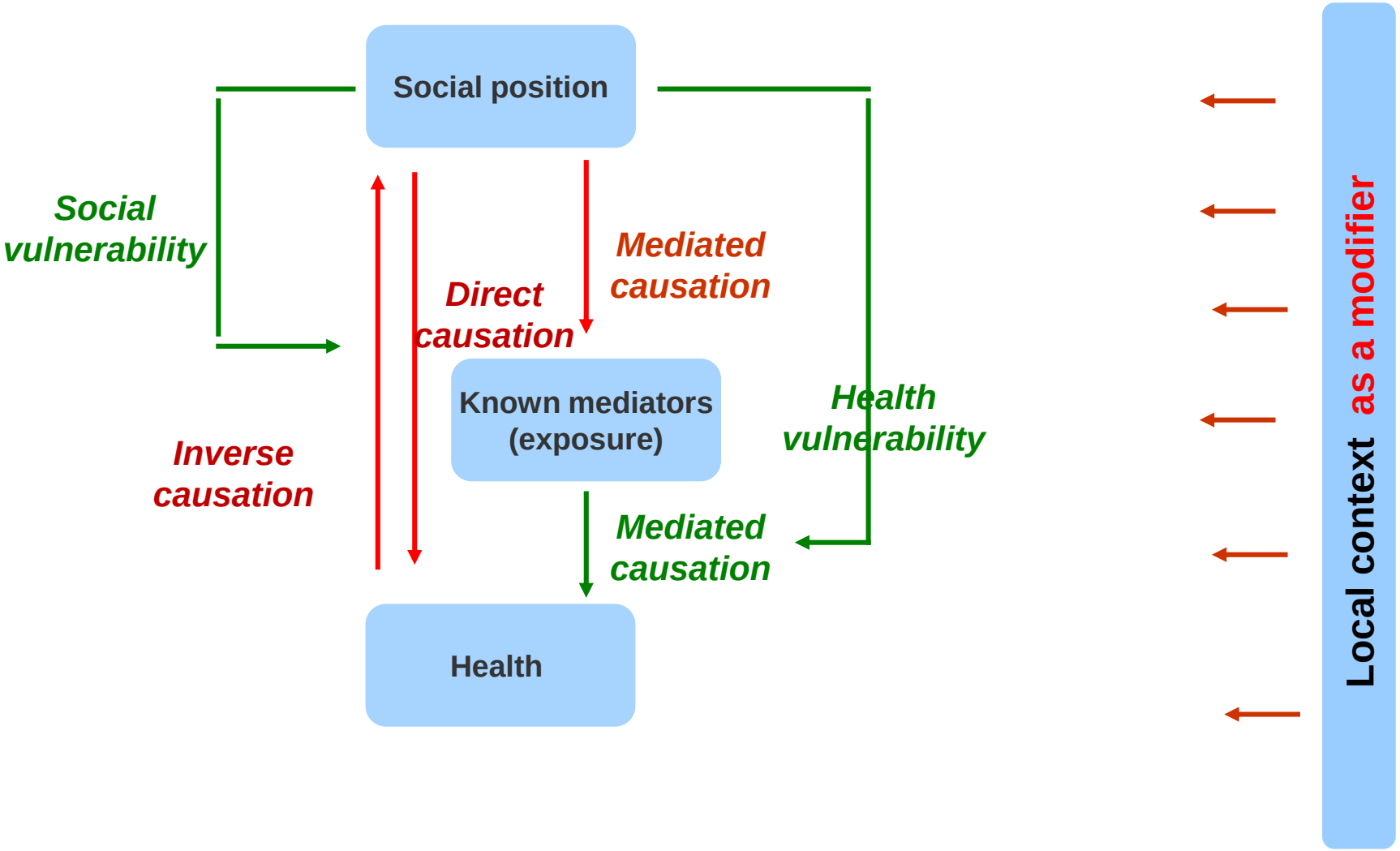
Health equity rationale for the «Piano Nazionale di Prevenzione»

Contribution of educational inequalities in exposure to risk factors to the mortality «attributable» to low education in Italy 2011-2014

Uomini	Fumo	Alcol	BMI	AF	F&V
Piemonte	15.8%	1.6%	9.2%	21.8%	0.6%
Liguria	23.8%	1.1%	8.4%	15.7%	3.0%
Lombardia	8.0%	1.7%	9.8%	18.5%	1.5%
Trentino	5.1%	4.9%	4.1%	11.7%	0.9%
Veneto	4.3%	1.7%	7.4%	14.1%	0.5%
Friuli	5.6%	2.5%	7.1%	14.1%	2.4%
Emilia	4.1%	0.4%	1.6%	9.2%	0.9%
Marche	5.2%	3.6%	7.5%	18.5%	1.5%
Toscana	11.7%	2.9%	9.5%	12.8%	1.1%
Umbria	7.5%	11.8%	8.0%	17.3%	1.5%
Lazio	15.0%	4.3%	4.0%	24.8%	3.9%
Campania	21.2%	6.0%	8.6%	17.5%	2.3%
Abruzzo	11.5%	2.6%	6.7%	22.6%	2.7%
Molise	12.1%	4.9%	7.0%	25.6%	2.6%
Puglia	12.0%	6.0%	4.5%	17.6%	1.0%
Basilicata	7.4%	13.2%	5.5%	22.3%	1.5%
Calabria	10.2%	7.3%	8.6%	19.8%	1.6%
Sicilia	11.3%	2.6%	4.7%	22.1%	1.7%
Sardegna	7.6%	7.0%	4.1%	18.8%	3.3%

Donne	Fumo	Alcol	BMI	AF	F&V
Piemonte	5.5%	1.0%	22.2%	30.3%	0.6%
Liguria	2.6%	3.8%	22.5%	28.2%	1.5%
Lombardia	2.9%	0.6%	19.2%	31.3%	3.6%
Trentino	2.1%	0.7%	11.6%	9.9%	2.5%
Veneto	0.4%	2.4%	10.2%	8.9%	0.3%
Friuli	5.7%	6.0%	12.2%	16.6%	1.3%
Emilia	1.5%	1.1%	26.3%	29.4%	1.2%
Marche	1.1%	0.1%	18.5%	11.2%	0.9%
Toscana	1.2%	0.0%	14.5%	15.1%	1.5%
Umbria	1.0%	2.0%	14.0%	13.2%	0.9%
Lazio	1.1%	0.5%	13.5%	24.1%	3.1%
Campania	0.4%	0.3%	13.0%	13.5%	1.1%
Abruzzo	0.5%	0.2%	18.9%	12.8%	0.8%
Molise	0.9%	1.6%	18.1%	13.1%	1.8%
Puglia	0.1%	0.8%	12.9%	13.9%	1.2%
Basilicata	0.1%	1.4%	10.0%	18.1%	2.1%
Calabria	0.5%	0.9%	14.6%	16.1%	2.7%
Sicilia	0.4%	0.9%	14.0%	11.5%	0.8%
Sardegna	1.9%	1.1%	13.9%	20.7%	1.3%

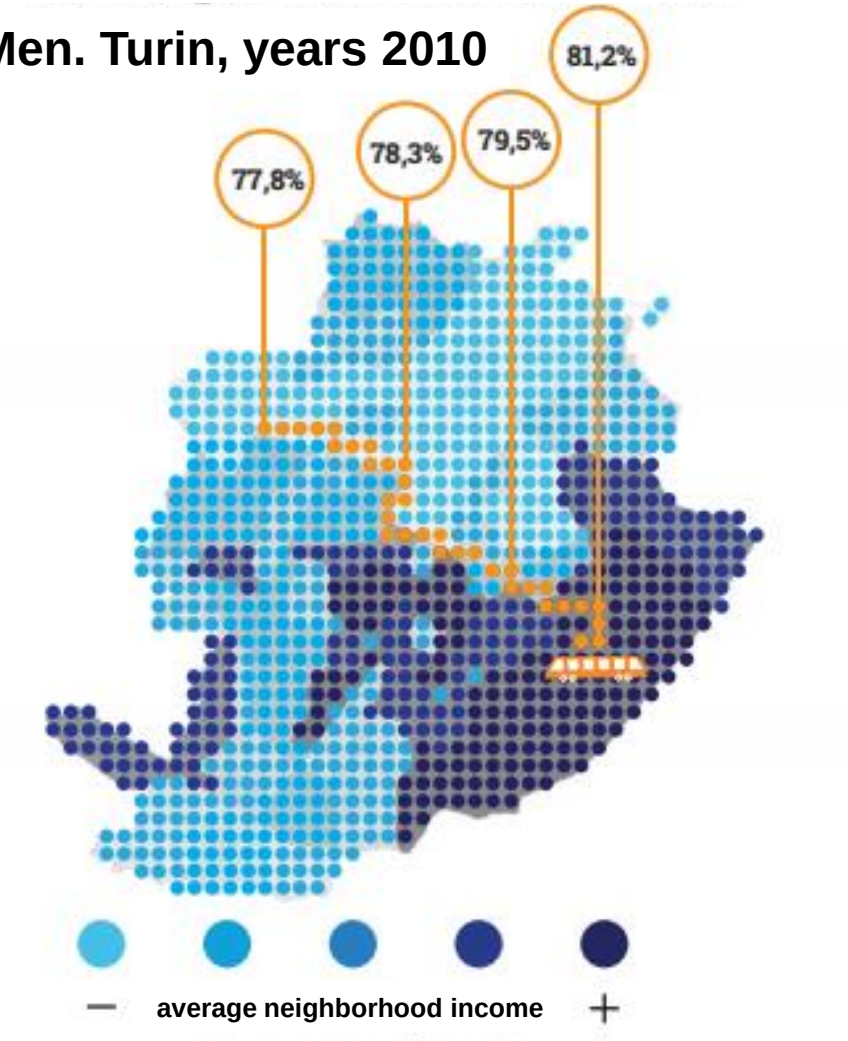
Explanatory framework: good poor evidence



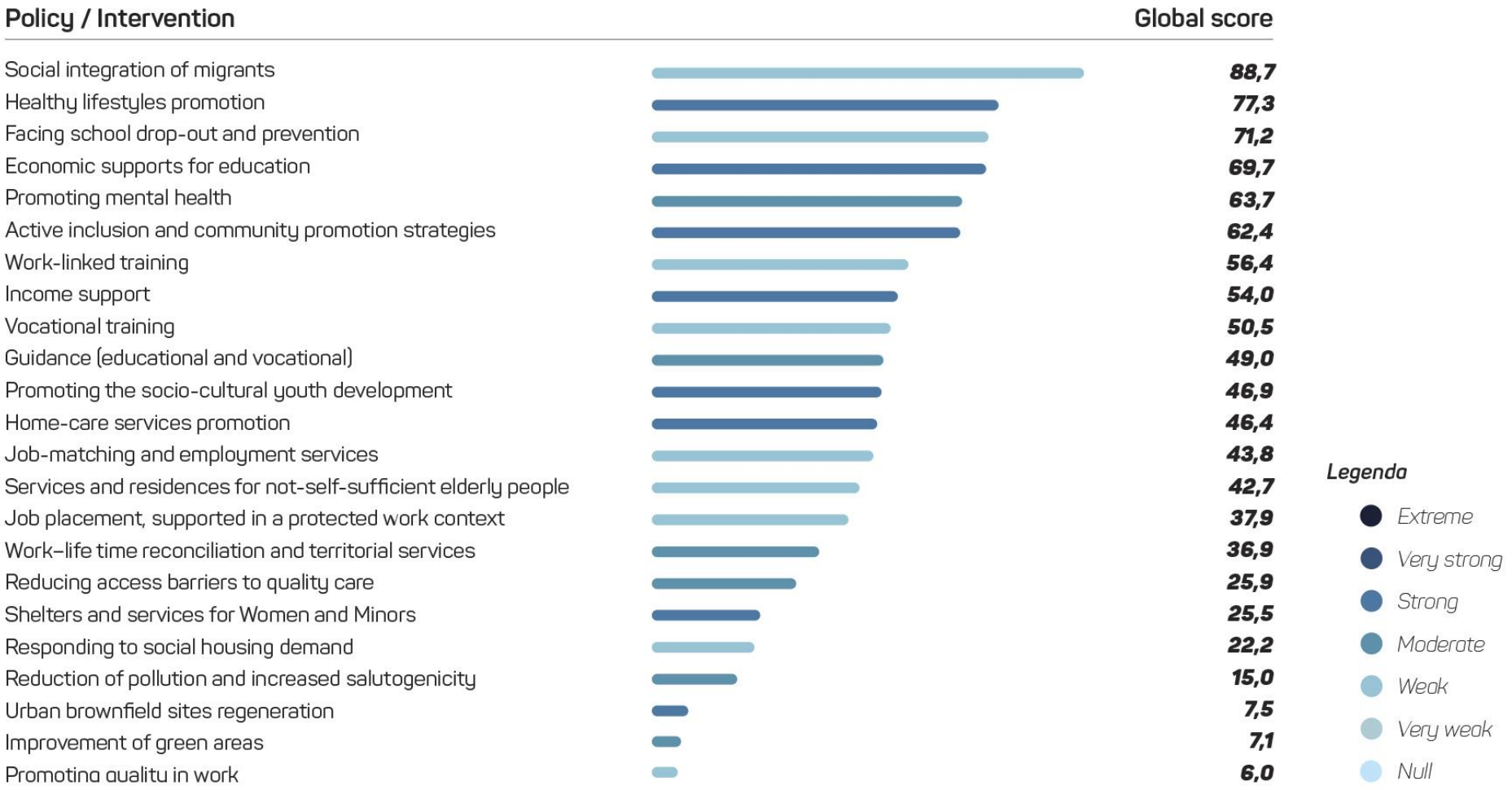
AT THE LOCAL LEVEL FACTS/DATA (EQUITY LENS) STARTER OF HEALTH EQUITY AUDIT PROCESS

Life expectancy at birth by area of residence

Men. Turin, years 2010



Ranking of policies according to weight on social inequalities in premature mortality.



Health equity rationale for the «welfare generating community initiatives»

The more recent effort of assessment of evidence of causality behind health inequalities

FEAM/ALLEA panel

second phase

THREE ADDITIONAL CONSENSUS WORKSHOPS

Paris January 2020 CAUSATION

Berlin March 2020 MEDIATION

Genua/Bologna May 2020 POLICY RESPONSE

Final conference Amsterdam Autumn 2020

KONINKLIJKE N
AKADEMIE VAN W

DISCUSSION
HEALTH INEQU
an Interdisciplinary
Socioeconomic Position, H

Health Inequalities
AN INTERDISCIPLINARY EXPLA
SOCIOECONOMIC POSITION H
CAUSALITY
SYMPOSIUM REPORT
November 2018

Amsterdam, November 2018
FEAM/ALLEA Committee on Health Inequalities
Reporters: Johan Mackenbach and Jean Philippe de Jong (Ki

ALLEA All European Academies

FEAM

KON AKADE

Annex 1: FEAM/ALLEA Committee on Health Inequalities

Professor Johan Mackenbach, *chair*

- Professor of Public Health, Erasmus Medical Center, Rotterdam, The Netherlands
- Royal Netherlands Academy of Arts and Sciences

Professor Giuseppe Costa

- Professor of Public Health, Department of Clinical and Biological Sciences, University of Turin, Italy

Professor Johannes Siegrist

- Senior Professor Work Stress Research, Institut für Medizinische Soziologie, Heinrich-Heine-Universität Düsseldorf, Germany

Professor Ioannis Kasthonis

- Max Planck Institute for Demographic Research, Rostock, Germany
- Center for Demographic Research, Vytautas Magnus University, Kaunas, Lithuania

Professor Alfred Spira

- Professor of Public Health and Epidemiology, Université Paris Sud, France
- French Academy of Medicine

Professor Johan Fritzell

- CHESS, Centre for Health Equity Studies, Stockholm University/ Karolinska Institutet, Sweden
- Royal Swedish Academy of Sciences

Professor Brian Nolan

- Professor of Social Policy, Institute for New Economic Thinking, Nuffield College, University of Oxford
- Royal Irish Academy

Dr. Jean Philippe de Jong, *secretary*

- Royal Netherlands Academy of Arts and Sciences

Health Equity in the agenda

- Facts: health inequalities in Europe, Italy and local level
- Explanations: causality issues behind health inequalities (FEAM/ALLEA)
- Entry points for policies (WHO Europe)
- Policy response: the new European joint action (JAHEE)
- The Italian agenda

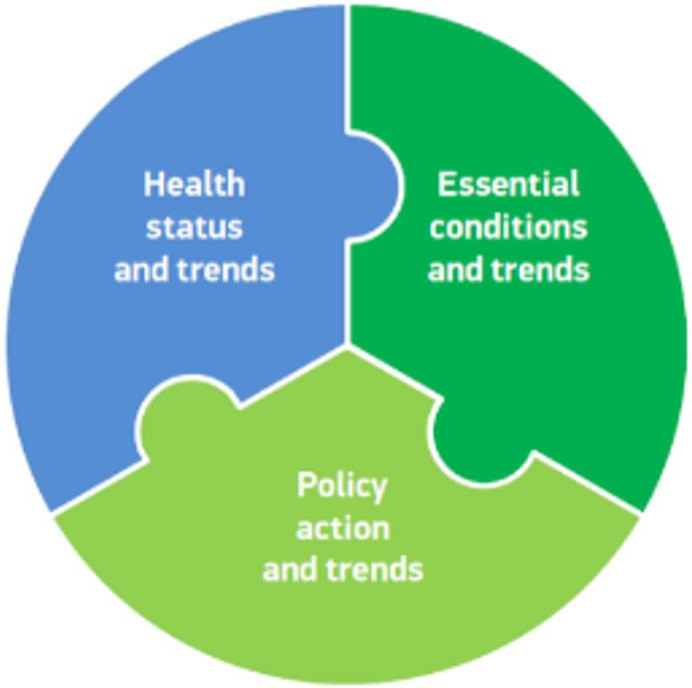
#EquityinHealth

World Health Organization
Europe

How will the Health Equity Status Report Initiative (HESRi) help us?

The Health Equity Status Report Initiative gives a full picture of trends in the **status, conditions needed,** and **effective policy** actions for health equity.

Country-specific data helps policy-makers to tailor their responses and investments in health equity.



#EquityinHealth

World Health Organization
Europe

5 conditions have a significant impact on health inequities in the WHO European Region

Health & Health Services

Health & Income Security and Social Protection

Health & Living Conditions

Health & Social and Human Capital

Health & Employment and Working Conditions

#EquityinHealth

World Health Organization
REGIONAL OFFICE FOR Europe

On average, 29% of the inequity in self-reported health between the most and least affluent 20% in a country is due to systemic differences in the **quality, affordability** and **safety of living conditions and local neighbourhoods.**

Breaking down subfactors of the gap explained by living conditions

- Housing deprivation
- Fuel deprivation
- Lack of green space
- Unsafe neighborhood
- Overcrowding
- Low air quality
- Food deprivation

Subfactors of the health gap explained by living conditions (%)

This two-year pilot project aims to invest in people and improve their immediate surroundings by providing a guaranteed minimum income. It focuses activities in the Eix Besòs area of Barcelona, which is characterized by lower average income, high unemployment and significant school drop-out rates.

#EquityinHealth

Health Equity in the agenda

- Facts: health inequalities in Europe, Italy and local level
- Explanations: causality issues behind health inequalities (FEAM/ALLEA)
- Entry points for policies (WHO Europe)
- Policy response: the new European joint action (JAHEE)
- The Italian agenda

JAHEE

JOINT ACTION HEALTH EQUITY EUROPE!

Italy is leading JAHEE
24 EU member states
willing to advance policy response in reducing health inequalities

Giuseppe Costa, Michele Marra and Angelica Valz Gris University of Torino and Piedmont Region
on behalf of the Italian coordinating team
ISS, AgeNas, INMP, Piedmont Region, Ministry of Health

Co-funded by the Health Program
of the European Union - CHAFEA

TWO IMPORTANT GAPS
TO BE FILLED IN BY JOINT EUROPEAN EFFORTS

HEALTH INEQUALITIES ARE STILL THE LARGER RESERVOIR OF HEALTH BENEFITS THAT COULD BE GAINED IN EVERY EUROPEAN COUNTRY

-large risks attributable to social determinants of health
-adequate evidence on mechanisms generating health inequalities
-reasonable evidence on effective solutions and good practices

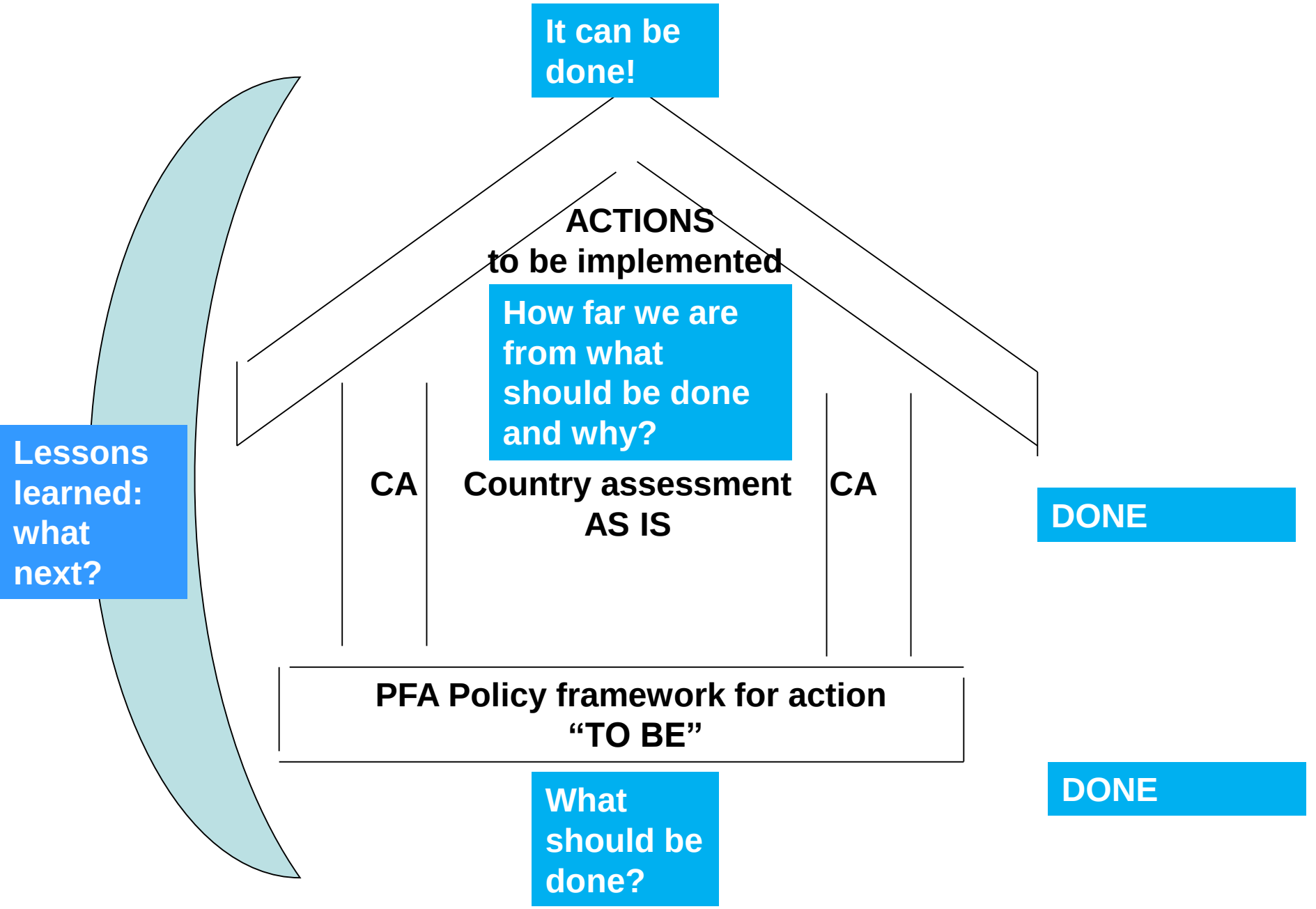
EU review 2013

LARGE HETEROGENEITY IN POLICY RESPONSE ACROSS EUROPE

-lack of integration btw more and less experienced countries
-lack of integration btw EC inputs and member states

Two main goals of JAHEE
- concrete actions (ACTION)
- better cooperation (JOINT)

JAHEE


It can be done!
ACTIONS to be implemented
How far we are from what should be done and why?
Lessons learned: what next?
CA
Country assessment AS IS
CA
DONE
PFA Policy framework for action "TO BE"
DONE
What should be done?

JAHEE frameworks in practice

IF	Are health inequalities our concern?
WHAT	What actions should be done?
HOW	How to make them happen?

JAHEE frameworks in practice

WP5
Monitoring

IF

Are health inequalities our concern?

WITHIN PROMISING SETTINGS
WP6 Healthy Environments
WP7 Immigration
WP8 Health system
(WP9 Health in All Policies)

WHAT

What actions should be done?

WP9 Governance in HiAP
(WP6 Governance in municipality setting)

HOW

How to make them happen?

JAHEE frameworks in practice

WP5 Monitoring

IF

Are health inequalities our concern?

WITHIN PROMISING SETTINGS
WP6 Healthy Environments
WP7 Immigration
WP8 Health System
(WP9 Health in All Policies)

WHAT

What actions should be done?

WP4 Harmonization of PFA for better integration of results into policies and sustainability.

WP9 Governance in HiAP (WP6 Governance in municipality setting)

HOW

How to make them happen?

WP4
Governance of health inequalities in Europe

1. **Legal framework, strategies and policies to tackle HI/SDH** (approaches, vertical level, targets, on HI)
2. **Sustained policy commitment** (agenda, mechanisms to protect commitment, funding)
3. **Role and equity of the health system** (access, health care, prevention, skills and resources on HI, advocacy)
4. **Accountability on HI and on the SDH** (who is responsible and how)
5. **Active intersectoral working and health in all policies** (institutions & experiences)
6. **Monitoring of system performance and evaluation** (tools and report mechanisms on progress)
7. **Communication, public engagement and community participation** mechanisms which promote involvement of local people and stakeh.in problem definition and solution develop.

Overall assessment of governance of HI

Bulgaria Croatia Estonia Grecia Romania	Belgium Czech Republic France Germany Italy Netherlands Portugal Serbia Slovenia Spain	Finland Norway Wales

General movement towards equity

Totally, 168 policies collected.

A clear inclusion of health and health inequalities is reported

	N	Directly & explicitly aimed at tackling HI	HI are one of the objectives	HI are one of the outcomes	**HI are considered**	Indirectly on SDH	Not considered
equity from the start	24	25.0%	29.2%	4.2%	**58.3%**	33.3%	8.3%
education	18	22.2%	5.6%	16.7%	**44.4%**	50.0%	5.6%
employment	19	10.5%	21.1%	15.8%	**47.4%**	42.1%	10.5%
living conditions	23	21.7%	17.4%	8.7%	**47.8%**	34.8%	17.4%
social protection	26	23.1%	0.0%	23.1%	**46.2%**	38.5%	15.4%
empowerment	15	33.3%	6.7%	13.3%	**53.3%**	26.7%	20.0%
gender	19	26.3%	0.0%	5.3%	**31.6%**	57.9%	10.5%
immigrant	20	20.0%	10.0%	10.0%	**40.0%**	35.0%	25.0%

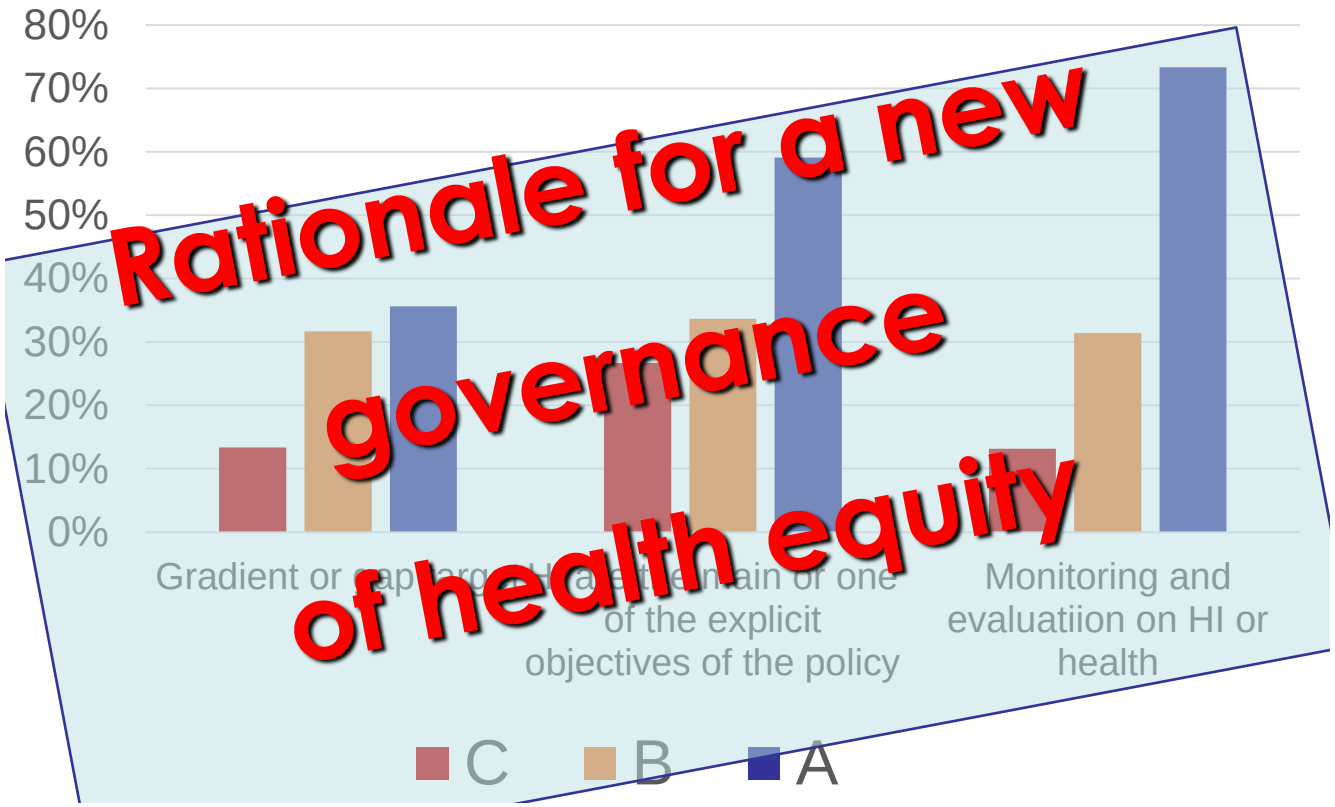
Main characteristics of policies on SDH

A temporal comparison is difficult but:

1. Cross sectoral work has increased (51,4% to 65,6%) with an increase also in the average number of ministries involved
2. Increase also in the variety of ministries acting (for example policies acting on the contexts as transports, urban planning and environment from 24,2% to 34%)
3. Dimensions of vulnerability have increased (more than 2 from 34% to 50%)
4. Policies not evaluated or monitored or without equity assessments have decreased (from 52,2% to 40%)
5. Approaches on the social gradient seem to have increased (from 27% to 37%)
6. The same happens for policies directly aimed at tackling health inequalities

Is there a relation among governance of HI and policies on SDH?

It seems to be associated with the advancement of policies….



Rationale for a new governance of health equity

The more the governance of HI is advanced the more policies and actions acting on the SDH are equity oriented

SUM UP OF POLICY IMPLICATIONS

PROVISIONAL FINAL RECOMMENDATIONS

IF

- Equity lens when/wherever possible
  - Data collection covariates (social, migrat.)
  - Valid equity indicators (accountability)

WHAT

- Health equity in HiAP/SDG (on SDH/rights)
- Health equity promotion on mediators
- Health equity management in health systems
  - For priority setting/alloc. proport. universal.
  - For tailoring interventions: vulnerables

HOW

- Supporting structure and practice for intersectoral H(E)iAP
- Particularly in municipal «umbrella» setting
- Multilevel coherence

Health Equity in the agenda

- Facts: health inequalities in Europe, Italy and local level
- Explanations: causality issues behind health inequalities (FEAM/ALLEA)
- Entry points for policies (WHO Europe)
- Policy response: the new European joint action (JAHEE)
- The Italian agenda

Examples of implementation actions in one country (Italy)

WP5 monitoring: **AN INDIVIDUAL SOCIAL COVARIATE IN NHS REGISTRIES FOR SYSTEMATIC HEALTH EQUITY AUDIT**

WP6 healthy living environments: **HEA IN THE NEW NATIONAL PREVENTIVE STRATEGY (CAPACITY BUILDING)**

WP7 immigration: **CAPACITY BUILDING**

WP8 health systems: **LEGAL DUTY OF EQUITY IN THE MECHANISM OF ACCOUNTABILITY OF THE NHS, HEA IN NHS AND EQUITY MANAGEMENT**

WP9 governance/HiAP: **INTERMINISTERIAL TASK FORCE FOR HEALTH EQUITY IN ALL POLICIES (MINIMUM BASIC INCOME AND RETIREMENT AGE?)**

FOR MORE INFORMATION

FEAM (causality)

https://www.feam.eu/wp-content/uploads/Health_Inequalities_Symposium_ReportFINAL.pdf

LIFEPATH (biological mechanisms)

https://lifepath/project.eu/

WHO (entry points)

http://www.euro.who.int/en/HealthEquityStatusReport2019

JAHEE (policies)

https://jahee.iss.it

Chi lo sa se i tempi migliori lo sanno che li sto aspettando?

Disuguaglianze di salute

Ridurre le disuguaglianze con azioni di contrasto sui determinanti sociali

http://www.disuguaglianzedisalute.it/