TRIANGULATE HEALTH

SCIENCE • POLICY • ECONOMICS

Scoping review of European studies related to health systems and the economy of well-being

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Abbreviations

World Health Organization	**WHO**
Universal Well-being Economy Initiative	**U-WE**
Organization for Economic Cooperation and Development	**OECD**
European Union	**EU**
European Public Health Alliance	**EPHA**
Preferred Reporting Items for Systematic Reviews and Meta-Analyses Scoping Review	**PRISMA- ScR**
Virtual reality	**VR**
Quality-adjusted life years	**QALY**
Artificial Intelligence	**AI**
Universal health coverage	**UHC**

Tables and figures

Abstract

Background. The imbalanced levels of well-being across the EU have been linked to significant economic losses. To strengthen the case for a well-being economy, the World Health Organization (WHO) and the Organization for Economic Cooperation and Development (OECD) recommend placing people's well-being, health and development at the top of the policy agenda (1,2). As a result, it is expected that economic growth and improved well-being support each other, resulting in improved living standards, reduced inequities and sustainable long-term economic developments over time.

Objective. The objective of this scoping review was to understand what is known about health as a driver for a well-being economy and to identify opportunities for engaging European policy makers in well-being economy processes.

Methodology. Using the Arksey and O'Malley scoping review framework as a guide, a search strategy was designed and informed by expert interviews. A PubMed and grey literature search screened for specific pillars of a well-being economy as advised by the expert interviews. These pillars were: 1) Access to healthcare, 2) Prevention and community development, and 3) Socially considerate procurement of health.

Results. A total of 34 studies were included in the review. Well-being economy research was mostly a product of Northern European countries. Only one country in Eastern Europe (Poland) was retrieved in our search. Twenty-three well-being economy interventions were examined. Nine studies focussed on accessibility of healthcare, 14 studies were found on prevention and community development, nine studies on socially informed procurement of health, and two studies touched on all three themes. Recommendations for further research were extracted from the studies with European policy makers in mind.

Discussion. Health as a driver for a well-being economy is an emerging concept which is largely practiced in Northern Europe. Promoting well-being alone features as a central concept to many health and social care studies, but it remains fairly novel to associate well-being with the economy. Interventions aiming to improve citizens mental health were mentioned in the most studies followed by support for carers and interventions aiming to improve access to care. An increasing trend in the number of publications discussing well-being economy in the last three years with a doubling of studies between 2021 and 2022 were noted. Practicing a well-being economy requires a shift in mindset embedded in prevention. This scoping review highlights some research and policy opportunities where further work is required to better advise the healthcare ecosystem how best to adapt.

1. Introduction

Background

The World Health Organization (WHO) launched the Universal Well-being Economy Initiative (U-WE) in 2022 which aims to inspire institutions to invest in practices focused on health, the economy, society, and the environment to achieve well-being for the WHO European region (1). Countering growing inequalities in the pan-European region is the primary aim of a well-being economy. The European Organization for Economic Cooperation and Development (OECD) suggests redefining how societal progress is measured. Instead of focussing on traditional measures such as gross domestic product (GDP), the OECD proposes people-focussed, rather than economy focussed indices. As such, well-being is achieved only when planetary, human, economic and social capital are preserved harmoniously.

A well-being economy strives to reduce inequalities in Europe that are seen both across and within countries. For example, inequalities in health can be seen through variations in life expectancy across Europe. The highest life expectancy is seen in countries such as Spain and Italy and the lowest in Latvia, Hungary, and the Slovak Republic (2). Economic inequalities can be observed within countries through rising income inequality between rich households and low- and middle- income households (3). Health and income inequalities can result in negative well-being and an economic cost to society. For example, in 2017, well-being imbalances across the EU-28 were linked to increased work-related illnesses and injuries and economic losses of around 476 billion euros (2). Mental ill-health reportedly cost the EU over 600 billion euros in 2015 (2). Furthermore, the effects of ill health stretch beyond the individual to the family, as loved ones often step in to provide informal care, reduce their work hours and thus also generate economic losses (4). The quality of the environment also impacts well-being (5). The World Happiness Report stated that being exposed to green, natural environments improves mental well-being, reduces stress and increases positive emotions (6). In the same way deteriorating environmental conditions can cause stress and anxiety. In the Gallup World Poll, an internationally representative survey conducted annually in more than 160 countries, 70% of respondents reported being very concerned about the consequences of climate change (6,7).

EU-28: Austria, Belgium, Bulgaria, Croatia, Cyprus, Czechia, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden, and the United Kingdom

2. Objectives

The European Public Health Alliance (EPHA) Strategic Plan 2021-2025, and the EU4Health programme 2021-2027, both place health in a prominent position in the policy hierarchy. Despite this, achieving the desired long-term health goals faces some of the most complex, global challenges (8,9).

The WHO noted healthy societies and well-being economies are a continuum (2) and as such tangible strategies for nations to promote well-being economies are needed. Four pillars support a well-being economy, namely, planetary, human, social, and economic. Linking all four is policy and governance. Due to the expansive scope of this well-being economy framework, a scoping review was conducted focussing on three key elements essential to a well-being economy. These elements were: 1) Access to healthcare, 2) Prevention and community development, and 3) Social considerate procurement. These elements are connected to the four well-being pillars. The aim of the scoping review was to:

"Understand what is known about health as a driver for a well-being economy and to identify opportunities for engaging European policy makers in well-being economy processes."

The objectives of the scoping review were to:

1. Analyse all relevant studies and available literature retrieved from a pragmatic literature search.
2. Identify key documents and associated recommendations related to health system strengthening and health investment towards a well-being economy.
3. Identify how influential actors invest in health in the European Union to improve well-being economy.
4. Identify opportunities to employ well-being economy approaches in European policies and areas for future research.

3. Methodology

This scoping review used the five-stem review process outlined in the Arksey and O'Malley framework (10). The steps included in the review process are the following: 1) identifying the research question; 2) identifying and selecting relevant studies; 3) study selection; 4) data extraction and charting the data; and 5) collating, summarising and reporting of the data. The Preferred Reporting Items for Systematic Reviews and Meta-Analyses Scoping Review (PRISMA-ScR) checklist guided the reporting of this study. Interviews with well-being economy experts were also conducted to help refine the search strategy. Three key experts were consulted who provided perspectives on focal points of the well-being economy worth exploring in this scoping review. A summary of the points raised in these interviews can be found in the Appendix.

Identifying the research question

The research question for this study was defined as: 'What is known about health as a key driver in well-being economy and its impact within the European Union?' We used the following definition for well-being economy from the World Health Organisation (WHO): "a goal which secures well-being for all people today and for future generations and includes the well-being of the planet as an overarching goal (11)." The well-being economy approach directs its interventions towards improving equity, inclusion, and sustainability.

Identifying and selecting relevant studies

We searched the PubMed database for scientific studies and grey literature searches were conducted in Google Scholar, the WHO website, The OECD website, EuroHealthNet, and the European Union website. Additional studies were suggested from expert interviews. The search strategy used key terms related to the main objective of this study. Appendix A summarises the search terms used, and the number of studies found per search. Table 1 shows the inclusion and exclusion criteria wherein all systematic literature reviews, scoping reviews, policy documents, chapters, and other reviews published in any language in the last three years were included. Studies were inputted into a single database (Microsoft Excel) and screened by a single researcher using the pre-determined inclusion and exclusion criteria and Mendeley software. This software was used to support the title and abstract screening and full text screening. From this, studies were then stored in Mendeley for referencing.

Table 1. Inclusion and Exclusion Criteria

Inclusion criteria	Exclusion criteria
• Healthcare accessibility interventions (i.e., primary health care services, digital health). • Socially informed procurement of health capital interventions (i.e., affordability and access of medicines, informal carers).	• Well-being economy interventions outside of priority pillars. • Interventions for specific diseases not targeted for population-level effects (e.g., COVID). • Studies published before 2021.

• Prevention and community development interventions (i.e., mental health care, patient-centred health care). • Studies with or without a comparator. • Outcomes with measurable impact using inequality indices. • Well-being interventions advised by National policies or strategies. • EU countries.	• Studies conducted in non-European countries.

Data extraction & collating and reporting of data

A data extraction form was created in Microsoft Excel and was piloted on two studies prior data extraction. Data extraction included title, author, year of publication, study type, setting, pillar of well-being economy, the scope of the well-being economy intervention, population, outcomes, and key messages. Non-English studies were translated using Google Translate prior to data extraction. The data extraction form was then analysed by the researchers to organise information and tabulate findings.

4. Results

All included studies were sorted based on the current studies proposed three key elements integral to a well-being economy. Within each element, studies were grouped into sub-themes based on the intervention or concept being studied (Figure 1). These elements were developed through expert consultation and using the WHO *Health in the well-being economy* report (11) as a guide.

The following definitions of each element were used in the review:

- Accessible healthcare includes the coverage of healthcare services and the methods of introducing health interventions to a wider population.
- Prevention and community development includes interventions that prevent disease or interventions targeted in community settings set to improve health and thus lowers disease risk.
- Socially considerate procurement includes allowing for the welfare of healthcare workers and/or carers in healthcare facilities or other settings.

Figure 1. Elements of a well-being economy used in the study.

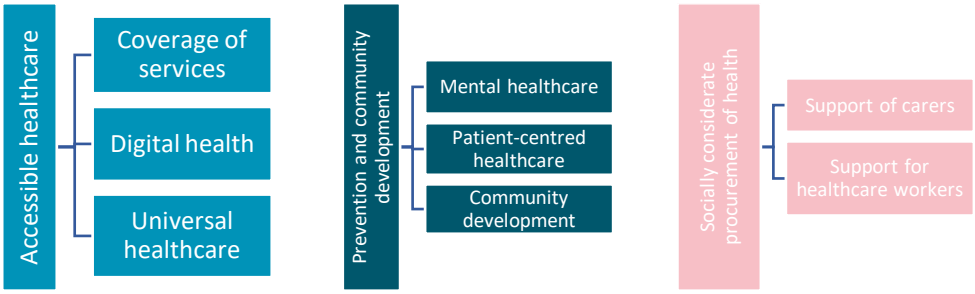
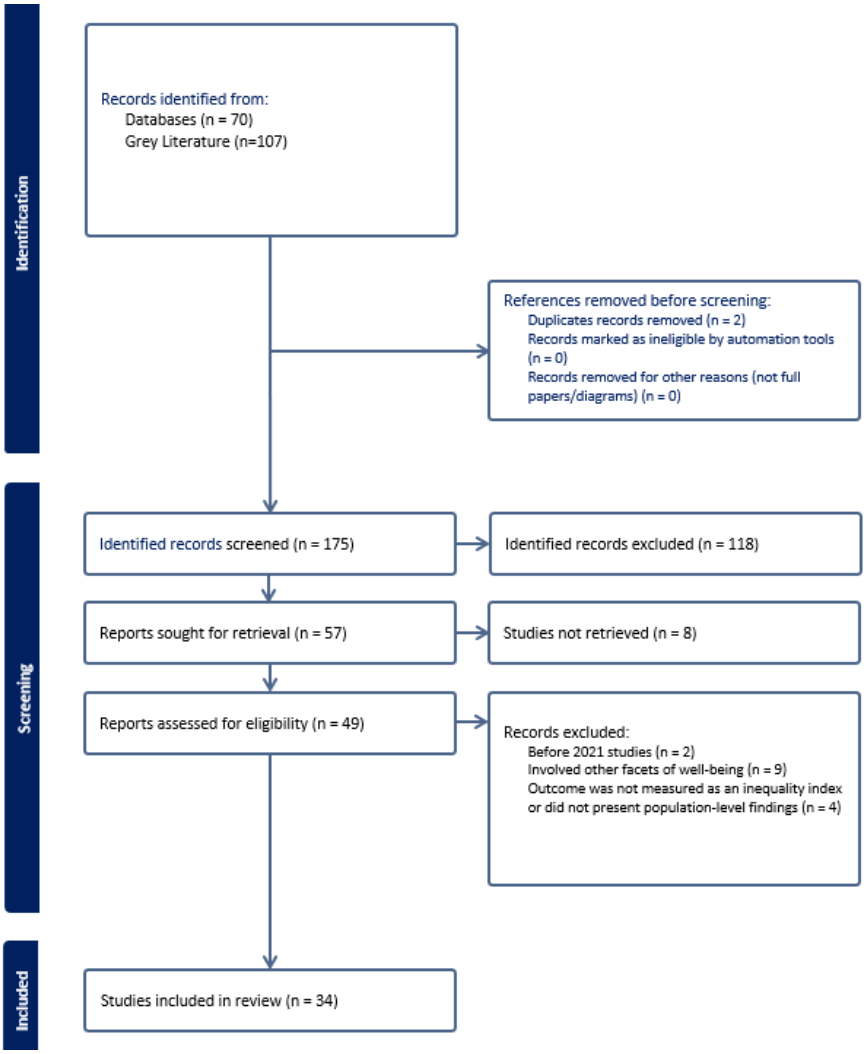


Figure 2 shows a PRISMA-ScR flow diagram which was created to summarise the search process. The PubMed database search generated a total of 70 studies. An additional 107 studies were retrieved from grey literature giving a total 177 studies. Following the removal of duplicates 175 studies proceeded to title and abstract screening. Applying the inclusion and exclusion criteria to a review of titles and abstracts left a total 57 studies sought for retrieval. Eight studies were not retrievable. Full-text screening removed a further 15 studies leaving a final 34 studies for inclusion in the review.

Among the excluded studies, two were studies that included data before 2021, nine included well-being economy interventions that were not aligned to objectives of this study, four had outcomes that did not present population-level findings, and two were descriptive studies on well-being economy that did not discuss specific outcomes.

Figure 2. PRISMA Flow chart



Characteristics of Included Studies

Of the 34 included studies, the majority (n=13) were published in 2022 (12–24) followed by 2023 (n=10) (11,25–33) and 2021 (n= 6) (34–39) (Table 2).

Table 2. Studies by year of publication

Year of publication	Number of studies	Citations
2023	10	(11,25–33)
2022	13	(12–24)
2021	6	(34–39)
2020	2	(38,39)
2019	3	(2,40,41)

Among study types, scoping reviews were the most common (n=9) followed by government and organisation level reports (n=6). Systematic literature reviews (n=4) and other reviews (n=3) (Table 3).

Table 3. Studies by study type

Study type	Number of Studies	Citations
Scoping review	9	(15,17,18,25,29–32,39)
Report (NGO and government documents)	6	(2,11,21,22,24,40)
Systematic literature review	4	(16,33,36,38)
Review	3	(20,27,37)
Position paper	2	(23,35)
Other study types	10	(12–14,19,26,28,34,41–43)

Other study types: rapid literature review, policy review, comparative review, overview of systematic reviews, meta ethnography, conceptual model, action plan, charter, multidimensional analysis

A total of 16 (2,11,15,19–21,28–34,37,39,43) out of the 34 included studies were global studies which included EU countries. There were 11 EU regional studies, and seven single country studies (13,14,16,17,26,27,38) retrieved which included studies from Spain, Norway, and the UK. The global studies included 17 European countries, which were mainly Northern European countries such as the United Kingdom (UK), Sweden, Finland, Denmark, Ireland, and Norway. Only one Eastern European country—Poland—featured in two global studies. Across all studies included in this scoping review, the United Kingdom was featured the most (n=14), followed by Germany (n=6) and Finland (n=5) (Table 4).

Table 4. Studies by country of focus

Country	European Region	Number of studies	Citations
United Kingdom	Northern	14	(2,13,15–17,20,26,30–33,37–39)
EU region	Not Applicable	11	(12,18,22–25,35,36,40–42)
Global studies that did not include EU countries	Not applicable	6	(11,19,21,28,34,43)
Germany	Western	6	(2,20,29,30,37,39)

Finland	Northern	5	(2,20,30,37,39)
Sweden	Northern	4	(2,20,31,39)
Italy	Southern	4	(2,31,33,37)
Norway	Northern	4	(2,14,20,39)
Spain	Southern	4	(2,27,29,39)
Ireland	Northern	3	(2,30,37)
The Netherlands	Western	3	(2,37,39)
Denmark	Northern	3	(2,20,39)
Austria	Western	3	(20,30)
Greece	Southern	2	(2,20)
Poland	Eastern	2	(2,37)

Study population

Most studies (n=18) (2,11–15,19–21,25–28,33,34,36,41,43) targeted the public followed by carers (n=7) (22–24,29,35,40,42). Among the seven studies focussing on carers, four (22–24,40,42) focused on informal carers, two (24,35) on any carer (formal and informal) and one study (29) focussed on grandparents. In addition, two studies focussed on employees (37,39), two studies focussed on doctors (16,30) and one each across a range of subcategories including children (32) and families of older people (18). (Table 5).

Table 5. Studies by population

Population	Number of studies	Citations
General public	18	(2,11–15,19–21,25–28,33,34,36,41,43)
Carers	7	(22–24,29,35,40,42)
Healthcare workers (Doctors)	2	(16,30)
Employees	2	(37,39)
Older people	1	(17)

Children	1	(32)
Care home patients	1	(38)
Families	1	(18)
Health systems	1	(31)

Interventions and their impact on well-being economy

Accessible Healthcare

Nine studies were categorised under the pillar of accessible healthcare. Of these, four studies described interventions aiming to improve the coverage of services such as extending services to underserved populations (migrants and the families of patients). Three studies focussed on digital technology as a tool to improve the efficiency of healthcare resource use, the coverage of services and improve patient experience. Two looked at coverage of universal health coverage (UHC).

Coverage of services

Two studies (14,36) presented interventions aiming to improve the coverage of healthcare services without jeopardising their quality and patient centredness. The first was a patient hotel model (36). Using a systematic review, the study examined whether using hotel-like facilities to care for patients' post-surgery can bring benefits in terms of cost to service providers and health outcomes of patients and guests. In some of the studies included in the systematic review, patients cared for in the hotel-like facility reported greater freedom, independence, and privacy compared to a traditional hospital setting. It was found to be cost-effective particularly for ambulatory surgical patients (36). In one included study, a cost saving of EUR€12.8 million was predicted to the French healthcare system (36). In another, the patient hotel model increased the ambulatory care capacity of one hospital and reduced the time patients were in hospital by 1,844 days over a period of six years (36). The patient hotel model thus could increase the number of free hospital beds for severe patients (36). A second study analysed access to healthcare services for Syrian refugees in Norway. The study found the perception of the healthcare professional, effective communication and reducing the waiting time to see a doctor improved access to services for Syrian refugees (14).

A scoping review looked at studies assessing the impact of family focussed psychoeducational support for older patients with coronary heart disease or heart failure on namely family caregiver burden and health-related quality of life (18). The scoping review found that including families in psychoeducational support in addition to patients led to positive changes in diet and physical activity for the families and the patients themselves (18). They suggest family-focused healthcare models should be further studied to develop European policy approaches centred around family health. (18).

A further scoping review suggests redefining equity and its perception when assessing healthcare system performance (31). The authors note a lack of consensus on how equity is defined across the studies they included (31). The most significant finding was that traditional measures of equity based on patients' sociodemographic characteristics continue to be the mainstay of equity assessments. While important, these measures no not provide insight on whether the healthcare system is

performing in an equitable manner (31). Reversing the longstanding norm that equity is based on patient characteristics and not the healthcare system, should be embedded into policies driving healthcare system performance.

Digital Technology

Of the three studies looking at digital technologies, two explored digital technology as a tool for improving access and efficiency of healthcare (19,33,38) and one explored digital technology for improving mental health care (33). One paper—a systematic review and meta-analysis—evaluated the evidence base on the quality of life and cost-effectiveness of telehealth interventions in the community compared to usual care. Telehealth in this study was defined as any remote exchange of medical information between a patient and healthcare professional. The study found one paper looking at cost-utility of telehealth which reported quality-adjusted life years (QALYs) for usual home care versus telehealth as insignificant (0.549 and 0.546 respectively). Patients did however report benefits such as better access to healthcare information and peace of mind using telehealth services (38).

A further systematic review examined the evidence base for the use of virtual reality (VR) relaxation techniques to treat patients with depression, anxiety, and stress-related problems (33). VR was found to have short-term effectiveness for increasing relaxation and reducing stress. It was also determined low intensity, meaning wider benefits could be seen healthcare workforce efficiency, despite the upfront expense of the equipment (33). Lastly, the application of artificial intelligence (AI) within UHC, health emergencies and health promotion, was explored in an overview of systematic reviews. The study found AI is being used for disease modelling, diagnosing and staging diseases such as neoplasms or musculoskeletal diseases (19). Additionally, the study found that AI was mainly used in public healthcare settings and adoption is unbalanced across disease areas (19). To expand the use of AI in health, the study suggested open databases and improved data sharing agreements are needed (19). In addition, the Geneva Charter for well-being stipulates that a well-being society must ensure access to technology is equitable to prevent isolation (34) and is provided as part of a UHC package.

Universal health coverage

Two studies discussed the impact of UHC on well-being economy (21,34). The Geneva Charter for well-being emphasised the importance of UHC for a well-being economy. Namely to ensure funding priority is given to primary care, health promotion and preventive services (34). National governments and healthcare decision makers should refer to healthcare financing as a well-being investment rather than an expenditure (34). The WHO has also provided examples of interventions at the national level to achieve UHC as part of societal well-being. These included but were not limited to:

- Shifting towards a primary care orientated model of care, focussed on prevention rather than emergency inpatient care.
- Introducing pre-payment mechanisms to reduce out of pocket spending.
- Conducting health impact assessments to understand the health effects of policies on populations.
- Promoting healthy nutrition and physical activity to reduce the burden of disease.
- Similarly introducing periodic health examination in non-health settings like workplaces and schools to catch diseases early (21).

Given the focus on primary care for achieving UHC, the WHO noted digital transformation might be most useful in primary care services to improve access and manage increased demand (21).

Table 6. Pillar 1 interventions: Accessible healthcare

Pillar	Scope	Intervention	Citations
Accessible Healthcare	Health inclusivity	Patient hotel model	(36)
		Healthcare for refugees	(14)
		Redefining health equity	(31)
		Family focussed healthcare models	(18)
	Digital Technology	AI	(19)
		Telehealth	(38)
		VR relaxation	(33)
	UHC	UHC for a well-being society	(21,34)

Prevention and community development

Sixteen studies were categorised into the pillar of prevention and community development. Seven studies explored the impact of mental health interventions on community development and prevention (13,15,17,20,25,27,43). Two studies explored the experiences of people seeking mental health services from different ethnic minority groups (13,25). Two assessed the impact of community-based interventions on older people and refugees (17,20). Three studies focussed on assessing the impact of mental health interventions (15,27,43) and two looked at patient-centred care (28,32).

Mental Health

A meta ethnography sought to understand why people from ethnic minority groups are underrepresented in primary care mental health services but overrepresented in crisis pathways, which refers to a collective group of services that respond to acute mental health events. These include but are not limited to helplines, home treatment teams and acute inpatient wards. The authors found statutory approaches to assessing and treating mental health exclude minority ethnic groups. Reasons for this included the need to be proficient in English language to receive care, lack of understanding regarding religious and spiritual beliefs, the reliance on a 'label' to define mental health which mirrored societal experiences of marginalisation and systemic oppression (13). The authors urge policy makers and healthcare commissioners to consider a shift in focus from individual symptoms to the structural causes of inequality. Lived experience of minority ethnic groups needs to be entrenched in the development and delivery of mental health services by including members of these communities in policy making. A scoping review of studies looking at interventions to improve the mental health or well-being of migrants in Europe suggested adapting interventions in a culturally

sensitive manner. Participatory approaches were also determined to be successful, such as awareness-raising groups, lifestyle programmes, arts-based interventions and self-help programmes (25).

Community-based interventions were specifically explored in two studies, one looking at mental health in older adults (65 years old and above) in the UK (17) and one looking at refugee children in eight European countries (UK, Norway, Greece, Finland, Sweden, Germany, Austria, and Denmark) (20). In the UK, community-based interventions are a focus of public health policy to reduce social isolation, improve mobility and thus physical health. Due to the varied methods of outcome measurement for community-based interventions for older people, this study found no particular method was identified as more promising than others. As well as consistent outcome measurement, community-based interventions most likely need theory driven evaluation reflecting older people's complex needs (17). Similarly, a study evaluating the utility of community-based interventions for refugee children struggled to find compelling evidence of their benefit (20). Some authors did report qualitative findings suggesting community-based interventions improved social connectedness and mental well-being among patients (17,25).

Three studies researched evaluation mechanisms for mental health interventions and policies (15,27,43). One study developed a gender sensitive index to analyse the gender inclusivity of mental health plans in Spain. The study reviewed implemented regional mental health plans to find overall, gender was not considered as a determinant of mental health. More than 50% of policies were assessed as having suboptimal gender scores. In addition, only seven autonomous communities had mental health plans in Spain in 2021 (27). Authors conclude this could reduce the effectiveness of interventions aiming to decrease gender inequalities (27). Another study used the social return on investment approach to assess the impact of mental health interventions (15). The study showed a positive return on investment of mental health interventions, with between GBP£0.79 to GBP£28.00 return for every GBP£1.00 invested (15). The interventions included in this review ranged from creative arts to nature-immersive interventions (15).

One study suggested the evaluation of mental health plans through a measure of psychological well-being (MPWB) (43). This global study used MPWB to measure life satisfaction and other mental health related outcomes from secondary data collected in the European Social Survey. They found positive mental health and reduced depression scores in countries with good national life satisfaction measures according to the survey (43). Nordic countries were generally noted to have the highest MPWB scores overall and Eastern European countries had the lowest scores. The only exception to this trend was in Portugal, which had the third lowest score (43). Four countries—The Netherlands, Belgium, Cyprus, and Portugal—reported significant differences in MPWB scores between men and women (43) and older individuals had lower scores compared to younger individuals (43).

Enhanced patient-centred care

Two studies explored patient-centred healthcare delivery. One literature review explored the impact of a person-centred rehabilitation programme for chronically ill patients (28). The study found patients receiving patient centred programmes were more likely to have improved self-reported health and nutrition (28). However, there was no significant association found between the intervention and disease deterioration or physical capacity (28). A global study explored how adolescent engagement in preventive policy development at several stages might improve the impact of the policy. This may in turn improve patient centredness of the interventions recommended by the policy. The study found

adolescents were more likely involved in the formative stages of policy making, but not in the entirety of the process (32). Patient-centredness was emphasised as central to improving the impact of interventions (28,32).

Community development

Three studies explored interventions to improve well-being for people who have not formally engaged with the healthcare service. One study—a scoping review—assessed the impact of psychological interventions in the workplace for people with chronic pain (39). The interventions were namely cognitive behavioural therapy and educational behavioural principles implemented in the workplace (39). The study found that despite the cause of the injury being at work, most of the interventions for chronic pain were completed in a healthcare setting. As such, the focus was on clinical outcomes rather than work outcomes. Further studies of chronic pain interventions were limited in older workers which should be rectified given an increasing trend towards older workers globally (39). An OECD report suggested making mental health interventions—among others—accessible in the workplace to prevent work absence. Integrating primary care led occupational safety into the workplace provides another less traditional access point to services (2). The second study explored opportunities for incorporating health into urban development plans in the UK. The study found including health interventions such as promoting cycling, improving indoor air quality of homes, improving security of tenure and accessible footpaths in local plans could improve health outcomes. The authors note that further research is needed to determine how such health inclusive policies are interpreted by developers in practices, and how health impact assessments should be designed for local plans (26).

Table 7. Pillar 2 interventions: Prevention and community development in the included studies

Pillar	Scope	Intervention	Citations
Prevention and Community Development	Mental Health	Mental health and community development	(13,15,17,20,25,27,43)
	Patient-centred care	Structured rehabilitation programme based on person-centred models of care	(28)
		Engaging adolescents in policy development	(32)
	Community Development	Urban planning for health	(26)
		Healthcare access in the workplace	(2)

	Psychological interventions in the workplace	(39)

Socially informed procurement of health

Nine studies were categorised into socially informed procurement for health. The well-being of carers was explored in seven studies (22–24,29,35,40,42). Five studies focused on well-being of informal carers (22,23,29,40,42). Two studies (24,35) suggested solutions for bolstering the rights of both formal and informal carers throughout Europe. Two studies focussed on healthcare workers (16,30).

Support for healthcare workers

One scoping review (30) looked at the experiences of international medical graduates working in countries other than the one they were trained. The study included perspectives of international graduates from five European countries—UK, Germany, Finland, Austria, and Ireland. The study suggests international medical graduates report inadequate professional recognition, a lack of opportunities for progression and pay increases, marginalisation and discrimination (30). The study proposed solutions such as experience sharing, workplace assistance, structural reviews and changes to the workplace environment to make healthcare facilities more culturally appropriate (30). Likewise, a systematic review of evidence for interventions aiming to improve the experience of newly qualified doctors in the UK found well-being interventions such as mindfulness courses, mentorship programmes, and clinical preparation courses showed improvements in well-being (16).

Support for carers

The European Association Working for Carers states that 12% of the EU population (50 million people) were informal carers in 2021 (23). Another Euro Carers study reported the results of a four-month survey which asked informal carers about their attitudes, experiences and expectations of long-term care. The survey found 79.5% of informal carers were women with 50% between the ages of 45 and 64 years of age. Informal carers were generally highly qualified (75% had completed a university-level degree) and made changes to their work schedule or quit their job completely to complete their care responsibilities (28.9% and 8% respectively)(22). Informal carers reported difficulties accessing healthcare services for themselves or their loved one, especially GPs (43.5%). Among carers who changed their working hours, 58.3% reported difficulty accessing healthcare compared to 52.7% of those with no changes in work schedule (22). The survey suggests informal care impacts well-being, with 62.9% of respondents saying their care responsibilities had negative effects.

Two documents—a position paper and strategy—outline the EU Strategy to support and empower informal carers (24,35). The strategy describes 10 steps for achieving carer-friendly societies in Europe. In addition to formal recognition of informal care, the steps include adopting carers perspectives in all relevant policies and support multisectoral care partnerships allowing integrated care. The latter intends to ensure carers are central to the planning of all care delivery for the individual, due to knowing the patient best (35). The position paper predicts around 11 million newly trained or internationally recruited health and social care workers are needed across the EU-27 to

meet population demands by 2030. These demands and shortages are in part why informal carers have no choice but to care for a loved one. The EU Care Strategy intends to promote choice for informal carers, by providing access to affordable formal care, whilst developing a legal recognition for informal carers (24).

The EU Care Strategy has achieved some traction towards a legal recognition of informal carers within EU employment law (23). They created a legal definition of informal care, championed by the EU Work-Life balance directive as "a worker providing personal care or support to a relative, or to a person who lives in the same household as the worker, and who is in need of significant care or support for a serious medical reason, as defined by each Member state" (23). This definition has encouraged rights such as additional work leave of five days per year.

Further advocacy for the rights of informal carers should be supported by economic evaluations according to one study reviewing methods for valuing informal care in Europe (40). Taking workers out of formal employed work to care for a family member is associated with significant indirect costs and thus losses to the economy. The economic costs accrued by informal care should be incorporated when considering the cost-effectiveness of healthcare interventions. Excluding this could result in recommendations which favour interventions that remove patients from the public health system to private care (or informal care at home) (40) A further study suggests 15.4% of young people aged 15 to 29 years of age are not in formal education or employment due to informal care work (42). Young carers are noted to require special attention as they have a higher risk of being excluded from education, employment, or formal care training (42). The study further described the kinds of support all informal carers might benefit from including education and training combined with regular support to prevent carer burnout, setting a minimum income for informal care or providing grants so that informal carers are not pushed into poverty as a result of their caregiving (42). The study found that implementing this support could improve the lives of 10 to 20% of the European population (42).

In a global systematic review of patterns of grandparent caregiving, positive health and well-being effects were dependent on the time and intensity of caregiving provided. Grandparent caregiving roles also varied significantly by culture, but in general grandparents experienced health benefits when providing moderate caregiving intensity for grandchildren (29). The study recommends grandparents—similarly to informal carers—are a resource for families and society which may boost fiscal space. Appropriate policies may be required to ensure formalising the role of the grandparent as a caregiver considers their health and well-being appropriately.

Table 8. Scope of well-being interventions and types of interventions for socially informed procurement of health in the included studies

Pillar	Scope	Intervention	Citations
Socially informed procurement of health	Support for healthcare workers	Support for doctors	(16,30)
	Support for carers	Interventions to improve informal carers well-being	(22,23,29,40,42)

	The rights of informal and informal carers	(24,35)

5. Discussion

The aim of this scoping review was ultimately to understand what opportunities are available to improve well-being economy, and how European policy makers could better engage in well-being economy processes. Due to the broad scope of well-being economy, we focussed on three specific elements: accessible healthcare, prevention and community development and socially informed procurement of health. While well-being alone features as a central concept to many health and social care studies, it remains fairly novel to associate well-being with the economy. Nevertheless, we found well-being economy perspectives in health care policies and health service delivery are emerging as a topic of interest. We noted an increasing trend in the number of publications discussing well-being economy in the last three years with a doubling of studies between 2021 and 2022. Most studies evaluating well-being economy were from researchers based in Northern Europe (2,13,15–17,20,26,30–33,37–39) with very few in Eastern Europe (2,37). Despite this, activity has also emerged from global and EU level organisations such as the EU commission, WHO (1,11), OECD (2), and Euro Carers (23,24,35,42) showing strategic appetite for a well-being economy.

Under the pillar of accessible healthcare, we found studies focussing on improving the coverage of interventions, whilst maintaining person-centredness and generating fiscal space. From a high-level viewpoint, continued efforts towards developing UHC is key to improving access to healthcare in a well-being economy. UHC has been a topic of discussion for decades, yet through a well-being prism, national governments and healthcare decision makers should refer to healthcare financing as a well-being investment rather than an expenditure (34).

More specifically, patient hotels and family focussed models of care were suggested to expand access to services (18,36). Other studies suggested accessibility might be improved if healthcare performance measures redefine equity to incorporate well-being focused indicators (31). The mainstay of equity measurement in healthcare relies on socioeconomic status. While important, this risks basing healthcare performance on patients' levels of deprivation, race, ethnicity and culture, which are closely correlated with socioeconomic status. Lower socioeconomic status and ethnic minority status is often linked to poorer health outcomes including low birthweight, avoidable hospitalisations and lower access to care (44). Equity measurement which incorporates social cohesion rather than socioeconomic status alone, might better detect the nuance in levels of health communities, especially multi-ethnic ones (45). This may also encourage healthcare systems to adapt to communities and should be embedded into policies driving healthcare system performance.

Digital technology is continuously generating interest in healthcare systems for both expanding access to healthcare for patients in their own home and assisting healthcare professionals with diagnosis and treatment regimens. However, researchers attempting to measure the cost-effectiveness and QALYs of digital technology versus usual care often find mixed results (19,33,38). This is consistent with other studies, reporting misleading claims related to digital interventions and poor clinical evidence (46). Despite this, a rapid shift towards digitally delivered health is happening. This presents an opportunity to shape digital technologies to meet well-being economy agendas. When used well, digital technology has the potential to inform healthcare decisions and make more efficient use of healthcare workers time, thus improving fiscal space. While the WHO has already made steps towards improving the research quality in digital technologies (47), the studies in this review suggest reimbursing digital tools within a UHC package to prevent exacerbation of inequalities. In addition, trust has been known to underpin the success of universal health coverage; digital technologies must safeguard the trust of

stakeholders (48). Data sharing agreements across vertical and horizontal service integration should be secured to prevent inefficiencies in care.

Within this pillar of prevention and community development, mental health featured heavily, specifically the inclusivity of mental health interventions. Studies suggest that statutory approaches to mental health care in Europe may be too heavily reliant on medical models which are largely diagnosis based (13,25). While important, refugees and ethnic minorities may consider these approaches exclusionary and find community, participatory interventions more appropriate (13). Mental health models that rely on labels were suggested by one study to mirror feelings of marginalisation. More research is needed however as very few studies found evidence that community-based approaches to mental health interventions were effective. This may be due to the quality of evaluation rather than the quality of the intervention. Some authors suggest social return on investment methods or measures of psychological well-being may be more appropriate and including patients from all corners of society in mental health policy development at several stages can help improve person-centeredness and reduce inefficiencies (15,27,32).

Targeting the public with healthcare interventions and advice before formally engaging with the healthcare service was suggested as a well-being economy approach (26,39). For example, providing employee access to medical services and occupational health assessments (39). Authors warned however that medical personnel providing employee services must focus on work outcomes and not just health ones. Ensuring urban development plans are designed with health in mind can also help develop healthy communities (26). The WHO has developed guidelines to encourage urban and plans to place health central to city planning (49). Yet researchers warn that translating healthy urban planning approaches to developers could require additional research to make sure well-being visions are interpreted (26).

Under the pillar of socially informed procurement of health, support for healthcare workers and informal carers were the focus of the research emerging. Most healthcare systems are in crisis due to increasing morbidity, mortality, and aging populations (50). Healthcare workforces are stretched, and the stress of the multiple demands placed on them has increased attrition. Well-being economy approaches would be well placed to focus on healthcare workforce retention. Two studies focussed on retention efforts for newly qualified doctors and international recruits such as orientation programmes and mental health support (16,30). Other studies stress the importance of providing informal carers official recognition in employment law, providing extra days off work and financial support (22,23,29,35,40,42). Currently formal recognition only exists for informal carers who were otherwise employed. More needs to be done to expand recognition to both young carers before entering employment, and adult carers who have left work completely to care for a loved one. An increase in studies focussing on the economic consequences of poor workforce retention and unofficial informal caregiving would strengthen advocacy efforts (51–53). Finally, when conducting economic evaluations of healthcare interventions, the costs of informal care must be included to avoid recommendations that encourage patients to be discharged from a hospital setting into unpaid informal care.

6. Conclusion and recommendations

This scoping review aimed to understand what is known about health as a driver for a well-being economy across three key aspects of the well-being economy agenda—access to healthcare, prevention and community development, and socially considerate procurement of health. The review has also identified opportunities for engaging European policy makers in well-being economy processes whilst uncovering areas for further research. By doing so it is hoped better directives and implementation of a well-being economy at EU level may be encouraged. Interest in a well-being economy approach—measured by the number of studies found—has increased in the last three years while multilaterals and NGOs developing policies and strategies marks progress. Most studies evaluating well-being economy approaches suggest further research. The following recommendations were formulated as priority areas:

1. Expanding well-being economy research to Eastern and Southern Europe, improving generalisability of current approaches which are largely clustered in Northern Europe.
2. Evaluating the use of digital technology, employed informal caregivers and family focussed models of care for improving access to care.
3. Continued advocacy for the rights of informal carers. More needs to be done to support informal carers who leave work completely to care for a loved one.
4. Redefining measures of healthcare performance making equity goals the health systems responsibility and not a measure of individuals socioeconomic status.
5. Viewing UHC as an investment rather than an expenditure and exploring how UHC can be expanded to primary healthcare and digital technologies as a priority.
6. Designing inclusive mental health assessments and interventions suitable for a diverse society. Moving away from statutory approaches and individual symptoms to understanding the structural causes of inequalities and designing psychiatry modules to reflect this.
7. Expanding entry points for healthcare information and advice beyond traditional services such as the GP. More research is needed on which entry points other than the workplace would be most effective.
8. Improve healthcare workforce retention through well-being support programmes, regular training and appropriate pay.

To summarise, civil society organisations such as the European Public Health Alliance have a role to play in advocating for further research and/or policies and campaigns related to the above recommendations. In doing so, a multi-sectorial approach across the key elements of a well-being economy is encouraged. The more engagement achieved improves awareness of the central role of health in economic development.

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Appendix

Appendix A: Search Strategy

Research question	What is known about health as a key driver in well-being economy and its impact within the European Union?			
Key words	**Health**	**Well-being**	**Impact**	**European Union**
Search Terms	Primary care	Wellness	Effect	EU
	Digital health	Patient-centred	Outcome	Europe
	Mental health	Community development	Inequality/equity indices	
	Healthcare	Well-being economy		
		Patient access		

Database searched	Date searched	Search terms/strategy	# of hits
PubMed	3 November 2023	((((health policy[MeSH Terms]) OR (healthcare[Title/Abstract]) OR (primary care[Title/Abstract]) OR ("Digital Health"[Title/Abstract]) OR (Mental Health[Title/Abstract]) OR ("Community development"[Title/Abstract])) AND (impact OR effect)AND (wellbeing OR equity index OR "wellbeing economy")) AND (European Union OR Europe OR EU)) NOT (COVID)	70

Appendix B: Summary of key points from interviews

Three key experts were selected to guide the direction of this study and to help select specific elements of well-being economy to explore. The following key points were mentioned by the interviewees:

1. Having a working definition of well-being economy is important as there are many definitions being used in the literature.
2. The link between health and well-being economies is cyclical. Health could be driving a well-being economy or health could be a benefit of well-being economy. Literature pertaining to both should be explored.
3. Building on the existing pillars of well-being economy is a good approach as well-being economy should be thought of as an 'umbrella approach'. There is no one thing that creates a well-being economy in isolation.
4. Studies on caregivers, including reimbursing informal caregivers for their time, appropriate wages for formal caregivers, better training, and support, are an important aspect of well-being economy of late. This is likely driven by an increase in illness and increases in demand for already overstretched healthcare personnel which leads to an increase in informal carers.
5. There is not much literature on the role of digital technology in relation to health and the well-being economy.
6. Preventative approaches to health are important to explore when studying health related to well-being economy.