Technical report

Social inequalities in health in the EU

Are countries closing the health gap?

About the report

This report, 'Social inequalities in health in the EU', is written by EuroHealthNet in collaboration with the Centre for Health Equity Analytics (CHAIN). The report provides a detailed analysis of social inequalities in health across Europe, based on:

- Quantitative data from the European Social Survey (ESS) rounds 7 (2014) and 11 (2024). Both rounds included a Health Module with questions on the determinants of health. The dataset spans 14 EU Member States (Austria, Belgium, Finland, France, Germany, Hungary, Ireland, Lithuania, the Netherlands, Poland, Portugal, Slovenia, Spain, and Sweden), as well as three additional European countries (Norway, Switzerland, and the United Kingdom).
- An overview and assessment of current measures to reduce health inequalities, informed by EuroHealthNet's work in the field and case studies from its members.

The purpose of this report is to raise awareness and provide evidence of social inequalities in health as a key priority for EU and national policies, as well as to identify areas where EU and national action on social inequalities in health is feasible and needed.

EuroHealthNet is a not-for-profit European Partnership for health, equity, and wellbeing. It encompasses more than 80 members from 32 European countries and includes public organisations, institutes, and authorities that work on public health, health promotion, disease prevention, and wellbeing. EuroHealthNet aims to tackle health inequalities within and between European States through action on the social determinants of health. For more information, visit www.eurohealthnet.eu

The Centre for Health Equity Analytics (CHAIN) is a world-leading centre and interdisciplinary research network focused on global health inequalities, based at the Norwegian University of Science and Technology (NTNU). It brings together expert researchers in the fields of health, social determinants, civil society, and the UN system to advance research on health inequalities. For more information, please visit: www.ntnu.edu/chain

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Preface

A social movement for health equity

The social movement is alive and well. It is being taken forward in Europe by EuroHealthNet, the Centre for Health Equity Analytics (CHAIN), and their partners. When we launched the report of the WHO Commission on Social Determinants of Health (I chaired the CSDH) in 2008, we said we wanted to create a social movement for health equity through action on the social determinants of health. The evidence from across Europe, gathered together in this report, is inspiring. Change is possible and is happening. WHO, too, has renewed its commitment with the 2025 report on Social Determinants of Health Equity.

Inequality is one of the two major challenges of our time, along with the climate emergency. As this report makes clear, inequality in social conditions leads to inequalities in health. Inequalities in health damage the social fabric. A good society is a healthy society. A healthy society has other benefits.

This new report presents a mixed picture of trends in health and health inequalities over the decade from 2014. One should pause over the finding that some European countries have seen deterioration in health, physical and mental. The implied promise of society is that things will continually improve. Such improvement will lead to health improvements. That was the case for countries that made up the EU14 for the latter part of the 20th century and less so in the former communist countries of Central and Eastern Europe. Now, in the 21st century, we see that in some countries, this promise has been broken, with deteriorations in health and no improvement or even worsening of health inequalities.

The evidence in the report makes clear that it is not a mystery why this should be happening. Material circumstances, conditions at work, psychosocial influences and behaviours, as reflected in body mass index, are major contributors to inequalities in mental and physical health. And, yes, unmet needs for health care are all too prevalent.

Action is needed at multiple levels. This report makes reference to Marmot Places, developed in the UK. These places act on our eight Marmot Principles: give every child the best start in life; education and life-long learning; employment and working conditions; having enough money to lead a healthy life; healthy environments in which to live and work, including housing; a social determinants approach to healthy behaviours; tackle racism, discrimination and their outcomes; tackle health equity and sustainability together.

Action has to be at both the national and European levels. As this report, and previous work from EuroHealthNet, show: the 20 principles in the European Pillar of Social Rights (EPSR) can be seen as social determinants of health. With the focus on equity of opportunity, fair working conditions, and social protection and inclusion, there is a great deal of overlap with Marmot's eight principles.

One of the principles that this report emphasises is the importance of monitoring health, health inequalities, and the social determinants of health. True to that principle, the report shows what is needed. It also lays out an ambitious but eminently achievable agenda to improve health and health equity. To come back to what we said when we launched the report of the Commission on Social Determinants of Health, Closing the Gap in a Generation. We have the knowledge to close the health gap. We have the means. Do we have the will?

Michael Marmot
Professor Sir Michael Marmot
CH Director UCL Institute of Health Equity
University College London (UCL)

A call to action for health equity in Europe

In today's rapidly evolving world, where Europeans have an average lifespan that is longer than ever, although not always in good health, a deeper understanding of the underlying social inequalities in health remains crucial. While the numbers reflect unprecedented advancements in health care and well-being, beneath this promising facade lies a more challenging reality: disparities in health persist, influenced by socioeconomic, educational, and occupational factors.

This report, a collaboration between EuroHealthNet and the Centre for Health Equity Analytics (CHAIN), delves into the intricacies of these inequalities across Europe. Drawing on robust data from the European Social Survey and enriched by policy expertise and case studies, this analysis unveils the existing health disparities that continue to impede progress across the EU.

The findings are startling yet enlightening. Although Europe leads in the world for social protection and health care systems, there are inequalities between and within Member States. The report shows that while there have been some improvements, inequalities not only persist but, in some cases, have widened or shifted, with lower socioeconomic groups continuing to experience poor health while higher socioeconomic groups face emerging health challenges. These disparities put at stake the fundamental right of everyone 'to timely access to affordable, preventive and curative health care of good quality' as affirmed in the European Pillar of Social Rights. They undermine Europe's potential, affecting quality of life and competitive standing on the global stage. Addressing these challenges demands a holistic approach, encompassing coordinated efforts at EU, national, and sub-national levels, as outlined in this report. By focusing on the root causes of social inequalities in health and integrating equity in health policies, we can work toward closing these gaps. This is also close to our intended approach in the current work of the Commission on poverty and inequality.

I extend my gratitude to the researchers, policy makers, and health professionals whose dedicated efforts have contributed to this comprehensive report. Your work ensures the prioritisation of health equity across Europe. As you engage with this report, consider it a call to action—a commitment to fostering a more equitable and healthy future for all Europeans. May it inspire policy changes and thoughtful discussions that pave the way for a more inclusive society.

Katarina Ivanković Knežević
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European Commission

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Introduction

Health and its distribution across Europe

Health forms the foundation of both individual wellbeing and societal progress. At the individual level, good health is essential for participating fully in daily life and pursuing personal ambitions without limitation. At the societal level, unequal or poor health weakens people's capacity to collaborate, innovate, compete, and uphold shared interests and values.

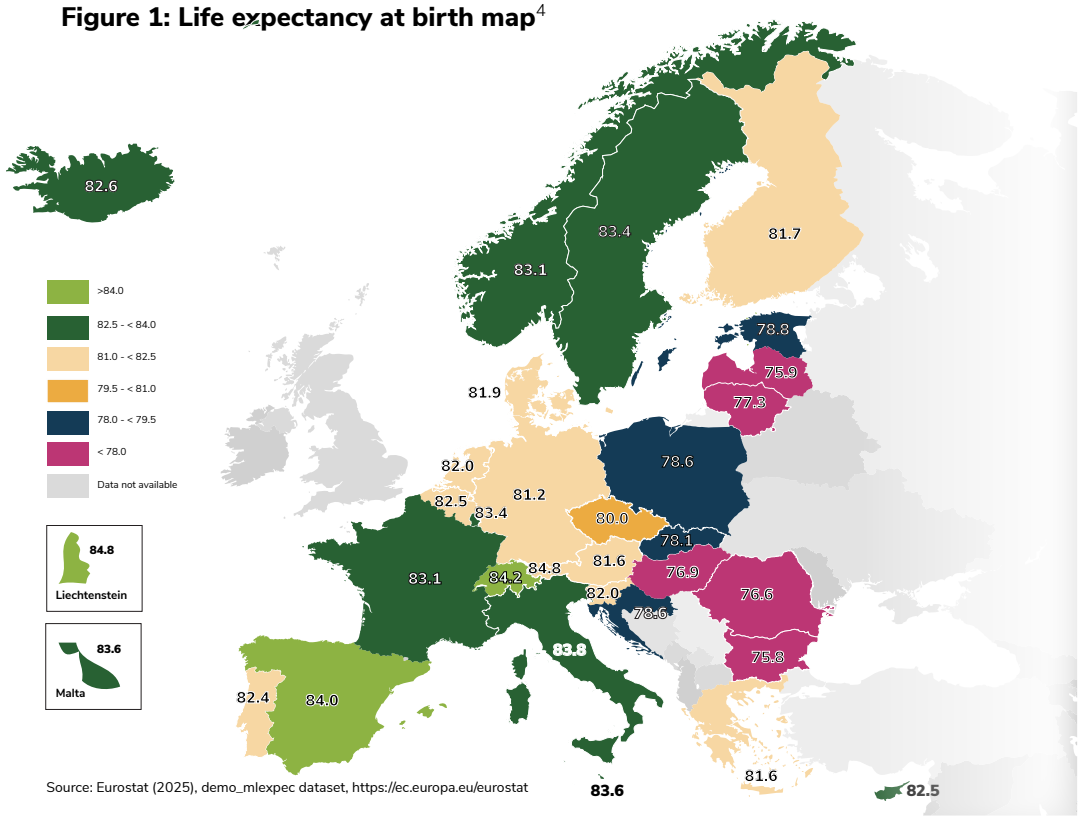
The enjoyment of the highest attainable standards of health is considered a fundamental right. By the European Union (EU) institutions, this right is expressed in terms of healthcare, masking that, as this report will outline, a wide range of conditions generate or undermine health.

Overall, health in the European Union (EU) and the European Economic Area (EEA) countries has improved significantly over the past century, with several countries ranking high on global life expectancy charts. Today, the life expectancy at birth in the European Union (EU) is, on average, 81.4 years,[1] of which 63 years are spent in good health.[2] This marks an increase of more than 20 years in average life expectancy across Europe compared with a century ago. Gains in life expectancy persisted through the 2008 financial crisis but declined during the COVID-19 pandemic. However, these **averages hide substantial disparities across Europe, as well as the reality that many Europeans, especially those who are less advantaged, do not enjoy good health.**

A child born in Spain, for example, which has the highest average life expectancy in the EU (84 years), **can expect to live 9 years longer than a child born in Bulgaria,** where life expectancy is 75.8 years.[3] The percentage of lifespan that people spend in good health varies across countries, too, from 86-82% in Malta and Sweden to 65-70% in Denmark and Latvia.[3] Countries with high average life expectancies do not necessarily have the highest healthy life expectancies. In Spain, for example, the average healthy life expectancy is 74%.

The findings of this report highlight large and persistent differences in both self-reported health and mental health across and within 14 EU Member States, as well as Norway, the United Kingdom, and Switzerland, based on data from the European Social Survey (ESS) in 2014 and 2024. In 2024, one-third of Europeans rated their health as poor, with substantial variation between countries, from 16% in Switzerland to 46% in Lithuania. Large disparities were also evident across social groups. For instance, in Austria, 13% of highly educated individuals reported poor health, compared with 38% of those with only secondary school qualifications. In Lithuania, the figures ranged from 28% to 58%, and in Spain from 29% to 41%.

Figure 1: Life expectancy at birth map[4]



Source: Eurostat (2025), demo_mlexpec dataset, https://ec.europa.eu/eurostat

While differences in health outcomes, such as life expectancy, have declined between EU Member States since the early 2000s, particularly between Eastern European countries and other European regions, they remain considerable.

Our study found that overall health inequalities in self-reported health across Europe increased slightly between 2014 and 2024. There were big differences, however, across countries. Health inequalities in self-reported health, for example, grew by 12% in Austria, but declined by 11% in Poland. In addition, as will be set out in this report, a decrease in health inequalities cannot always be considered positive if it results from a decline in the health of other social groups.

Differences in life expectancy and healthy life expectancy represent the tip of the iceberg and obscure a much broader and deeper set of inequalities in ill health and the social conditions that produce it. Children born into poorer families across Europe are more likely, for example, to be raised in polluted environments and attend overcrowded schools, which affects their future employment prospects, income, the conditions in which they live, their access to good quality health services, and ultimately their health and wellbeing.

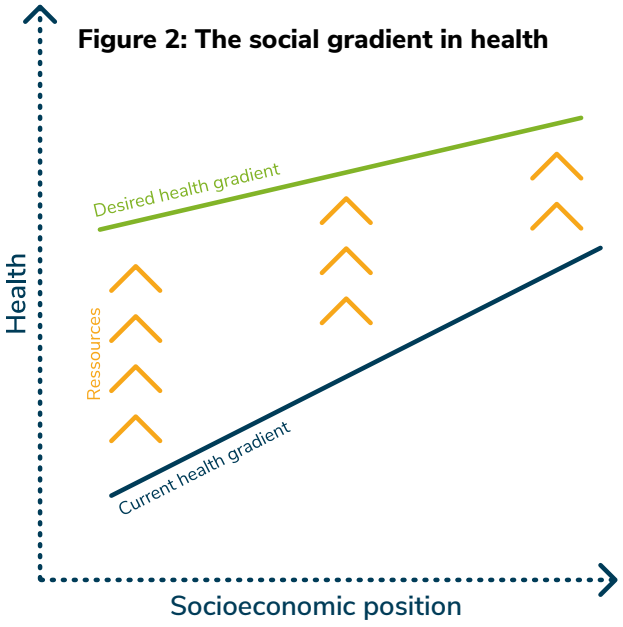
What are social inequalities in health?

Inequalities in health are **defined as 'differences in health status or in the distribution of health resources between different population groups'.**[5]

Inequalities in health outcomes between population groups can arise from differences in age, sex, genetics, disability, environmental adaptations, or voluntary choices relating to, for example, occupation. Mostly, however, these differences **arise from 'the social conditions in which people are born, grow, live, work and age'.**[6]

Health inequalities do not just exist between the rich and the poor. They can also affect people differently based on gender, ethnicity, or race. These inequalities can be intersectional. This means someone may face overlapping disadvantages. Being both a woman and part of a marginalised ethnic group. These disadvantages can compound health risks. They can also make it harder to access care.

Figure 2: The social gradient in health



**Resources are the support that people need to stay healthy, such as healthcare, education, safe jobs, clean environments, and social support.*

Social inequalities in health are caused by obstacles to health, such as poverty, discrimination, lack of power, and unequal access to the resources that help people stay healthy. These include fair jobs, safe environments, quality education, housing, healthcare, and social support.[7] The social conditions or factors that influence the health status are known as the **social determinants of health.**[8]

Differences in health status do not just exist between the most privileged groups and the most disadvantaged. They exist across the entire social ladder, which is often referred to as **the social gradient in health**. The higher the social position, the better the health.

When health inequalities stem from systemic disadvantage due to poor education and healthcare services, a lack of social protection, discrimination or other factors that make them avoidable and therefore unfair, they are also referred to as **health inequities**. This report uses both terms interchangeably, since the phrase social inequalities in health carries the same connotation of health differences that are unfair and unjust.

Why focus on health and its distribution?

The main reason to reduce social inequalities in health is that they are one of the most evident signs of injustice. These inequalities rob individuals not only of their potential and quality of life, but sometimes of life itself. Everyone has the right to health, no matter who they are or where they come from. Health is a fundamental human right, not a privilege. A society that puts health for all above economic interests creates a stronger, fairer future. Some level of inequality between different social groups can be expected in all societies. However, **the fact that there are considerable differences in the 'steepness' of the socioeconomic gradients in different localities, regions, and countries reflects that they are neither natural nor inevitable, but unjust and unfair.**

Addressing health inequity is not only in the interest of the groups and individuals who are falling behind, but in the interest of everyone. Wilkinson and Pickett studied 23 countries worldwide and all 50 United States. They found that more equitable societies perform better across a wide range of measures of progress. For example, they showed that countries with higher levels of inequality also had higher rates of health and social problems, such as obesity, mental illness, homicide, teenage pregnancy, imprisonment, child conflict, and drug use. These countries also had lower levels of social goods, including life expectancy, educational performance, trust among strangers, the status of women, social mobility, democratic engagement, and even the number of patents issued by public institutions.[9]

Other studies have established a link between health equity and social cohesion, social capital, and resilience, thereby highlighting the capacity of communities to function in times of crisis. Strong correlations have been found between high income inequality and low social capital, defined as a set of networks, norms, and trust that facilitate cooperation for mutual benefit. Low social capital is also associated with poorer health outcomes,[10] while improving access to health in marginalised communities has been shown to increase social capital.[11] Studies have also found that lower health and income inequalities predict higher trust in institutions and between individuals, as well as higher levels of civic participation and community attachment.[12] Poor health outcomes have been linked to support for fringe and populist parties.[13]

The World Economic Forum, in its latest Global Risks Report 2025, identified inequalities as one of the greatest risks to society because it plays a central role in driving societal fragmentation, weakening trust, and fuelling social instability.[14] The report highlights that inequality is not only a standalone risk but also intensifies and is worsened by other global threats, such as economic downturns, inflation, and demographic shifts, such as ageing populations, all of which have dire consequences for public health and wellbeing. **Measures to reduce social inequalities in health not only improve individual wellbeing but also rebuild trust in public institutions, foster democratic engagement, and promote social stability. In turn, these outcomes enhance a society's ability to prepare for and remain resilient in the face of economic and political challenges**. Accordingly, the latest EU Strategic Foresight report calls for a 'Resilience 2.0' approach that involves a renewed social contract that strengthens trust by improving welfare, reducing disparities, and ensuring access to high-quality public services, by, amongst other things, tackling health inequalities and promoting healthier lifestyles.[15]

Improving health and its distribution can also help to make Europe more competitive, and vice-versa. Enormous gains in life expectancy and standard of living made over the past century are the result of innovations that improved public infrastructure and services, as well as medicine. Economic growth has improved health across the EU, but the extent to which it has done so has and will continue to be the result of political choices at all levels of governance: countries with similar levels of growth do not have the same health or social outcomes.

David Susskind, author of the book Growth, writes that 'beyond the compelling moral arguments against **inequality, it is extraordinarily inefficient**. A world where some people cannot discover and share the ideas they otherwise might is diminished economically as well as culturally.'[16] Our findings, presented in chapter one, show that 30–50% of individuals from lower socioeconomic groups in many countries report poor health, while in some countries, health outcomes are simultaneously improving among higher socioeconomic groups. These disparities **represent significant losses of human potential, productivity, and innovation** for European societies.

Further evidence on the economic benefits of investing in closing the gaps in health

- Poor health attributed to low socioeconomic status is not only unethical, but also costly: a 2020 report by the European Parliament estimated that the efficiency gains for the European economy, from EU action to reduce health inequalities, could be up to 72 billion euros per year.[17]
- Economic slowdowns attributable to population ageing are avoidable through policy interventions supporting healthy and active ageing.[18]
- A review on the cost-effectiveness of health promotion interventions found that they have a median cost-benefit ratio of 14.4, which means that every €1 invested gives a return of €14.[19]

Reductions in health inequalities mean more people benefit from a better quality of life, while societies benefit from higher levels of social and workforce participation and productivity.[20]

Finally, **investing in efforts to 'level up' health across the socioeconomic gradient also contributes to the EU's social targets** in relation to employment, and reducing poverty and social exclusion. Health, poverty and social exclusion are interrelated, since ill physical or mental health can lead to poverty and social exclusion, while experiencing these conditions can, in turn, lead to poor health. Investing in initiatives to reduce social inequalities in health, through the kinds of approaches outlined in Chapter 2 of this report, can break through these cycles. It enables people to re-enter education and the labour force, contributing to society and the economy while reducing their costs to public health, social security, the criminal justice system, and pension systems.[21]

European values, aims and principles

The EU Treaties do not explicitly identify health equity as an aim and objective of the EU, but these are implicitly included. One of the core aims set out in Article 3 of the Treaty of the EU is wellbeing, while one of the core EU values is equality.

The European Union has established a framework, called the European Pillar of Social Rights (EPSR), setting out principles to encourage EU Member States to promote social measures linked to equal opportunities, fair working conditions, and social protection that are also needed to promote health across its Member States. Therefore, the EPSR can be considered a framework for health and health equity, since implementing its principles would contribute significantly to the reduction of social inequalities in health across the EU.

In addition, EU-level strategies and policies are oriented towards 'upward convergence', which entails making EU Member States more similar by converging to a higher standard. The European Semester, Cohesion Policy and the European Pillar of Social Rights are all oriented to **achieving upward convergence between and within EU Member States.** In health public terms, **this entails 'levelling up' the social gradient in health, both within and between countries.** An influential discussion paper by Dahlgren and Whitehead defines levelling up as the process of bringing up the level of health of the groups of people who are worse off to that of the groups who are better off. The paper emphasises that narrowing the health gap equitably can only be achieved by improving the health status of the disadvantaged groups rather than levelling down the better-off groups.[22]

Lessons from the COVID-19 pandemic

The COVID-19 pandemic highlighted the central importance of health and brought greater awareness of social inequalities. It showed that those already vulnerable were more likely to grow, live, work, and age in conditions that increased their risk of infection. This, in turn, compounded their difficulties and deepened existing inequalities.

While all countries experienced declines in health during and shortly after the crisis, most countries have recovered in terms of gains in life expectancy. Nevertheless, individuals with pre-existing conditions, as well as communities with pre-existing health inequalities, suffered disproportionately in terms of morbidity, mortality and economic disruption.[23]

The COVID-19 pandemic was followed by a geopolitical crisis that led to cost-of-living strains, and further geopolitical insecurity and instability, distracting attention from lessons on the importance of investing in health promotion and prevention, and in closing the gaps in health.

This report

The purpose of this report is to offer insights into the state of health and its distribution both between and within the fourteen EU Member States that participated in the European Social Survey (ESS) health modules, as well as Norway, the United Kingdom and Switzerland.

The **first section** focuses on the current situation of health and its distribution across fourteen countries in the EU, as well as three other European countries that participated in the ESS (Norway, Switzerland, and the UK). It provides a comparative overview of health levels and inequalities in self-reported health across countries, examining whether these countries have achieved levelling up in these areas over the past ten years. This section demonstrates why it is important to consider more than just averages when assessing health levels in countries. It will also demonstrate why numerous factors must be considered to assess health-related trends in a country, since a reduction in health inequalities does not necessarily signal overall improvements in health. The section also presents the results of an analysis of underlying social determinants responsible for poor mental health outcomes in participating countries, and the main factors driving inequalities in this area.

The **second section** focuses on what can be done. It demonstrates that leadership in the health sector is essential, but that closing health gaps cannot be achieved by the health sector alone and requires embedding a focus on equity across sectors. This section also includes illustrative examples, contributed by EuroHealthNet's members and deriving from its work in the field of what is being done across EU Member States to reduce health inequalities.

The **third section** provides an overview of measures taken at the EU level of governance to reduce social inequalities in health. While explicit action has been limited to the health sector at the EU-level, progress has, indirectly, been made through a stronger focus on social rights, and on achieving a just, environmental and green transition. This progress is, however, being undermined by the EU's current policy priorities. At the same time, there are some promising policy opportunities to address key underlying determinants of health and reduce health gaps.

The **fourth section** explores what it looks like to disaggregate existing indicators or proxy indicators in the European Pillar of Social Rights, to demonstrate the importance of going beyond European averages, to understand better who is benefiting, or is not, from these principles and rights. This knowledge can contribute to identifying how the EU and its Member States can design better 'proportionate universal', and targeted policies and programmes and invest resources as efficiently and effectively as possible.

The **final section** sets out recommendations on what the EU, EU Member States, and associated countries can do better to tackle social inequalities in health within and between Member States. It also addresses how to improve the resilience, competitiveness, and preparedness of the Union in today's more unstable geopolitical and economic environments, in ways that align with its principles and values. The aim is to uphold the health and social rights of those who need it most. It also seeks to ensure that more countries across Europe embark on favourable trajectories to reduce social inequalities in health.

This report, and its summary report, are primarily **intended for policymakers and public officials at all levels of government,** to enhance understanding of social inequalities in health and to show how addressing them supports the achievement of shared policy objectives. It is also aimed at **public health and social service professionals,** offering insights into how EU-level policy initiatives can be leveraged to improve both health outcomes and their equitable distribution, thereby strengthening overall wellbeing in their countries.

Important considerations

This report uses the terms Europe and the EU interchangeably. However, our analysis focused primarily on 14 EU Member States (2 Northern, 6 Western and 4 Central and Eastern European) as well as Norway, the United Kingdom and Switzerland, which participated in round 7 (2014) and round 11 (2024) of ESS.

Given the scope of this report, the primary focus is on social inequalities in health, rather than on other critical dimensions of inequality, such as those related to gender or racial and ethnic groups, to establish a baseline of the current situation and trends. Future editions will broaden the analysis to include these additional forms of inequality.

1. Overview of health and health inequalities in the EU

1.1 What is the situation?

The EU's overarching objectives, and those of its Member States, are set out in its Treaties, including equality and wellbeing. The Treaties also establish 'upward convergence' as one of their foundational aims, to strengthen the economy, ensure social cohesion, and promote social progress. Maintaining high levels of health and a good distribution of good health within and between EU Member States is also essential to advance on the EU's most recent priorities of competitiveness, preparedness and security.

This section presents a trends study that sheds light on Europe's progress in maintaining high levels of health and reducing social inequalities in health, both within and between countries. The chapter analysed changes in health equity over ten years in 17 countries that took part in ESS Survey rounds 7 (2014) and 11 (2024), namely fourteen EU Member States, as well as Norway, the United Kingdom, and Switzerland. It also includes some data on a larger group of twenty-four countries that only took part in ESS round 11 (2024).

The focus of our analysis, reported in the first parts of this section, **was on self-reported health (SRH) and self-reported mental health (SRMH) amongst 25–75-year-olds, and disparities within as well as between countries.** Annex III of this report elaborates on the statistical methods used.

Self-reported health reflects an individual's own assessment of their health status and wellbeing. Self-reported health can capture not only known medical conditions but also more subtle, unmeasured aspects like cultural attitudes toward health and levels of social and community support that influence perceptions.[24]

Over the past 30 years, studies have convincingly demonstrated that perception of health is a more powerful predictor of future health and social outcomes than any other combination of objective health measures.[25,26,27] One study found, for example, that people rated their health as poor many years prior to receiving an official diagnosis and death, making self-rated health a sensitive early warning sign for serious illness.[28]

This report demonstrates that, overall, levels of health are slightly increasing, and levels of mental health have remained stable, over the past ten years, due in large part to improvements in Southern and Eastern European countries with overall lower levels of SRH and SRMH. Nevertheless, health inequalities in these areas remain persistent across Europe and are growing in several countries.

We explain how reporting on averages can be misleading without understanding the dynamics between countries, across social groups, and within countries on a country-by-country basis. **Our analysis reveals that while health in Europe is converging, the gradient in health is levelling, but not levelling up, suggesting halted progress.**

To gain a better understanding of the causes behind the trends in self-reported health and self-reported mental health, **we also investigated changing patterns of chronic diseases, including non-communicable diseases (NCDs)** in countries that participated in the ESS rounds 7 and 11.

We then present the results of a regression analysis to determine what **selected determinants of health are most likely to be driving poor health and poor mental health across the population,** as well as **which factors are driving inequalities in these areas,** in a broader range of countries that participated in the ESS in 2024. Policy makers can use this information to determine how best to invest scarce resources as efficiently and effectively as possible to design and implement policy reforms and other measures to 'level up' health.

1.2 The European Social Survey

ESS offers a unique opportunity to explore recent trends relating to health and health equity and to shed more light on the underlying determinants that may be involved in generating patterns, within and between countries.

The European Social Survey

ESS is a biennial, cross-national survey that has tracked attitudes, beliefs, andbehaviour patterns across Europe since 2002. The survey is currently in round 11 (as of 2025) and covers around 30 countries, providing high-quality, cross-nationally comparable data for researchers, policymakers, and students.

Key features:

- **Core module:** Repeated every round, covering trust in institutions, democracy, immigration, and well-being.
- **Rotating modules:** Thematic topics such as climate change, health, digital life, and values; some are repeated over time to track change.
- **Target population:** All residents aged 15+ in private households, regardless of nationality or legal status.
- **Sampling:** Strict random probability sampling (typically 1,500 respondents per country; 800 in smaller countries).
- **Data collection:** through face-to-face interviews (approx. 1 hour), conducted by trained interviewers.
- **Methodological rigour:** Translation protocols and strict fieldwork standards ensure comparability. National fieldwork agencies are monitored under central ESS supervision. Fieldwork periods last 1–4 months, with enforced contact protocols and reporting requirements.

- **Data processing:** Centralised data cleaning and harmonisation. Design and post-stratification weights applied.
- **Open access:** All data and documentation are freely available via the ESS website.

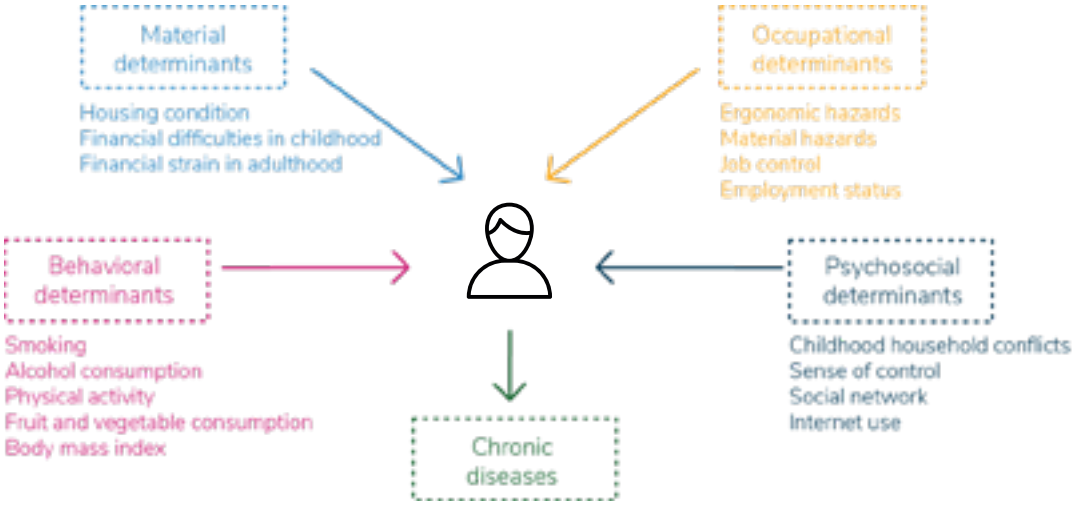
The full ESS Round 11 (2023/2024) **source questionnaire**, including card references, is available here.

The **visual showcards** that interviewers use are here.

1.2.1 The ESS health module

Among the rotating modules of the ESS is the ESS health module, first introduced in Round 7 (2013/2014) and updated in Round 11 (2023/2024). This module examines chronic diseases, including non-communicable disease (NCD) risk across five key groups of underlying determinants: behavioural (e.g., smoking, diet, BMI), material (e.g., childhood and adult financial hardship, housing conditions), occupational (e.g., ergonomic and material hazards, job control), psychosocial (e.g., early-life conflict, sense of control, social support), and healthcare access (e.g., GP and specialist access, unmet need). This report explored four of the five key groups of underlying determinants, as set out in Figure 3.

Figure 3: The social determinants of health from the ESS health module[a] explored in this report



[a] The questions included in this study from the ESS questionnaire that relate to the social determinants and that were used in this study can be found in Annex I.

While ESS surveys youth and adults over the age of 15, we limited our analyses to adults between 25 and 75 years of age. Our analysis, therefore, captures the situation of people across Europe who have completed education, in a large part of the working age and with limited health selection bias. In addition, at 75 years of age, many Europeans are experiencing multi-morbidity. However, they are, on average, still healthy enough to contribute to society, in informal caring capacities or through voluntary services.

The total sample size of respondents to the ESS survey in 2024 was 40,156 people (ranging from 685 in Cyprus to 2,757 in Great Britain).[b] When restricting our analysis to those in the age range of 25-75, the number of respondents was 31,738. The total sample size of the ESS survey in 2014 was 40,185. The restricted sample of 25-75-year-olds was 31,971.

The trend analysis of self-reported health and self-reported mental health was based on data from the 17 countries that participated in ESS rounds 7 and 11, for a total of 47,730 participants.

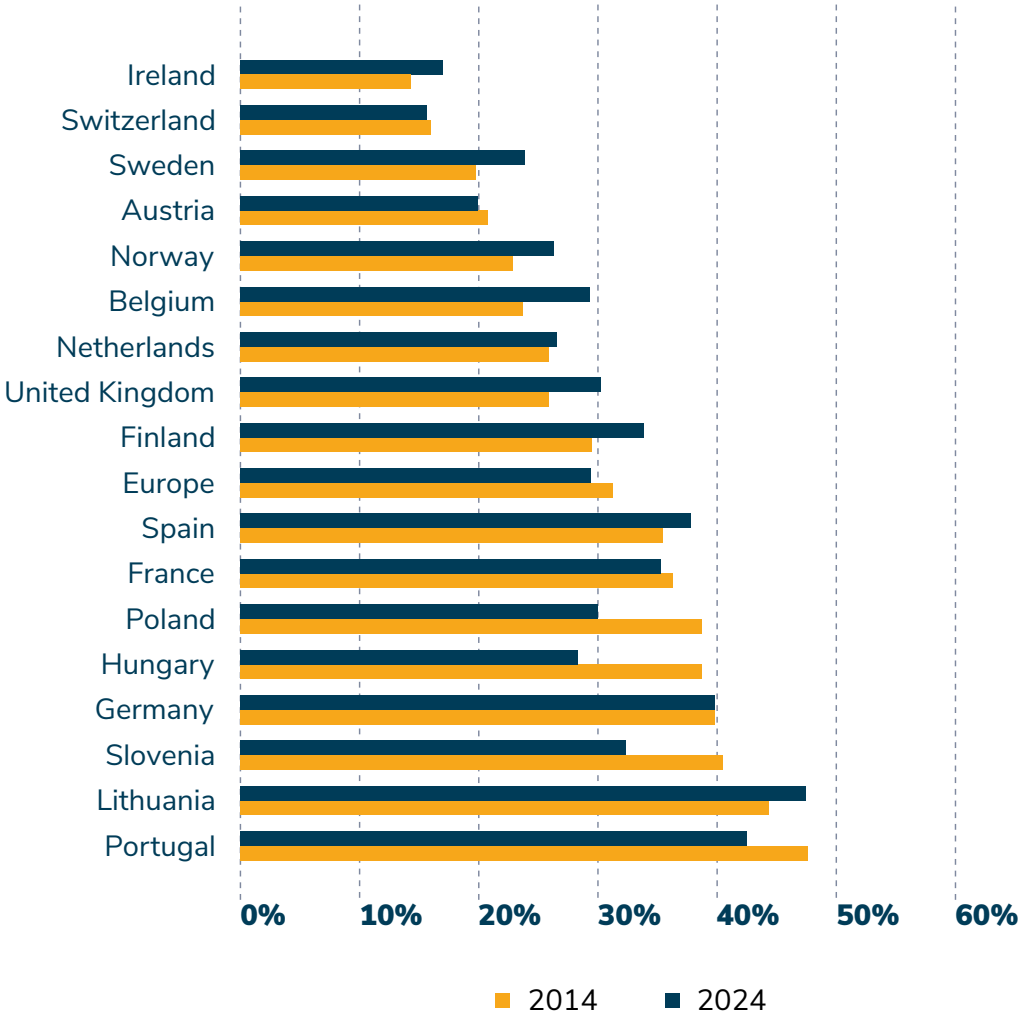
1.3 Trends in poor self-reported health, by education

1.3.1 Overall levels of poor self-reported health, and changes between 2014 and 2024

Self-reported health was determined by the share of respondents per country who were asked to rate their health on a five-point Likert scale (very good, good, fair, bad, very bad). **This report uses the term 'poor health' to refer to respondents who rated their health as fair, bad, or very bad.** In this report, self-reported health is referred to as SRH.

[b] Information on sample sizes per country is available in Annex I.

Figure 4: Rate of poor self-reported health, 25–75-year-olds, 2014-2024



As mentioned earlier, self-reported health can be a powerful predictor of future health and social outcomes because it captures dimensions of health that biomedical measures alone often overlook. Self-reported health also captures the influence of cultural norms, illness perceptions, and socio-environmental factors in shaping health evaluations. In Spain and Portugal, people, for example, have long life expectancies but less healthy life years, and this coexists with relatively low levels of self-reported health.

Figure 4 highlights that across the countries analysed, average levels of 25–75-year-olds reporting poor health ranged from 15.1% in Ireland to 49.5% in Portugal in 2014. In 2024, 15.2% of Swiss individuals reported their health as being fair, poor or very poor, versus 47.5% of Lithuanian's. **At the European level, poor health declined by 1.8 percentage points (p.p.[c]) over the ten-year span. This average is both statistically significant and relevant at the population level.**

Overall levels of poor health decreased significantly in four countries: Hungary, Poland, Portugal and Slovenia. They increased in eight countries: Belgium, Finland, Sweden, the United Kingdom, Norway, Lithuania, Ireland and Spain. Overall levels remained relatively stable in five countries, namely Austria, Switzerland, Germany, and France.

[c] P.p. refers to percentage points, which indicate the absolute difference between two percentages

Most health losses occurred in countries that had lower levels of poor health (less than 30%) in 2014. The largest and statistically significant health losses took place in Belgium (5.6 p.p), the UK (4.3 p.p.), Finland (4.2 p.p.), Sweden (4 p.p.), and Norway (3.4 p.p.).

Among eight countries with higher shares of poor health (over 30%) in 2014, all with exception of Spain (loss of 2.5 p.p.) and Lithuania (loss of 2.9 p.p.) experienced statistically significant health gains. Countries with the highest gains were Hungary (10.4 p.p.), Poland (8.7 p.p.), Slovenia (8.1 p.p.), and Portugal (5.1 p.p.).

1.3.2 Distributional differences

The average number of people in society reporting poor health, along with changes in these numbers over time, can mask significant differences in the health status of different groups and changes within those. For example, overall improvements in population health are less positive if only one group pulls up the overall average, and the health of other groups is stagnating or even declining, to a lesser extent. The following graphs, therefore, set out the percentage of people from the highest educational group and the lowest educational group that reported poor health, and how these percentages changed between 2014 and 2024.

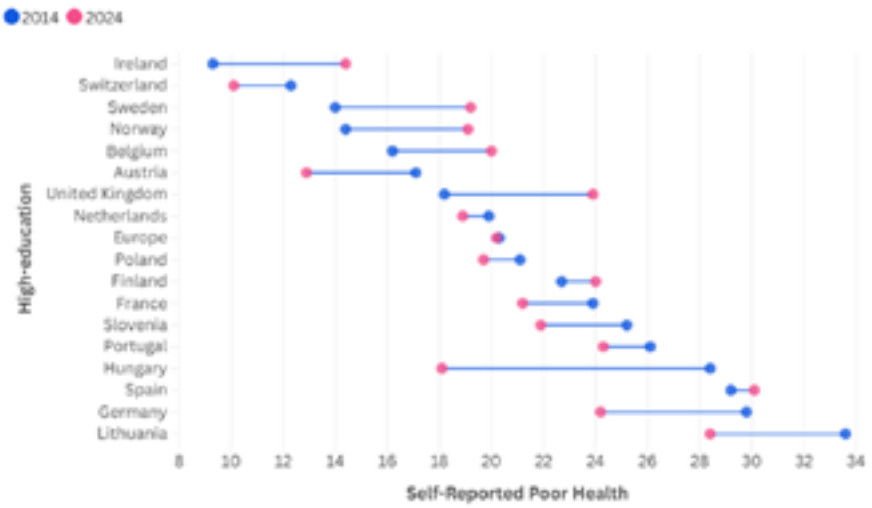
ESS use of ISCED categories to define educational groups

The ESS Survey applies the ISCED categories to break down educational groups.

ES-ISCED Level	Description	Educational group referred to in this report
I	Less than lower secondary	Low-education
II	Lower secondary completed	
III	Upper secondary completed	Mid-level education
IV	Advanced vocational / sub-degree (post-secondary non-tertiary)	
V1	Lower tertiary education (Bachelor's level)	High-education
V2	Higher tertiary education (Master's level or higher)	

Changes in the predicted rate of poor self-reported health amongst high-education, 2014-2024

Figure 5: Changes in poor self-reported health in high-educated groups, 25–75-year-olds, 2014-2024



As Figure 5 shows, in 2024, the range of respondents with a higher education in the countries examined reporting poor health ranged from 10% in Switzerland to 30% in Spain.

The high-education groups in four of the seventeen countries reported statistically significantly worse levels of health compared to a decade ago, namely Ireland (5.1 p.p.), Sweden (5.2 p.p.), Norway (4.7 p.p.), and the United Kingdom (5.7 p.p.). In Belgium, high-education group reports considerably worse health (3.8 p.p.), but this is not reaching statistically significant levels.

In seven of the seventeen countries—Switzerland, the Netherlands, Poland, Finland, France, Portugal, and Spain—the health of the high-education group is mostly stable, with most showing a positive trend that is not statistically significant.

In five countries, stronger positive trends can be observed, with health gains accruing to the highest-educated group in Hungary (10.3 p.p.), Germany (5.6 p.p.), Lithuania (5.2 p.p.), Austria (4.2 p.p.) and Slovenia (3.3 p.p.). These improvements in health are statistically significant only for high-education group in Hungary.

Changes in the predicted rate of poor self-reported health amongst the low-education group, 2014-2024

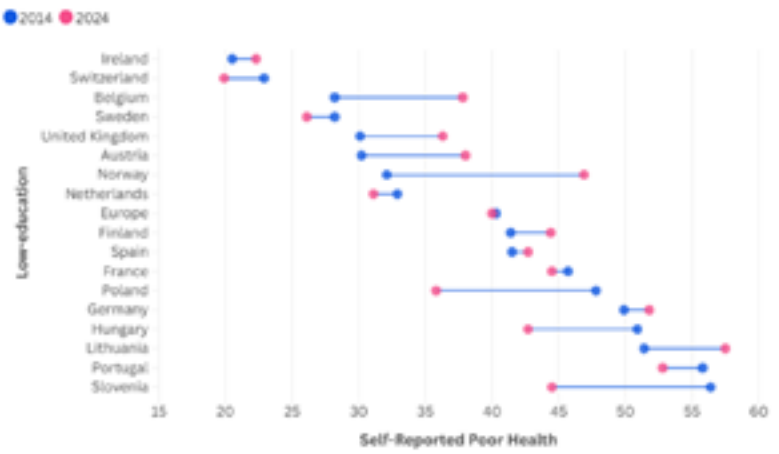


Figure 6: Changes in poor self-reported health in lower educated groups, 25–75-year-olds, 2014-2024

As the figure above reflects, **in 2024, the percentage of respondents from the low-education group who reported poor health ranged from 19,9% in Switzerland to 57,5% in Lithuania.**

In four of the seventeen countries, namely Norway (14.8 p.p.), Belgium (9.6 p.p.), Austria (7.8 p.p.), and the United Kingdom (6.2 p.p.), the low-education group experienced substantial and statistically significant health loss between 2014 and 2024. The low-education group in Lithuania (6.1 p.p.) and Finland (3 p.p.) also showed considerable negative trends, but did not reach statistical significance.

Large health gains took place amongst the low-education group in five of the 17 countries, Poland (12 p.p.), Slovenia (11.9 p.p.), and Hungary (8.2 p.p.) had the largest and statistically significant health gains. In Switzerland and Portugal, the low-education group also showed improvements of 3 percentage points, but these shifts were not statistically significant.

In Sweden, the Netherlands, France, Ireland, Spain, and Germany, levels of poor self-reported health amongst the low-education group remained stagnant, with slight trends of decline in the former three and of an increase in the latter three countries.

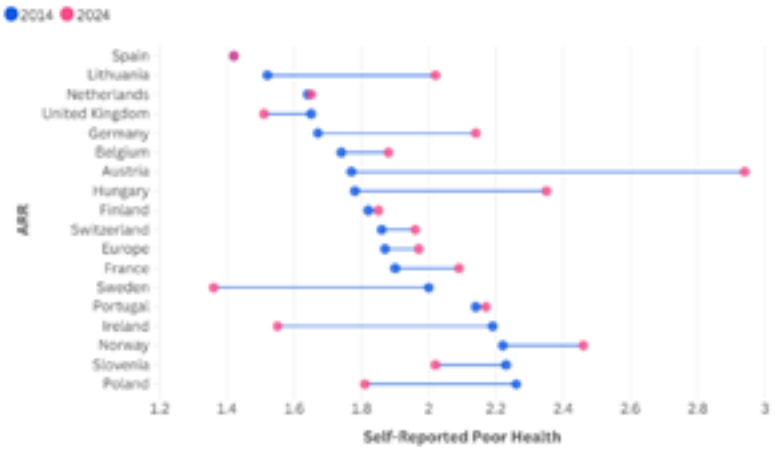
1.3.3 Changes in relative inequalities

Relative inequalities show how much more likely people in lower socioeconomic groups are to report poor health compared with higher socioeconomic groups.

Absolute inequalities show the actual difference in the percentage of people with poor health between lower and higher socioeconomic groups.

Changes in the average relative rate of inequalities between the low- and high-education groups, 2014-2024

Figure 7: Changes in relative inequalities in poor self-reported health, 25–75-year-olds, by education 2014-2024



Adjusted relative risk of inequality (ARR) refers to the ratio of the predicted probability of reporting poor health amongst individuals in lower socioeconomic groups compared to the predicted probabilities among those in higher socioeconomic groups. Figure 7 demonstrates the ARR amongst the countries involved in this study in 2024, and how these have changed since 2014. It reflects that the highest levels of inequality in poor health were in Austria, with an average relative risk of 2.94. This means someone from the low-education group was almost three times more likely than someone from the high-education group to report poor health. Sweden had the lowest ARR in 2024, at 1.36.

Overall, in Europe, relative inequalities in self-reported health have increased slightly between 2014 and 2024. They increased in seven countries, namely Austria, Hungary, Lithuania, Germany, Norway, France, Belgium and Switzerland. They decreased in five countries, namely Sweden, Ireland, Poland, Slovenia and the United Kingdom. In four countries, Finland, Portugal, the Netherlands and Spain, relative inequalities remained stagnant, with trends of a slight increase in the first two.

Favourable and unfavourable trajectories to reduced health inequalities

Just as information on average levels of (poor) health in a population does not reflect differences and what kinds of changes have occurred amongst different groups in society, changes in average rates of health inequalities provide an incomplete picture, too. They do not, for example, reflect whether these changes are taking place in the context of an overall increase or decrease in health. While decreasing health inequalities is positive, it is less so if the decrease results from a deterioration in the health of higher or other groups, in a situation of levelling down, rather than up towards better health.

The matrix below brings existing data on absolute inequalities provided in earlier sections together to contextualise them better and to explore whether the European countries involved in this study are on favourable or unfavourable paths to improving health.

- Countries are on a favourable path if overall health is improving, in a pattern that is also leading to a reduction in health inequalities, since the health of lower socioeconomic groups is improving at a faster rate than that of higher socioeconomic groups (Quadrant I).
- Countries can, however, also be on unfavourable trajectories while overall health is improving or being stable, as they can still experience a rise in health inequalities (Quadrant IV).
- They are also on unfavourable trajectories when overall health is declining. Even though, for some countries, this decline is leading to reduced health inequalities, since the decline in health is, for example, sharper amongst higher socioeconomic groups (Quadrant II).
- Finally, the worst-case scenario occurs when health is declining, and even more sharply amongst lower socioeconomic groups, leading to an increase in health inequalities as well (Quadrant III).

Data points for Figure 8 can be found in Annex IV.

Figure 8: Paths to equity or inequity in poor self-reported health, 25–75-year-olds, by education 2014-2024, based on absolute inequalities

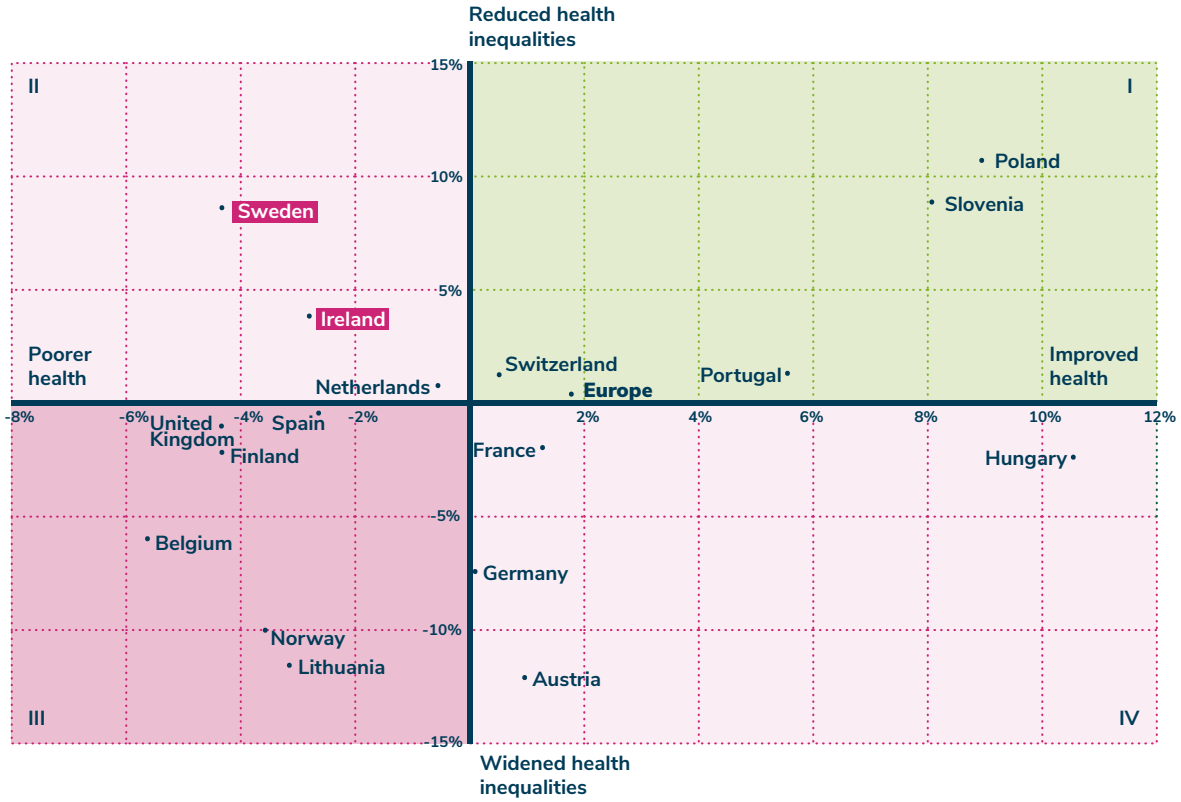


Figure 8 shows that only **Poland and Slovenia in quadrant I are on the most favourable path to simultaneously improving health and reducing health inequalities**. A more in-depth examination of the health trajectory of the three educational groups demonstrates a significant reduction in poor health among the mid- and low-education groups (refer to Figures 9 and 10). In Poland, the predicted probability of poor health for these groups has decreased by 10.1 and 12 percentage points, respectively. In Slovenia, the reduction has been of 8.5 and 11.9 p.p. This places Poland and Slovenia on a clear levelling up trend, with both absolute and relative inequalities decreasing.

Figure 9: Trajectories in poor health by education level in Poland

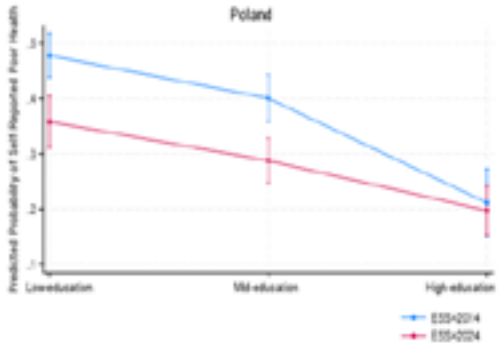
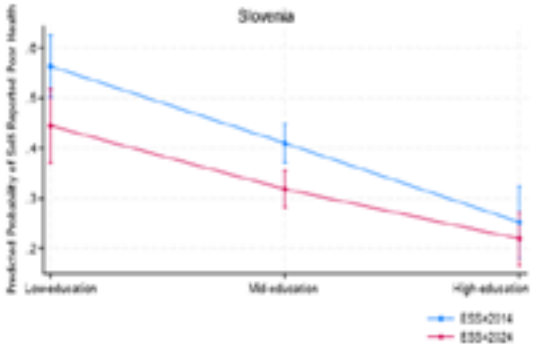


Figure 10: Trajectories in poor health by education level in Slovenia



In **Portugal** (Fig. 11), the situation is also quite favourable, since all groups reported less poor health but most significantly so amongst those with upper secondary and vocational education, the mid-education group (13.3 p.p). As a result, absolute and relative health inequalities have been significantly reduced only between mid- and high-education groups, while they remained the same, overall, with a marginal trend towards reduction between low- and high-education groups. Despite these positive trends, the low-education group in Portugal continue to report among the worst health levels in Europe, with over 50% reporting poor health.

Figure 11: Trajectories in poor health by education level in Portugal

In quadrant IV, **Austria** exemplifies the case where stability in average population health levels resulted from a strong redistribution of health across social groups. Indeed, the more detailed analysis of educational groups' health trajectory depicted in Figure 12 demonstrates that the low- and

high-education groups moved in opposite directions in terms of health. Low-education group reported poorer health, whereas the high-education group reported better health than a decade ago. This divergence in health trajectories led Austria to have the highest increases in relative and absolute inequalities amongst the countries studied. Germany demonstrated a similar pattern, although there was only a trend in declining health amongst the low-education group (refer to Annex IV).

Hungary presents the scenario where all educational groups reported better health in 2024. The significant reduction in predicted probability (Figure 13) was roughly 10 p.p. for mid- and high-education groups, but only 8.2 p.p. for the low-education group, leading to widening absolute and relative inequalities.

Figure 12: Trajectories in poor health by education level in Austria

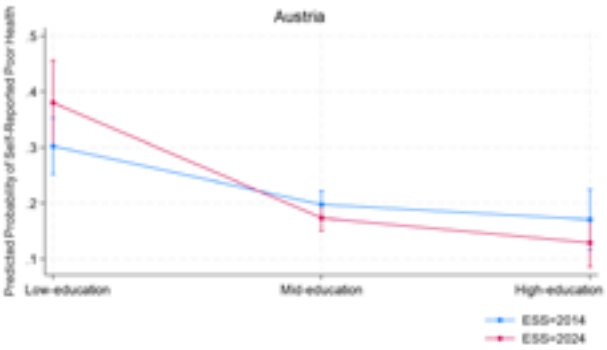
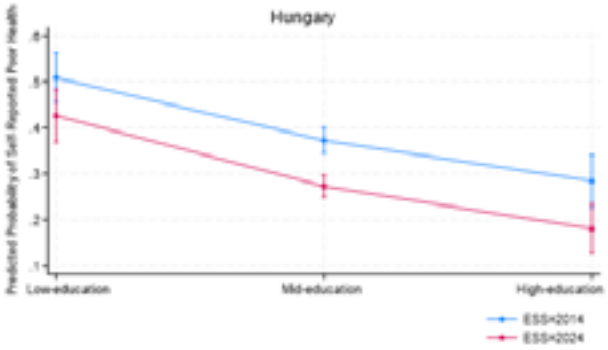
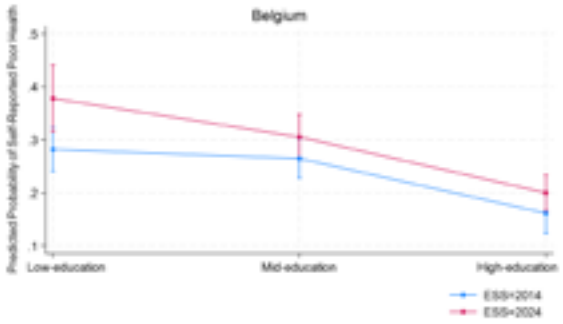


Figure 13: Trajectories in poor health by education level in Hungary



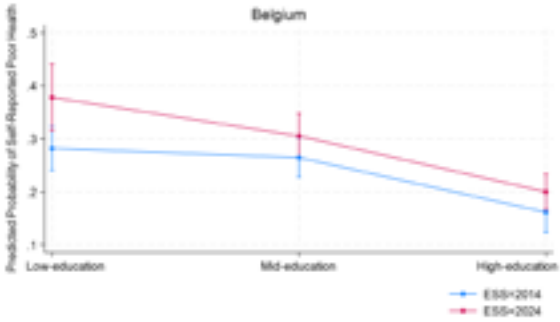
In quadrant II, in Sweden, relative inequalities indeed narrowed, but this was because respondents in the high- and mid-education groups reported a significant 5 p.p. increase in poor health. This same pattern was observed in Ireland (refer to Annex IV). A reduction in health inequalities due to a decline in the health of more advantaged social groups does not constitute progress in reducing social inequalities in health.

Figure 14: Trajectories in poor health by education level in Sweden



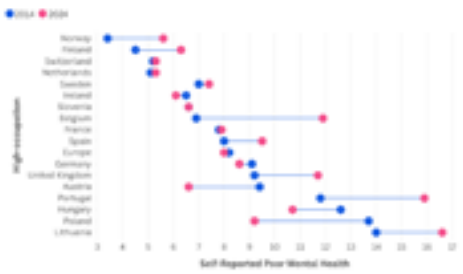
In quadrant III, we observe the worst-case scenario, characterised by a decrease in both overall population health levels and an increase in health inequalities in the clearest case of levelling down. Among the countries in this quadrant, **Belgium** has the largest increase in overall levels of poor health. In addition, this increase in poor health has been unevenly distributed among educational groups, with the biggest significant change amongst the low-education group (Figure 15). A similar trajectory is observed in all the countries in this quadrant (refer to Annex IV).

Figure 15: Trajectories in poor health by education level in Belgium



The various health trajectories (all countries available in Annex IV) demonstrate that w**hile health inequalities declined in seven of the seventeen countries studied (Poland, Slovenia, the Netherlands, Portugal, Switzerland, Ireland, and Sweden), health only levelled up in the first two. In the latter countries, social inequalities in health have reduced due to poorer levels of health in at least one or more of the higher educational groups, reflecting unfavourable trajectories towards a reduction in health inequalities.**

Figure 16: Trajectories in poor health by education level in Europe



As Figure 16 demonstrates, for all countries, there was a trend of overall improvements in health, but this was driven by increases amongst the high- and mid-education groups in some countries, and not for the low-education group, leading to a slight overall increase in health inequalities.

1.4 Trends in poor self-reported mental health, by occupation

Definition of occupational groups, derived from ESS

Working occupational group = Lower sales and service, lower technical, routine work.

Intermediate occupational group = administrative assistants, IT support, marketing or communication officers, real estate agents, electricians, retail managers, small employers and self-employed.

Salariat occupational group = Large employers, senior managers, higher-grade professionals, high-level administrative or managerial roles.

Hereafter, we will refer to these three groups as **low-occupation, mid-occupation, and high-occupation groups.**

Figure 17: Rate of poor self-reported mental health, 25–75-year-olds, 2014-2024

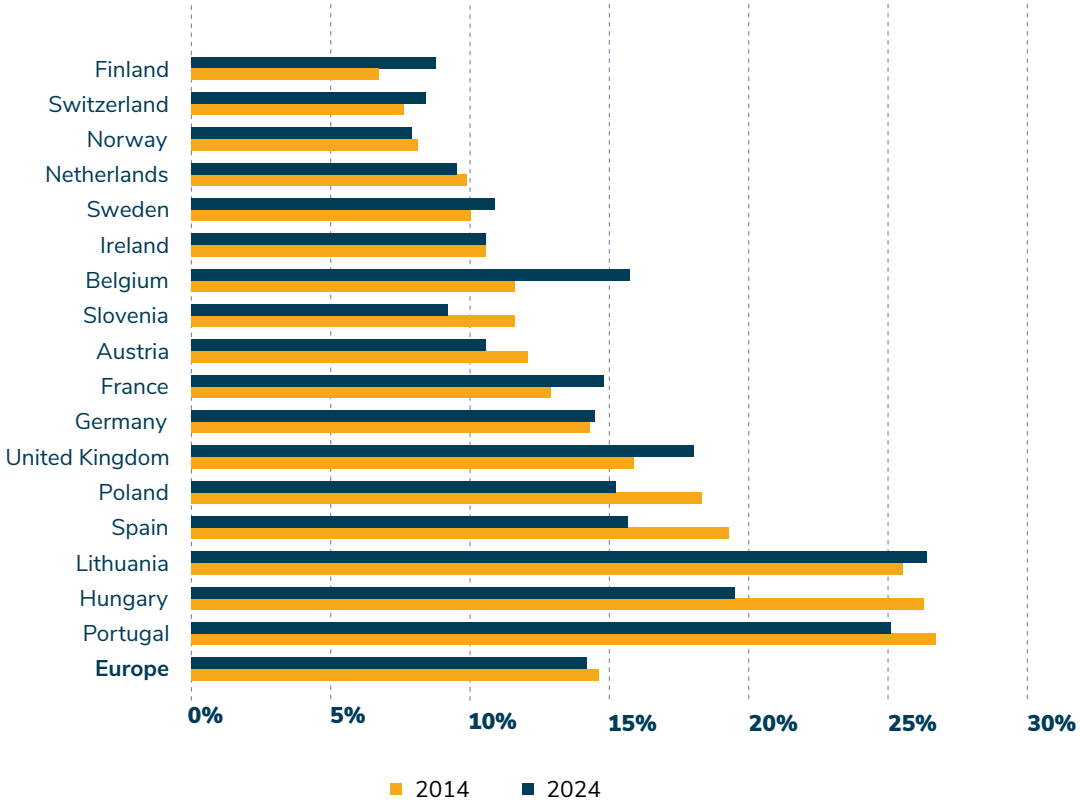


Figure 17 reflects that levels of poor mental health in 2024 in surveyed European states ranged from 7% in Norway to 24% in Lithuania.

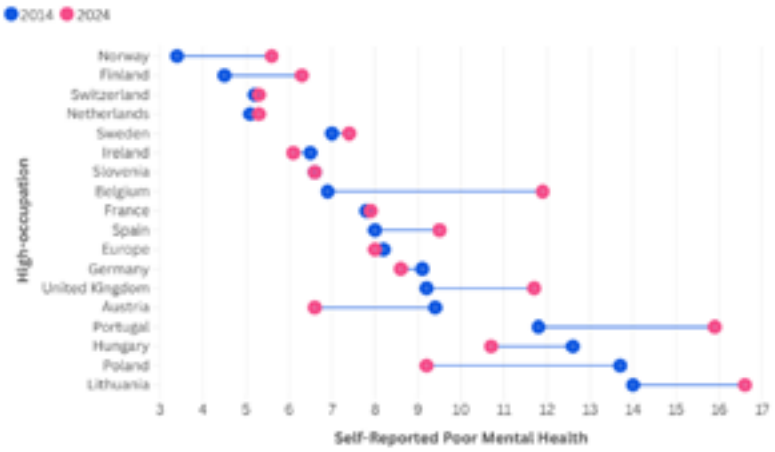
Overall, **shifts in mental health outcomes were smaller than those observed in general health**. Among countries bearing the greatest burden of poor mental health in 2014, the most substantial and statistically significant improvements occurred in Hungary (5.4 p.p.), Poland (3.8 p.p.), and Spain (2.6 p.p.). Although there were marginal improvements in Portugal, it has not benefited from the extent of improvements observed over the past decade in countries that previously exhibited comparable levels of poor mental health. Even with meaningful improvement, Hungary, Poland, and Spain continue to rank among the European nations with the highest prevalence of poor mental health.

Belgium (3.6 p.p.), the United Kingdom (2.5 p.p.), and Finland (2.0 p.p.) experienced the largest and statistically significant deteriorations in mental health at the population level. In the remaining countries, as well as across Europe overall, average levels of poor mental health either remained stable or showed changes that are not statistically significant.

1.4.2 Distributional differences

Poor mental health amongst higher-occupational groups

Figure 18: Changes in poor self-reported mental health amongst the highest occupational groups, 25–75-year-olds, 2014-2024



In 2014, there was an 11.6 p.p. gap between countries reporting the highest level of mental health amongst the high-occupation group and the low-occupation group. This ranged from 3.4 % in Norway to 14 % in Lithuania. By 2024, this gap remained similar (11.3 p.p.) but occurred at higher overall levels of poor mental health, from 5.3% in Switzerland to 16.6 % in Lithuania.

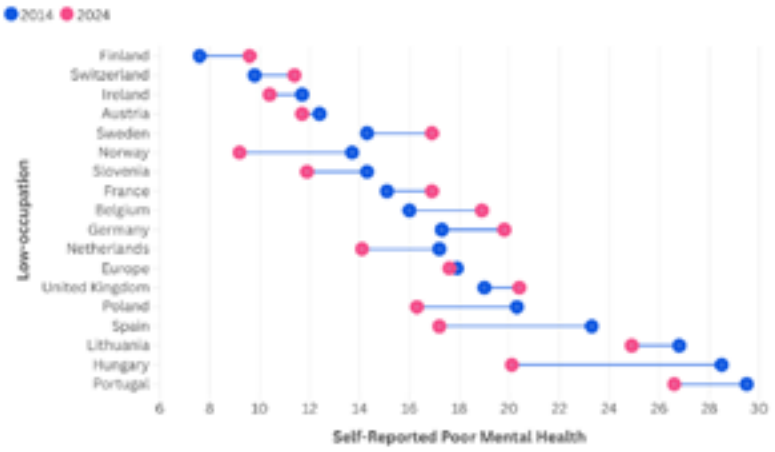
Between 2014 and 2024, seven countries recorded increasing levels of poor mental health among the high-occupation group: Belgium (5 p.p.), Portugal (4.1 p.p.), Lithuania (2.6 p.p.), the United Kingdom (2.5 p.p.), Norway (2.2 p.p.), Finland (1.8 p.p.), and Spain (1.5 p.p.). Of these, only the rise in Belgium reached statistical significance.

By contrast, the higher occupational group in three countries, Hungary (1.9 p.p.), Austria (2.8 p.p.), and Poland (4.5 p.p.) reported decreasing levels of poor mental health. The decrease in poor mental health in Poland was statistically significant.

In the remaining seven countries and across Europe as a whole, mental health levels stalled, with no significant changes.

Poor mental health amongst the lowest occupational groups

Figure 19: Changes in poor self-reported mental health amongst lowest occupational groups, 25–75-year-olds, 2014-2024



In 2014, absolute cross-country **difference in poor mental health among the lowest occupational group** was 21.9 p.p., ranging from 7.6 % in Finland to 29.5 % in Portugal. By 2024, this difference narrowed slightly to 17.4 p.p., with the lowest prevalence of 9.2 % in Norway and the highest prevalence of 26.6 % in Portugal.

Between 2014 and 2024, nine countries—Hungary, Spain, Norway, the Netherlands, Poland, Portugal, Slovenia, Lithuania, and Ireland—showed improvements in mental health. The most pronounced statistically significant improvements occurred in Hungary with 8.4 p.p. and in Spain with 6.1 p.p.

Conversely, in seven countries—Belgium, Sweden, Germany, Finland, France, Switzerland, and the United Kingdom—mental health among the working occupational group declined by between 1 and 3 percentage points. However, none of these changes reached statistical significance.

In Austria and across Europe as a whole, mental health levels stalled, with no significant changes.

The data show that mental health is stagnant among the lowest occupational group in Europe. However, between-country inequalities are decreasing as countries that used to have better mental health for the low-occupation group in 2014 now have higher rates of poor mental health, and countries that in 2014 had higher rates of poor mental health for the working group have slightly lower rates in 2024. In short, countries

are ‘meeting in the middle’ when it comes to mental health rather than levelling up.

1.4.3 Changes in relative inequalities in poor self-reported mental health, 25–75 years, 2014-2024

Figure 20: Changes in relative inequalities in poor self-reported mental health, 25–75 years, 2014-2024

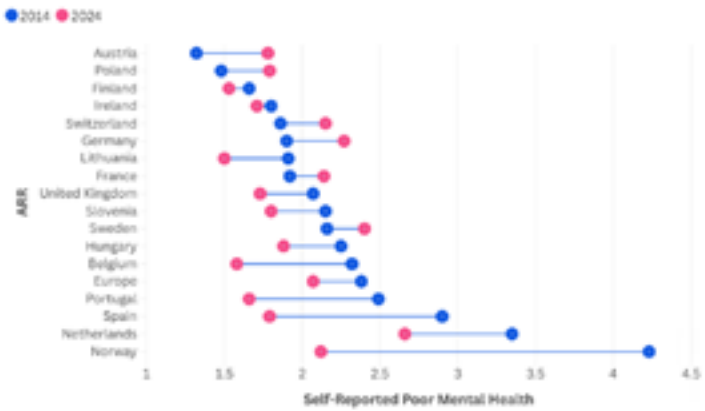
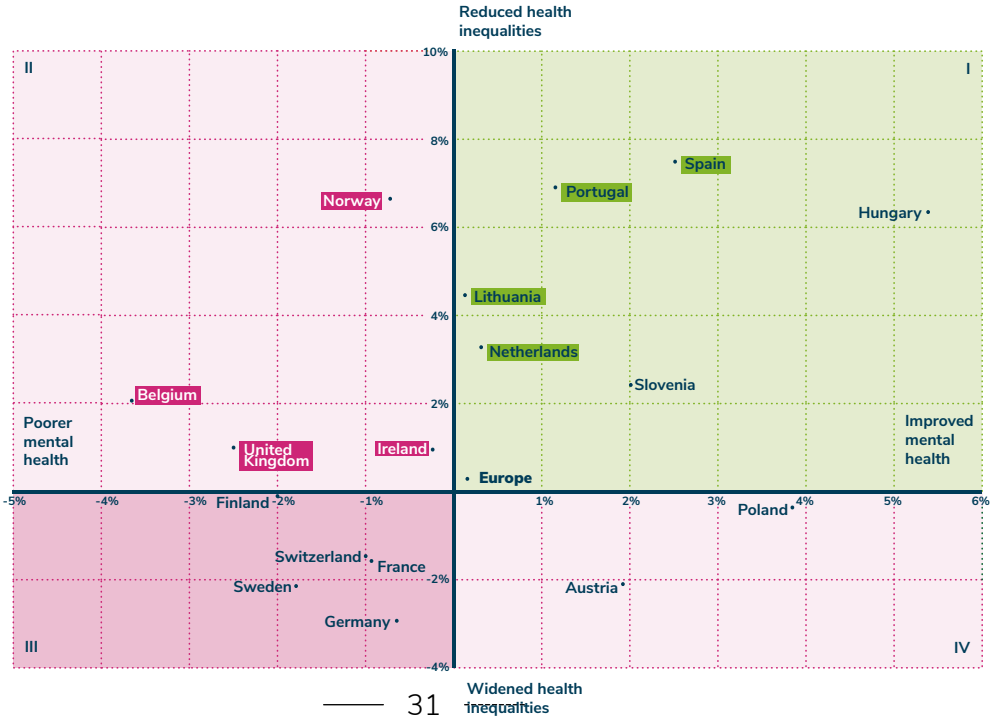


Figure 20 reflects that **relative inequalities in poor mental health declined in eleven of the 17 countries studied**, namely Norway, Spain, Portugal, the Netherlands, Belgium, the United Kingdom, Lithuania, Hungary, Slovenia, Finland and Ireland. These declines were significant in Norway, Spain and Portugal. Relative health inequalities in poor mental health increased in six countries —Austria, Germany, Poland, Switzerland, Sweden, and France— but these increases were not statistically significant. **While it is encouraging that relative inequalities in poor mental health have declined in most countries, it is important to consider the context. This decline may reflect overall improvements in health, or less positively, worsening health in one or more social groups**, as the section below will explain

Figure 21: Paths to equity or inequity in poor self-reported mental health, 25–75-year-olds, by occupation 2014-2024, based on absolute inequalities



Levels of poor mental health appear to be stagnant or are declining amongst over half of the European countries involved in our analysis. At the same time, inequalities in poor mental health also appear to be persistent or declining in most European countries. (Refer to Annex IV)

Despite these trends, only two of the six countries in quadrant I of the figure above, which represent countries with improving levels of mental health and decreasing health inequalities, are levelling up health, namely **Hungary and Slovenia.**

Figure 22: Trajectories in poor mental health by occupation level in Hungary

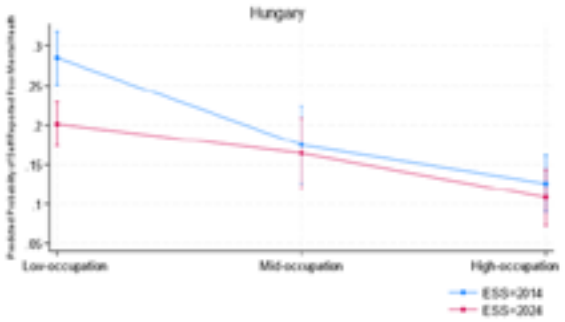
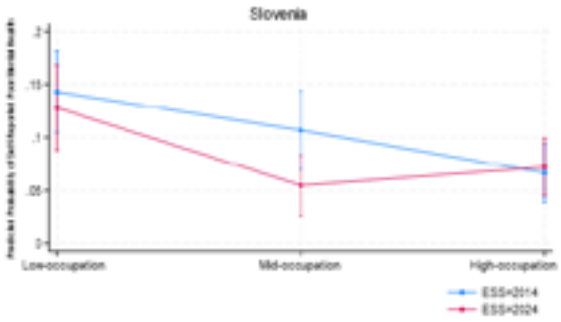
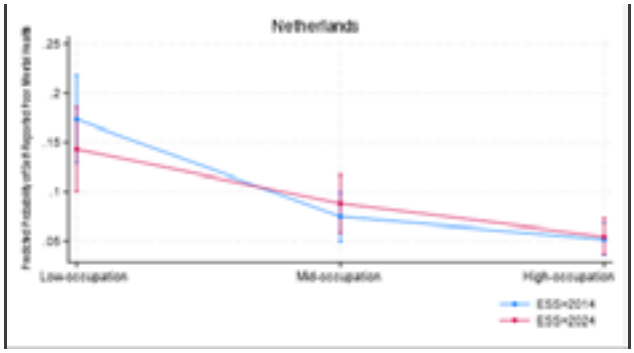


Figure 23: Trajectories in poor mental health by occupation level in Slovenia



In the **Netherlands, as in Slovenia**, the mental health of the higher occupation group remained stable. The Netherlands (Figure 24) also saw an improvement in the low-occupation group, but there was a slight decline in mental health among the mid-occupation group.

Figure 24: Trajectories in poor mental health by occupation in the Netherlands



In some countries with statistically significant declines in mental health and health inequalities, such as **Spain, Portugal and Lithuania**, these declines resulted in part from decreases in mental health among the high-occupation group (refer to Annex VI for graphs of all countries in each trajectory).

Figure 24: Trajectories in poor mental health by occupation level in Portugal

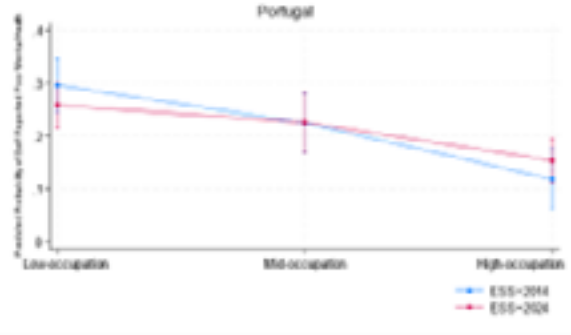
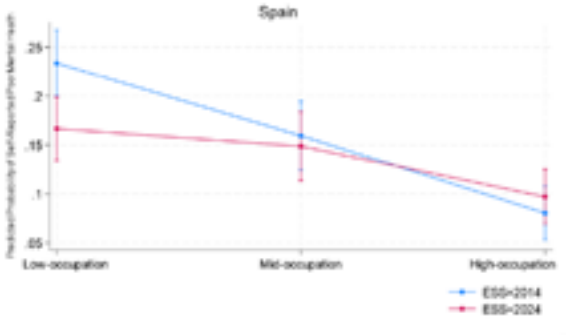


Figure 25: Trajectories in poor mental health by occupation level in Spain



In Austria and Poland in quadrant IV, overall levels of mental health improved across the population. Still, health inequalities in poor mental health widened, although to a statistically non-significant level. In Austria (Figure 27), most of the improvement in mental health was concentrated amongst the high-occupation group, contributing to a trend of increasing inequality. In Poland, both the significant improvements in mental health amongst the high- occupation group were better than the improvements amongst the mid-occupation group and slightly better than amongst the low group, slightly widening health inequities.

Figure 27: Trajectories in poor mental health by occupation level in Austria

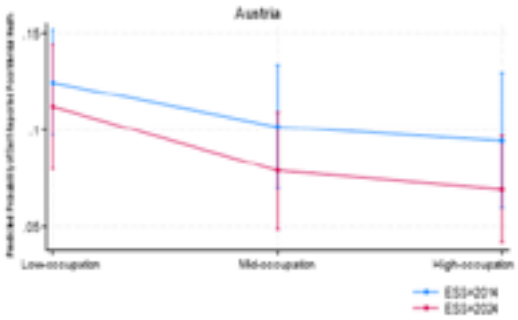
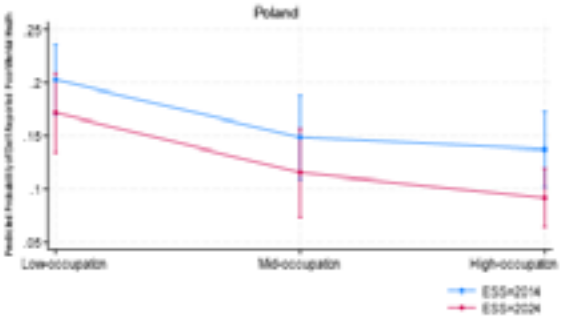


Figure 28: Trajectories in poor mental health by occupation level in Poland



In quadrant II, Belgium and the United Kingdom saw statistically significant increases in poor mental health, but a reduction in inequalities, which were driven by a significant increase in poor mental health amongst high-occupation group. This trend applied mainly to the high-occupation group in Belgium (Figure 29) and the mid-occupation group in the United Kingdom (Figure 30). The reduction of health inequalities in these countries, therefore, resulted from overall reductions, or a levelling down of mental health.

Figure 29: Trajectories in poor mental health by occupation level in Belgium

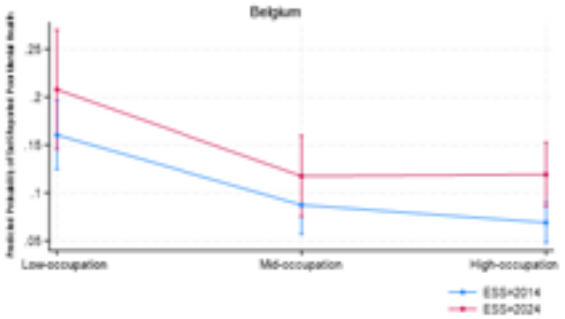
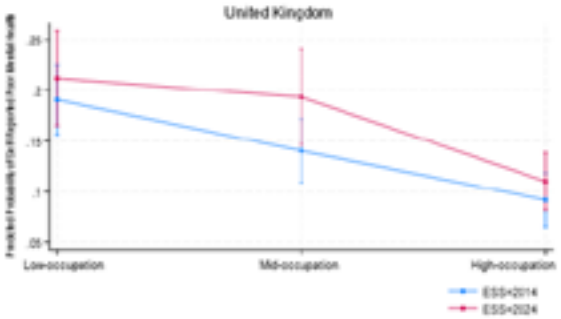


Figure 30: Trajectories in poor mental health by occupation level in the United Kingdom



In Norway and Ireland, by contrast, under a stable overall level of mental health over the last decade, important social redistributions have taken place. A large burden has been shifted towards high-occupation group in Norway (Fig. 31), and towards the mid-occupation group in Ireland (Fig. 32)

Figure 31: Trajectories in poor mental health by occupation level in Norway

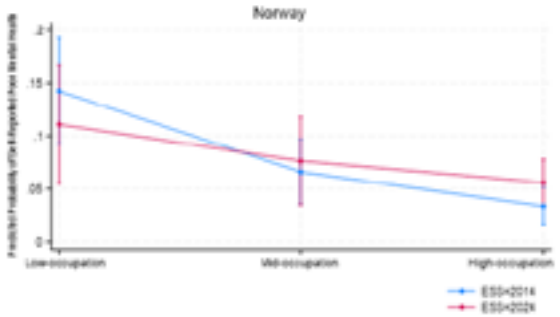


Figure 32: Trajectories in poor mental health by occupation level in Ireland

France, Sweden, Switzerland, Germany and Finland, quadrant lll, show the most concerning trends. In the first three countries, mental health was stable for the high-occupation group, but declined for the low-occupation group, leading to an increase in health inequalities in mental health (Figure 33). In Germany (Figure 34), the rather stable levels of overall mental health were redistributed; they improved amongst the high-occupation group but declined amongst the low-occupation group.

Figure 33: Trajectories in poor mental health by occupation level in Sweden

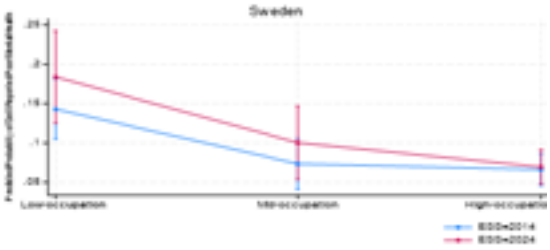
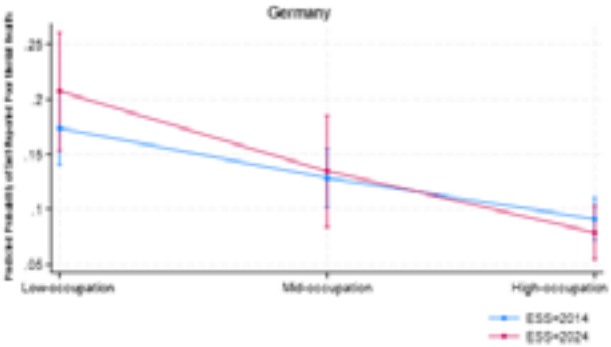


Figure 34: Trajectories in poor mental health by occupation level in Germany



Finland is the only country in quadrant IV that has more equally distributed the statistically significant increase of overall levels of poor mental health between the low- and high-occupation groups. Despite the negative trend, all occupational groups in Finland continue to have among the lowest levels of poor mental health in Europe.

Overall levels of self-reported poor mental health across Europe have remained stagnant over the past ten years, despite the shifts that occurred across occupational groups within countries across Europe. There was a slight decrease in health inequalities in poor mental health across Europe, but this masks, as was demonstrated above, highly varied situations per country.

1.5 Changes in health problems including chronic conditions and NCDs and their causes

1.5.1 Changes in chronic diseases, including non-communicable diseases (NCDs)

ESS round 11 and round 7 asked respondents about health problems that they had or experienced over the last 12 months. The responses across 17 European countries were then compared to those provided in ESS round 7, to see to what extent these health problems had changed. Figure 35 presents how responses in terms of percentage changed between 2014 and 2024. See Annex VII for actual prevalences of health problems.

In 2024, **arm pain, leg pain and especially back pain continued to affect large shares of Europeans in all included countries**, without apparent regional variation. The same applied to stomach problems, except for the lower rate in Hungary, Portugal and Ireland. Regional disparities in the prevalence of cardiovascular conditions that were evident in 2014 have largely converged: northern European countries have seen an increase in rates, while many Eastern European countries have experienced marked declines. The prevalence of breathing problems remained particularly low in central and eastern Europe, whereas allergies appeared to be more problematic and rising faster in northern Europe. **A large part of the European population continued to live with multimorbidity**. However, between-country inequalities in multimorbidity remained large, ranging from a prevalence of approximately 20% in Ireland and Hungary to over 50% in Belgium, Finland, Germany and Norway.

Figure 35: Changes in health problems between ESS round 7 (2014) and round 11 (2024) for 25–75-year-olds

Central/East		Heart	HBP	Breathing	Allergy	Back pain	Arm pain	Leg pain	Stomach	Skin	Headache	Diabetes	Morbidity	Multi Morbidity
Hungary	M	-0,2	2,1	-1,7	-2,4	-4,1	-0,2	3,9	-2,3	1,2	-3,0	1,8	-1,7	-2,3
	F	-3,6	-1,1	-2,7	-4,4	-4,4	-5,2	-6,2	-3,5	-1,2	-8,4	0,3	0,4	-9,5
Lithuania	M	-1,8	-0,2	2,0	1,7	4,8	5,0	3,2	1,0	6,0	6,4	1,7	1,7	6,2
	F	-5,7	-2,4	0,4	5,7	9,3	3,8	6,0	4,1	7,6	3,3	3,7	1,4	8,1
Poland	M	-5,7	-2,7	0,2	-0,2	-2,8	-4,2	-3,6	-0,1	-0,2	-2,6	1,4	-1,6	-4,4
	F	-9,4	-2,1	-1,3	-0,7	-1,9	-5,6	-1,9	-2,0	0,9	-0,3	0,4	-4,3	-3,7
Slovenia	M	0,2	-3,1	-1,3	-0,3	-2,9	-3,2	-0,8	2,1	0,3	-1,7	2,2	-3,0	0,4
	F	-4,2	-6,5	-1,5	2,2	-4,7	-1,6	-0,3	1,6	2,8	-1,6	-3,0	-0,2	-3,9

Sounth		Heart	HBP	Breathing	Allergy	Back pain	Arm pain	Leg pain	Stomach	Skin	Headache	Diabetes	Morbidity	Multi Morbidity
Portugal	M	2,3	-2,6	-1,2	-2,6	-8,3	-0,9	-4,1	-1,1	-0,9	1,5	-1,7	-7,2	3,5
	F	-7,9	-7,4	-6,2	-13,3	-23,3	-25,7	-20,1	-11,7	-3,2	-21,2	0,4	6,9	-33,5
Spain	M	-0,4	2,7	0,7	3,6	3,9	1,8	2,1	0,9	3,7	-0,5	0,8	-4,1	8,7
	F	1,7	0,3	1,6	7,0	4,2	-3,0	-3,1	4,2	3,1	-0,5	0,8	-3,2	8,1

North		Heart	HBP	Breathing	Allergy	Back pain	Arm pain	Leg pain	Stomach	Skin	Headache	Diabetes	Morbidity	Multi Morbidity
Finland	M	1,3	5,6	0,0	5,6	2,3	-5,9	-0,6	2,8	4,2	3,0	0,7	-2,2	5,2
	F	-0,1	-2,2	-1,2	9,0	-3,1	2,1	3,6	3,5	2,0	5,2	0,8	-4,4	4,6
Norway	M	0,6	2,7	-2,2	5,7	4,9	-2,2	2,7	0,8	0,6	4,1	0,8	2,2	3,1
	F	-0,8	-2,0	-0,7	5,6	0,2	-3,7	-2,2	4,5	2,6	0,1	0,3	-4,7	6,9
Sweden	M	1,6	2,9	-1,2	11,1	3,9	2,8	1,9	1,7	5,0	2,8	0,1	-3,0	7,3
	F	0,0	-1,6	-0,1	7,8	-1,6	-2,3	5,0	3,5	4,9	-2,0	0,2	-1,1	5,0

West		Heart	HBP	Breathing	Allergy	Back pain	Arm pain	Leg pain	Stomach	Skin	Headache	Diabetes	Morbidity	Multi Morbidity
Austria	M	-2,5	1,4	-1,2	-0,6	1,3	1,0	3,2	2,5	-1,6	-2,4	0,4	-4,7	1,0
	F	-1,7	-1,2	-1,0	0,7	1,0	-2,8	4,1	0,1	-2,2	-2,2	0,5	-1,5	-1,5
Belgium	M	0,6	2,1	3,3	4,0	-2,0	1,2	3,0	3,5	1,2	5,1	1,8	0,0	2,1
	F	0,6	-3,6	1,6	3,6	0,7	-2,4	2,6	2,5	3,8	3,4	0,8	-3,4	2,7
France	M	1,0	1,8	-3,0	0,9	-10,2	-1,9	-3,0	-1,5	-2,2	-4,4	0,0	-1,7	-4,7
	F	0,1	-0,8	-1,1	1,2	-13,7	-5,7	0,1	2,0	1,0	-5,4	-0,4	4,5	-8,4
Germany	M	0,4	1,2	0,9	4,3	-0,6	2,5	3,3	-1,1	2,5	-0,5	1,6	-3,4	4,9
	F	0,0	-2,6	-0,4	1,9	0,0	0,4	-1,2	-0,8	3,3	3,2	-1,7	-0,3	0,1
Ireland	M	1,8	1,8	0,7	1,5	-6,2	1,8	-1,4	-0,4	-0,2	-1,4	0,8	1,3	-2,3
	F	-0,5	0,6	0,3	2,1	-0,9	0,6	1,7	0,8	-0,6	-1,3	0,3	-6,1	1,6
Netherlands	M	-2,7	-3,2	-0,8	3,7	4,7	1,2	-0,4	1,6	3,4	0,4	-2,3	-1,9	2,6
	F	-0,5	-5,4	3,2	4,6	-2,3	0,9	-1,0	2,3	2,7	-0,5	-0,7	-4,5	4,2
Switzerland	M	-1,5	3,4	2,8	8,6	3,0	0,7	-2,6	1,3	2,2	1,3	0,5	-3,2	5,5
	F	1,1	0,6	1,2	3,4	-1,2	-0,3	1,4	1,0	3,9	2,4	-1,1	-2,1	3,3
UK	M	-1,1	-2,6	-1,7	2,9	-4,1	-2,2	-3,0	0,3	-0,4	-0,9	-0,4	-4,7	-3,1
	F	-1,1	-2,1	-0,5	-1,3	-1,8	0,0	-3,1	3,8	-1,1	0,0	1,5	5,9	-1,9

1.5.2 Changes in healthcare access and health behaviours

Survey participants were also asked about access to health care and their health-related behaviours. The following figure reflects changes in responses between 2014 and 2024. See Annex VII for actual prevalences.

Figure 36: Changes in health access and health behaviours between ESS rounds 7 (2014) and round 11 (2024) for 25–75-year-olds

Central/East		Unmet need	Waiting List	No appoint	Visited GP	Visited specialist	Used alternative treatment	Alcohol >once / week (%)	Binge at least weekly(%)	Physical activity on 3-4 days (%)	Fruit & veg at least once / day (%)	Smoking (current %)
Hungary	M	5,6	5,5	2,7	-5,3	0,9	2,1	-6,5	4,9	2,6	-0,5	-5
	F	3,5	3,0	2,7	-5,2	-1,5	-1,8	-0,5	0,5	7,3	8,9	-5
Lithuania	M	6,6	5,2	5,3	22,1	7,6	7,1	-7,5	-9,4	2,9	11,4	1
	F	5,8	3,8	3,1	9,4	9,5	8,4	-1,8	-1,8	2,1	7,2	5
Poland	M	-2,3	-2,5	-0,3	-2,6	3,0	4,9	-5,6	1,2	1,7	-9,1	-5
	F	-1,6	-0,7	1,3	-1,7	8,0	10,4	-1,0	1,3	3,3	-4,8	-2
Slovenia	M	2,9	1,4	1,2	-2,9	-1,5	3,7	-1,2	-1,3	5,1	-10,2	-5
	F	6,7	5,7	1,7	2,5	0,8	14,5	-1,3	-0,7	6,0	-8,2	-4

Sounth		Unmet need	Waiting List	No appoint	Visited GP	Visited specialist	Used alternative treatment	Alcohol >once / week (%)	Binge at least weekly(%)	Physical activity on 3-4 days (%)	Fruit & veg at least once / day (%)	Smoking (current %)
Portugal	M	-3,7	-1,5	0,6	-12,7	-2,8	-1,5	-2,7	6,3	0,5	-19,7	-9
	F	3,0	3,8	3,4	-6,0	9,2	6,1	-4,7	5,6	1,4	-13,7	-1
Spain	M	6,6	6,1	4,3	0,4	5,1	9,7	-6,9	1,4	-1,1	-7,9	-4
	F	13,8	11,1	8,5	0,8	6,3	8,7	-4,5	-0,6	4,2	-8,8	-9

North		Unmet need	Waiting List	No appoint	Visited GP	Visited specialist	Used alternative treatment	Alcohol >once / week (%)	Binge at least weekly(%)	Physical activity on 3-4 days (%)	Fruit & veg at least once / day (%)	Smoking (current %)
Finland	M	0,2	0,0	-1,8	-4,6	6,1	1,6	-2,1	-3,3	-1,6	-14,1	-10
	F	4,5	1,4	2,7	-1,5	7,2	-1,3	-1,0	0,7	2,9	-6,9	-9
Norway	M	8,3	1,8	4,4	1,8	6,4	-1,8	-1,4	0,0	2,3	-12,9	-8
	F	9,6	2,5	6,8	2,6	8,4	2,8	1,6	2,5	-0,8	12,6	-8
Sweden	M	6,6	3,2	2,2	-1,1	10,4	1,0	0,8	1,9	1,1	-12,8	-8
	F	7,3	3,7	3,8	-5,5	6,9	6,7	4,3	1,9	1,8	-14	-7

West		Unmet need	Waiting List	No appoint	Visited GP	Visited specialist	Used alternative treatment	Alcohol >once / week (%)	Binge at least weekly(%)	Physical activity on 3-4 days (%)	Fruit & veg at least once / day (%)	Smoking (current %)
Austria	M	5,7	2,5	2,2	0,1	10,8	-2,0	3,5	-7,1	3,4	3,2	-6
	F	5,0	2,6	2,2	-1,4	13,1	1,6	3,4	-1,4	3,0	3,2	-6
Belgium	M	5,2	2,9	0,6	5,6	6,7	8,8	-2,0	0,9	3,5	-9,9	-7
	F	8,8	4,4	4,6	0,0	9,6	11,6	-2,1	2,5	-3,2	-3,9	-7
France	M	2,8	1,6	6,3	0,5	3,5	8,7	-7,7	-1,0	-1,4	-5,8	-9
	F	-0,6	1,3	5,8	-0,3	4,6	11,0	-2,1	1,2	2,8	-13,2	-9
Germany	M	5,0	4,2	6,0	-0,1	2,2	1,0	-1,3	2,2	-2,4	-7,8	-3
	F	1,4	2,0	4,7	2,3	-4,6	1,2	-3,2	0,5	-0,1	3,7	-4
Ireland	M	6,2	3,9	3,0	2,1	2,4	1,5	-2,2	-1,9	-1,6	-7,3	-5
	F	7,0	3,6	4,3	3,7	5,2	0,0	0,3	-0,5	0,0	-6,3	-8
Netherlands	M	3,6	2,4	1,0	-1,8	1,8	8,2	-8,1	-2,0	0,1	2,6	-12
	F	4,1	3,4	0,5	-0,1	-0,8	9,7	-7,3	0,6	2,0	-3,3	-9
Switzerland	M	3,8	2,2	2,0	3,6	4,5	9,5	-3,0	-1,7	4,6	-10,6	-3
	F	1,4	1,8	2,0	-2,2	5,8	1,3	-2,8	-0,7	4,6	-14,8	-5
UK	M	12,3	5,6	9,3	-10,5	1,7	1,8	-10,4	-3,4	2,7	-9,0	-7
	F	13,8	5,4	7,5	-8,8	2,2	0,4	-6,1	4,2	3,0	-6,3	-5

The results of the analyses reflect that overall, **Northern and Western European countries have experienced rising levels of chronic diseases and multimorbidity in the last decade.** At the same time, **improvements in Eastern European countries were observed, except for Lithuania.** This trend also corresponds with outcomes relating to self-reported health and mental health, as presented earlier.

In terms of changes to social determinants of health, **higher levels of unmet need** were found in most European countries, primarily driven by **long waiting times** or unavailable appointments. A decrease in the **use of general practitioners** was observed, while the **use of specialist care increased**.

Substantial lifestyle changes have also taken place. Considerably less smoking was reported in all countries except Lithuania, and less frequent alcohol consumption was reported, except for Sweden and Austria. On the other hand, a healthy diet, measured as consumption of at least one serving of fruits or vegetables per day, was found to have decreased in all countries, except for Austria, Hungary, and Lithuania.

1.5.3 Changes in material and psychosocial determinants

Figure 37: Changes in material and psychosocial determinants between ESS rounds 7 (2014) and 11 (2024), amongst 25–75-year-olds

Central/East		Any ergonomic hazards	Any material Hazards	Often/always conflict growing up	Often/always finacialhardship growing up	Any problem with housing	Provide unpaid care	>10 hrs unpaid care/ week
Hungary	M	-20,9	-11,3	-3,8	-11,8	-2,4	-0,7	9,5
	F	-18,0	-16,2	-2,8	-12,0	-1,1	-3,2	-2,1
Lithuania	M	-13,4	2,7	1,1	-5,6	-7,1	7,2	-10,0
	F	11,4	-2,6	6,2	-8,0	-3,4	5,2	-18,6
Poland	M	15,3	-17,6	3,1	-7,5	-1,7	-4,7	-2,0
	F	-19,0	-16,9	3,1	-7,2	0,3	-1,5	-13,8
Slovenia	M	-13,5	10,3	1,7	-5,3	-5,9	-2,1	-3,6
	F	10,9	10,2	1,6	-9,4	-5,4	3,7	1,2

Sounth		Any ergonomic hazards	Any material Hazards	Often/always conflict growing up	Often/always finacialhardship growing up	Any problem with housing	Provide unpaid care	>10 hrs unpaid care/ week
Portugal	M	-20,9	-25,3	-0,2	-14,7	9,8	-8,8	-3,0
	F	-28,7	-18,4	-2,4	-8,6	5,6	-2,9	-4,9
Spain	M	-7,4	-10,4	2,0	-4,3	2,1	3,1	-6,8
	F	-6,2	-8,8	6,2	0,3	-0,1	-2,1	-8,9

North		Any ergonomic hazards	Any material Hazards	Often/always conflict growing up	Often/always finacialhardship growing up	Any problem with housing	Provide unpaid care	>10 hrs unpaid care/ week
Finland	M	-10,3	-7,6	2,6	-4,3	8,0	4,8	-2,9
	F	-9,7	-5,9	2,3	-3,0	2,9	4,1	-0,4
Norway	M	1,9	-0,4	2,5	-0,5	7,9	8,3	-0,7
	F	6,7	0,4	0,8	-1,2	7,9	0,1	1,7
Sweden	M	-1,8	0,0	-0,3	-2,3	14,2	4,2	1,3
	F	-3,2	-1,6	-0,6	-4,9	12,1	-1,5	-5,6

West		Any ergonomic hazards	Any material Hazards	Often/always conflict growing up	Often/always finacialhardship growing up	Any problem with housing	Provide unpaid care	>10 hrs unpaid care/ week
Austria	M	-15,1	-13,9	0,8	-6,2	2,5	12,1	-6,1
	F	-8,9	-4,2	-2,0	-7,0	1,2	4,3	-4,7
Belgium	M	-7,5	-9,2	2,0	-4,2	9,1	6,4	-3,2
	F	-3,5	-2,5	6,5	-1,2	5,4	1,5	-6,1
France	M	-9,9	-8,9	-3,7	-5,0	4,7	3,3	1,9
	F	-11,2	-5,7	-2,3	-9,8	2,0	5,2	-2,5
Germany	M	-8,8	-8,2	1,3	-1,5	12,8	2,4	0,5
	F	-12,3	-4,3	2,5	1,3	8,6	3,4	1,7
Ireland	M	-11,3	-7,2	3,8	-1,7	6,4	1,9	-6,5
	F	-4,8	-9,0	4,4	-2,1	6,8	-2,9	-7,7
Netherlands	M	-0,9	-0,6	1,5	-6,9	5,8	-2,6	-8,3
	F	-2,4	1,0	-0,9	-3,6	7,4	-4,6	-3,2
Switzerland	M	-4,9	-7,7	-0,5	-3,5	10,5	3,1	-0,1
	F	2,2	0,7	-0,8	-2,5	7,7	1,8	-3,2
UK	M	-19,6	-17,2	-0,1	-1,2	2,6	-2,4	-9,3
	F	-3,8	-4,4	0,9	-3,5	6,3	2,2	5,6

Europeans are experiencing more housing problems, providing more unpaid care, and have been raised in households with more frequent conflicts but with fewer financial hardships.

Working conditions present a strong and positive trend in terms of less exposure to ergonomic and material hazards.

See Annex VII for actual prevalences per country, by males and females.

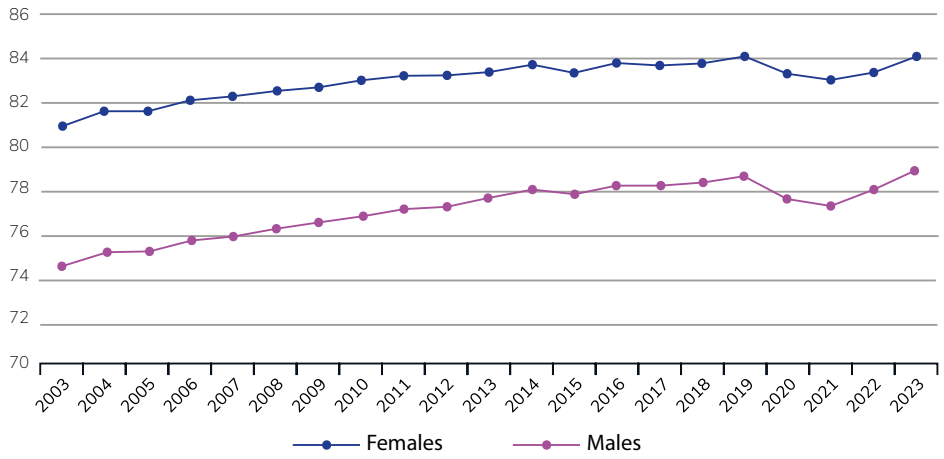
Gains in life expectancy are slowing across Europe

While levels of life expectancy continue to increase in most Member States, the rate of growth has slowed considerably since the early 2000s. This can be attributed to the effects of the COVID-19 pandemic, although general trends of slowing life expectancies predate this. xxiv

According to Eurostat, between 2019 and 2023, 18 EU countries experienced an increase in life expectancy 2023, while two countries remained stable, and 6 saw a decrease. The largest increase has been estimated in Romania (+1.0 years), followed by Lithuania (+0.8 years), Bulgaria, Czechia, Luxembourg and Malta (all with a rise of +0.7 years). Conversely, Austria and Finland recorded the largest decreases (-0.4 years each), followed by Estonia and the Netherlands (-0.2 years).

While the COVID-19 pandemic has been responsible for this slowdown in life expectancy, a trend of slowing preceded the pandemic.

Life expentency at birth in the EU, 2003-2023
(years)



The slowdown in life expectancy may, in part, be because highly industrialised countries are reaching life-expectancy ceilings, but not entirely so. The Global Burden of Disease Study (GBDS), for example, suggests that the biological limit of human lifespan may be around 110 years.[29] Whether or not there is a fixed upper limit to lifespan is, however, a topic of active debate.[30] The GBDS notes, however, that there is still considerable scope for a reduction in key health risks and therefore mortality in highly industrialised countries, like those in the EU.

1.6. Underlying factors associated with poor mental health and inequalities in poor mental health and poor health

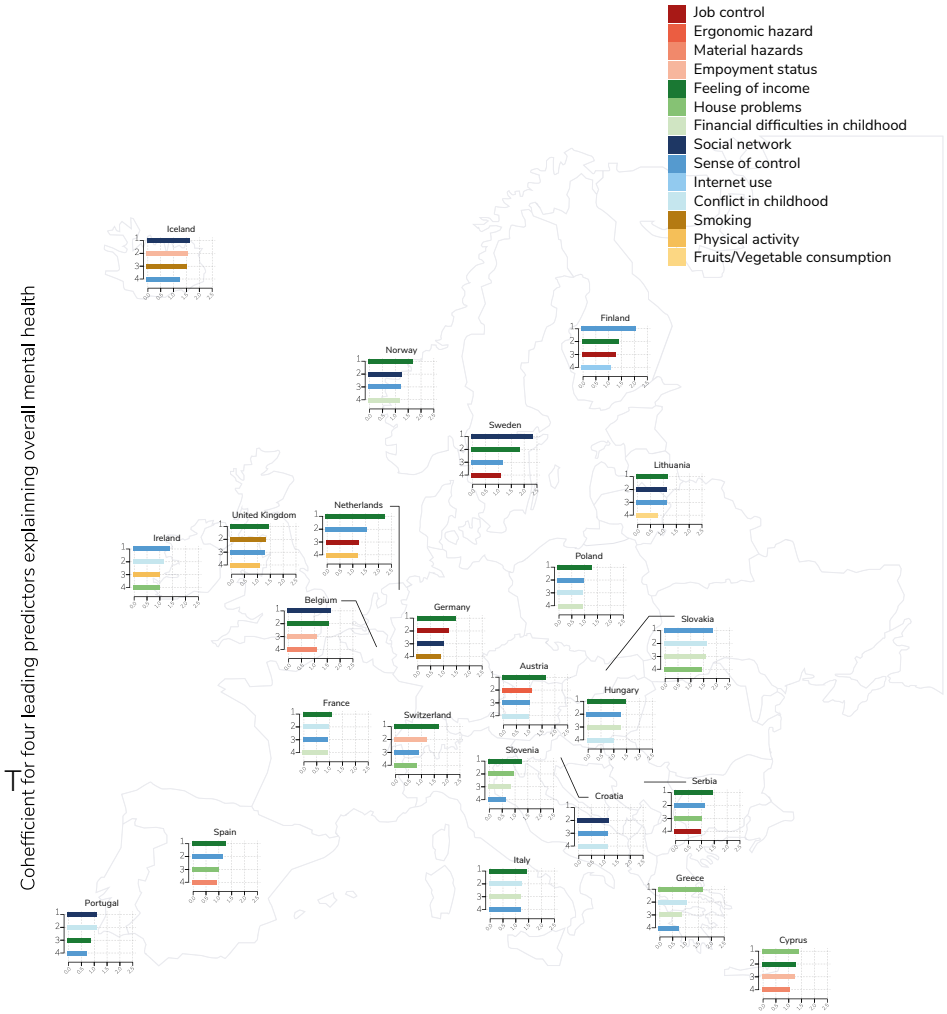
For each of the 24 countries in ESS round 11, the data were examined to identify which factors most strongly correlate with poor mental health and health, focusing on those that best predict these outcomes. The analysis focused on occupational, material, psychosocial and behavioural factors. The baseline model included age, gender, and socioeconomic group. Each of the seventeen candidate predictors (e.g., BMI, physical activity, smoking behaviour, childhood financial hardship, refer to Annex II) was then added individually to form separate extended models.

1.6.1 Factors explaining poor mental health

The analyses found that in nearly half of the twenty-four examined countries, including Switzerland, Germany, Spain, France, the United Kingdom, Croatia, the Netherlands, Poland, Portugal, Serbia, and Slovakia, **being female is significantly associated with a higher likelihood of reporting poor mental health.**

The association between age and mental health shows a broader geographical pattern. In eleven Eastern and Southern European countries, seven countries, Hungary, Croatia, Italy, Lithuania, Portugal, Serbia and Slovakia, older age groups, from 45 to 75 years, are more likely to report poor mental health. Conversely, in Western and Northern European countries, including Belgium, Switzerland, Germany, Iceland and Sweden, younger age groups, from 25 to 44 years, exhibit a greater risk.

Figure 38: Factors explaining poor mental health amongst 25 – 27-year-olds (2024)



The figure above illustrates each country's four most strongly associated predictors of poor mental health, with colour-coding to denote categories of social determinants:

- occupational (red)
- material (green)
- psychosocial (blue)
- behavioural (brown)

A notable finding is that **perceived financial strain, or feelings about income, emerges as the strongest predictor in fourteen countries,** namely Norway, the United Kingdom, the Netherlands, Lithuania, Germany, Poland, France, Switzerland, Austria, Spain, Italy, Slovenia, Hungary and Serbia. In these settings, the strength of the association is predominantly large, except in Spain, France and Slovenia, where it is moderate. Additionally, **perceived financial strain is the second strongest predictor in four other countries,** Sweden, Finland, Belgium and Cyprus, again with associations ranging from moderate to large.

Psychosocial factors also appear prominently. **Control over one's life ranks first or second in eight countries,** namely Finland, Ireland, the Netherlands, Poland, Slovakia, Spain, Hungary and Serbia, with associations varying from moderate to large. **Social networks are similarly prominent in seven countries**, Iceland, Sweden, Norway, Belgium, Lithuania, Portugal and Croatia, again showing moderate to large associations.

By contrast, **behavioural factors, such as physical activity, alcohol use or diet, are among the top predictors in only six countries, Iceland, Ireland, the United Kingdom, the Netherlands, Germany and Lithuania**. Yet, they demonstrate moderate to large associations in only three: Iceland, the United Kingdom and the Netherlands.

See Annex VIII for specific coefficients.

1.6.2 Factors explaining inequalities in poor mental health (by occupation)

The figure below illustrates the percentage reduction in occupational inequalities and the gap between the salariat, or the highest occupational group, and the working class in poor mental health after controlling for each factor independently. To focus on the most impactful factors, we report the four factors with the largest attenuation of relative inequalities.

Here, too, perceived financial strain (feeling of income) emerged as the single most influential factor in reducing relative mental health disparities between salariat and working groups. In thirteen countries—Belgium, Switzerland, Spain, the United Kingdom, Hungary, Ireland, Italy, the Netherlands, Norway, Poland, Portugal, Slovenia, and Slovakia—it accounts for 44 to 82% of observed inequalities. It also ranks as the second most influential factor in Germany, France and Sweden, where it explains 30 to 35% of the disparities.

Job control emerges as the next most powerful contributor to reducing occupational mental health inequalities. It is the most significant explanatory factor in Finland, France, Iceland, and Lithuania, accounting for 36–50% of the gap. In Belgium, the United Kingdom, the Netherlands, Poland, and Slovenia, job control is the second most important factor, explaining 32–47% of inequalities.

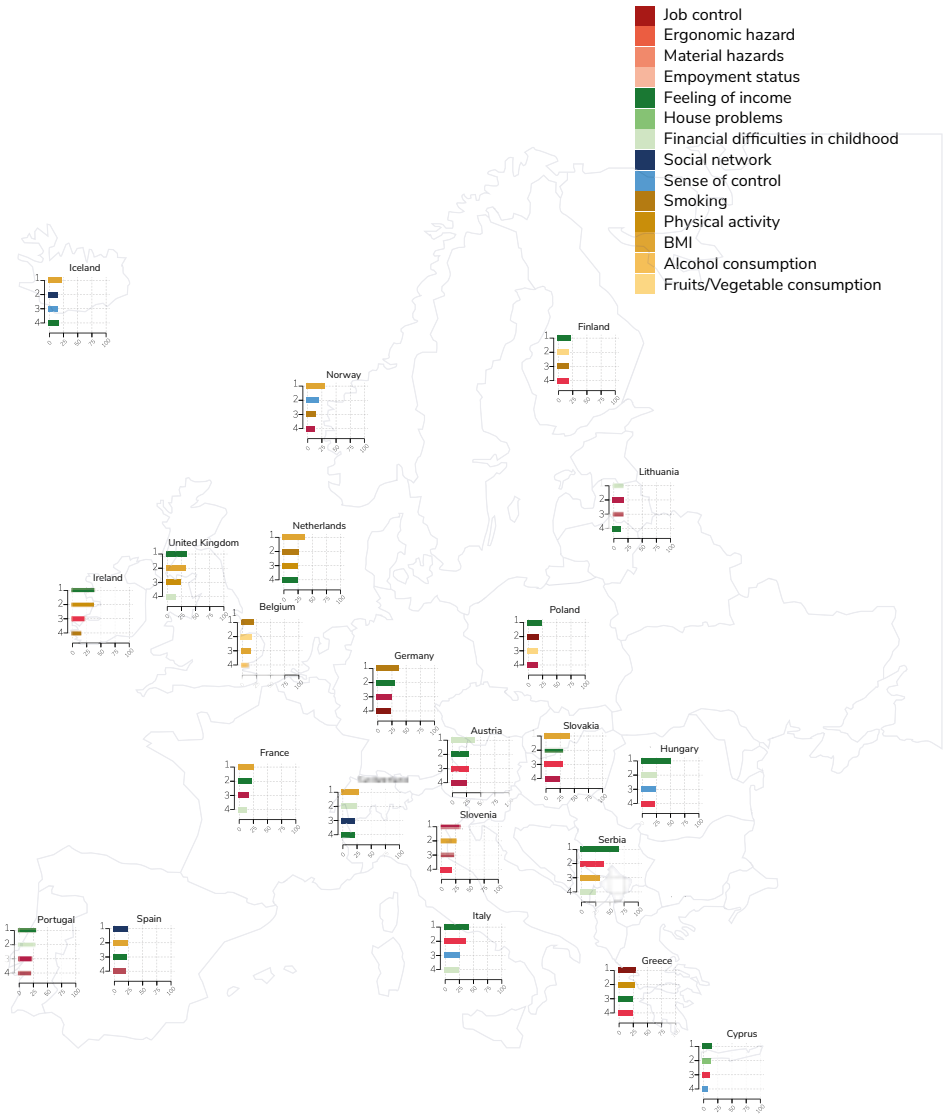
Overall, the main explanation of **occupational mental health inequalities within countries derives from material and occupational determinants.** Psychosocial and behavioural influences play a more minor role. However, smoking-related differences in Iceland, Norway, Denmark and the United Kingdom, and variations in sense of control over one's life in Iceland, Finland, the Netherlands, Lithuania and Slovakia, also contribute meaningfully.

Figure 39: Factors explaining occupational inequalities in poor mental health amongst 25-75 year-olds (2024)

See Annex VIII for specific percentages.

1.6.3 Factors explaining inequalities in poor self-reported health (by education)

Figure 40: Factors explaining educational inequalities in poor self-reported health amongst 25-75 year-olds (2024)



The analysis of the most influential factors in reducing relative health inequalities found that material factors were the most predominant, followed by BMI, a key behavioural factor. Additional explanatory power was provided by other occupational and behavioural factors, including employment, childhood conditions, ergonomics, and smoking.

The feeling of income is present in nearly all countries examined, except in Belgium and Norway. It stands out as **the primary mechanism in nine countries**—Cyprus, Finland, the United Kingdom, Hungary, Ireland, Italy, Poland, Portugal, and Romania—reducing educational inequalities in self-reported health by 12-65%. **BMI is the second most frequent explanation**, relevant in eleven countries. In six of these countries —Switzerland, France, Iceland, the Netherlands, Norway, and Slovenia —it serves as the leading explanation, attenuating inequalities by 16-35%.

In ten countries, **employment status significantly contributes to educational inequalities** in self-reported health, accounting for 9-41% of the disparity. **Childhood financial hardship** is present in nine countries. This pathway is the principal explanation in two countries, Austria and Lithuania, explaining 12-32% of the educational gap in SRH. **Ergonomic hazards** are identified in nine countries, though they are not the leading factor in any. Exposure to ergonomic risks explains 12-21% of the educational disparities. **Smoking is detected as a relevant pathway** in six countries, and the main explanation in two: Belgium and Germany. Differences in smoking habits account for 14-31% of the self-reported health inequalities.

See Annex VIII for specific percentages.

1.7 Summary and conclusions

This study investigated levels of self-reported poor health and poor mental health, across seventeen countries in Europe (14 EU Member States, as well as Norway, the United Kingdom and Switzerland), and how social inequalities in these measures of health have evolved over the past ten years. Measures of self-reported health can differ from more objective measures of health, like diagnosed conditions and mortality, since they capture an individual's physical health as well as the social, psychological, and environmental conditions in which health is lived. It also accounts for cultural norms, social comparison, and individual coping mechanisms, which are factors often missing from objective health data, such as diagnosed conditions. People with the same medical conditions may, for example, rate their health differently due to differences in social support or financial stability. Self-reported health, therefore, captures the lived experience of health, explaining variation that objective measures alone cannot capture.

Levels of self-reported health and mental health in a locality, region, or country, and how this is distributed across different groups across the population, provide an essential indication of how well societies are doing. Ideally, there should be a trend of 'levelling-up', or 'upward convergence', whereby the health and wellbeing of those who are doing less well is brought to the level of those who are doing better, without reducing the health of those who are doing well.

The study has found that **the overall situation in Europe, in terms of health and wellbeing, is concerning**. On average, one-third of people in the countries across Europe involved in the study reported having less than good health, while approximately 13% reported having less than good mental health. Those in lower socioeconomic groups, whether measured by education or by occupation, were twice as likely to report less than good health or mental health.

In terms of how self-reported poor health and mental health across Europe have evolved over the past ten years, overall figures suggest that the situation is largely stagnant. Levels of self-reported health increased slightly, by 1.8%. Nevertheless, there was also a small increase in relative health inequalities (from ARR 1.87 in 2014 to 1.97 in 2024), reflecting that people in higher social groups benefited slightly more from this increase. Levels of self-reported mental health, however, have remained stable while

the average relative rate of inequality has decreased slightly over the past ten years (from ARR 2.38 in 2014 to 2.07 in 2024).

However, as this study revealed, such averages conceal a wide range of differing situations. **The number of people reporting poor health in 2024, for example, ranged from 16% of adults in Switzerland to 46% in Lithuania 2024**. Figures between different social groups vary too. T**he number of people from lower socioeconomic groups reporting poor health, in fourteen of the seventeen countries studied, ranged from 30-57%, while it ranged from 9-33% amongst higher socioeconomic groups.** This range remained the same for lower socioeconomic groups, between 2014 and 2024, while it narrowed somewhat for higher socioeconomic groups, reflecting that they are 'meeting in the middle'.

The results of this study reflect that there is an overall trend of convergence between EU Member States, but not of upward convergence. The health of ESS respondents in Eastern and Southern European countries, namely Hungary, Slovenia, Poland and Portugal, but not Lithuania, that have historically had highest levels of poor health, are showing significant improvements, while the self-reported health of respondents in many Northern and Western European countries like Belgium, the UK, Sweden, Norway and Finland is declining, albeit at a slower rate. In other Northern and Western European countries, the situation remains unchanged.

There is a great deal more variation in changes occurring in levels of poor health and mental health amongst social groups within countries, too, which indicates that tailored country-based policy and actions are required. **There are very few countries that are experiencing the ideal scenario of levelling up. Of the 17 countries studied, only Poland and Slovenia levelled up in the case of health, while only Slovenia and Hungary did so in the case of mental health**. In all other countries, one or more social groups are experiencing a decline in good health.

It is important to note that this study focused on adults aged 25 to 75 and excluded younger and older age groups, who tend to report higher levels of poor mental health. Therefore, the reported levels of poor mental health in this study may be lower than those found in studies that include these age groups.

The fact that health inequalities remain persistent and have increased for some countries is cause for concern and action. It is worrying that the health amongst the middle and upper educational or professional groups is also declining in many countries. Further research should be conducted to understand the causes of this decline. The changing nature of work and the various challenges and crises facing societies amid digital and green transitions may be affecting people in different socioeconomic groups differently. Higher socioeconomic groups have historically been the first to benefit from public health improvements. Any reversal in the health of these groups may signal the emergence of new and powerful determinants of ill health, such as specific work-related stressors, lifestyle shifts, availability of quality food or environmental exposures, that could eventually spread to and disproportionately affect disadvantaged populations. Studying these patterns can make it easier to identify emerging risks and how to address them, to the benefit of everyone, with the greatest absolute gains for the most disadvantaged.

Our study aimed to gain further insight into the factors causing poor self-reported health and mental health, and what factors are driving the gap between the highest and the lowest educational or occupational groups. **A comparison of factors reported in ESS health modules 2014 and 2024 reveals an increase in certain health problems, such as allergies, stomach problems, and multimorbidity, which may contribute to the declining health of different groups in various countries**. While certain health-related behaviours that are detrimental to health, like smoking, are decreasing, others, like poor nutrition, are on the rise. Overall, respondents also reported more unmet needs for health care, housing problems, and frequent conflicts in households.

Our analyses of underlying factors also revealed that **it is primarily females who report poor mental health. Older people (45-75 yrs) in Central and Eastern Europe were more likely to report poorer health, while this was the case for younger people (25-45 yrs) in Northern and Western Europe. We also found that material factors like perceived financial strain and psychosocial factors like control over one's life are primarily responsible for poor mental health**. At the same time, perceived financial strain is also the main factor explaining relative inequalities in poor mental health amongst higher and lower occupational groups. This suggests that measures to reduce financial strain amongst different population groups are likely to be the most effective in improving mental health across the population.

These findings on the main factors driving poor health and mental health reflect that it is far beyond the scope of the health sector to address them, and to reduce health inequalities: it requires a whole-of-society approach. What can and is being done to improve the current situation across Europe is the focus of the next section.

2. What can be done to improve health equity?

Progress in health is stalling in many parts of Europe, while health inequalities persist, and are in some cases growing. This chapter turns to the question of what can be done to improve this situation. It draws on the framework developed by the World Health Organization (WHO) Commission on the Social Determinants of Health, which set out different factors that shape health and health inequalities. It also presents what can be done to reduce health inequalities, and provides practical examples, drawn from the EuroHealthNet partnership.

2.1 A holistic conception of health

Health can be understood in a variety of ways, and these interpretations fundamentally influence both the possible actions to promote health and the sectors that must be engaged in reducing health inequalities. Health is too often narrowly equated with healthcare provision, illness, medical professions, and the pharmaceutical industry. For instance, a **biomedical definition of health focuses on the absence of disease**,[31] pain, or abnormal biological functioning, typically caused by pathogens, genetic factors, or physiological malfunction.

Within this model, health is restored primarily through diagnosis, treatment, and cure of illness. As chronic diseases rise and cures remain out of reach, health systems struggle to provide the care people need to stay as healthy as possible.

In contrast, the WHO landmark 1948 definition frames health as '**a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity.**'[32] This holistic perspective emphasises that health is shaped by a broad spectrum of factors extending far beyond clinical care or the work of health professionals alone. Rather than viewing health as simply the lack of illness, this definition highlights the importance of social, psychological, and environmental factors. It underscores the need for multi-sectoral action to truly advance health and reduce disparities. This more holistic conception of health is also included in, for example, the International Covenant on Economic, Social, and Cultural Rights (ICESCR) and the Universal Declaration of Human Rights, which establish the right to health, rather than just healthcare.

To explore this complexity, the WHO Commission on the Social Determinants of Health (CSDH),[33] chaired by Professor Sir Michael Marmot and established in 2005, examined the social, economic, and political conditions that influence health outcomes. Its goal was to synthesise the evidence on how societal structures affect the health of individuals and communities, and to identify what actions governments and the public health sector can take to reduce health inequalities and promote health equity.[34]

The work of the Commission on Social Determinants of Health is underpinned by a conceptual framework that highlights how structural factors shape the conditions of daily life, which in turn influence health and generate health inequalities. This framework emphasises that health inequities are not inevitable or biologically determined but are instead the result of the unequal distribution of power, resources, and opportunities within and across societies. Crucially, these disparities are modifiable through policies and actions that address the root causes of poor health, rather than its symptoms.

Structural determinants, which the WHO has defined as '**the wider set of forces and systems shaping the conditions of daily life', including economic and social policies, governance, and cultural and societal norms**, create **unequal living conditions** for different groups.[35] For example, economic systems and social norms determine what kinds of occupations get valued and well remunerated, or not. Tax or subsidy policies may disproportionately benefit certain income groups or regions. In contrast, industrial and trade policies might favour large corporations and capital owners at the expense of small businesses, workers, or specific geographic areas. Such structural determinants shape the social determinants of health, or the conditions in which people are born, grow, live, work and age. They influence which groups have access to, for example, good quality of housing, education, employment, and other resources, and which groups do not.

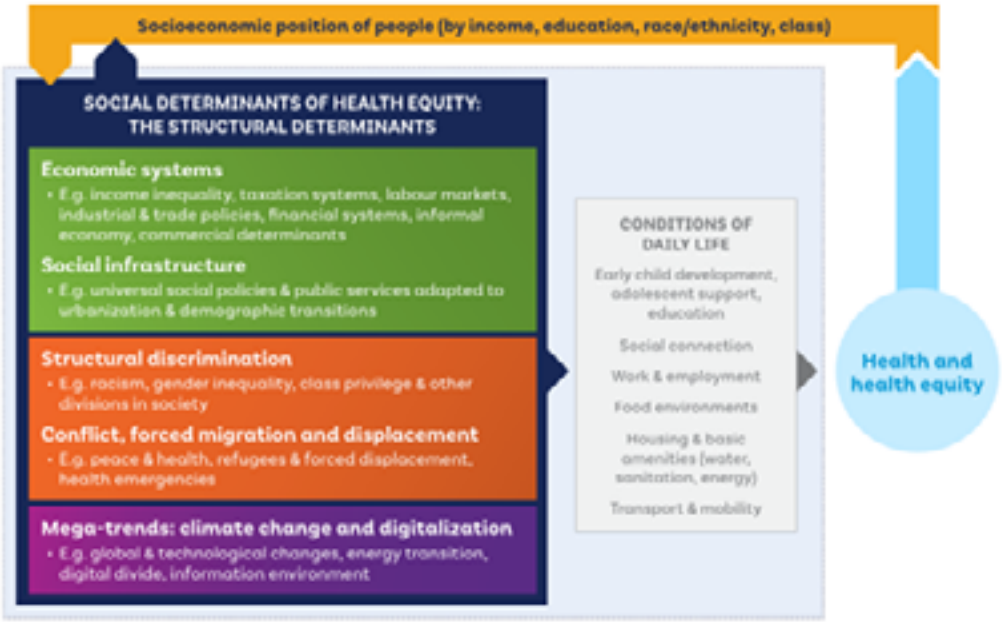
Economic and political systems play a significant role in shaping how commercial actors, and the commercial determinants of health more broadly, influence both physical and increasingly virtual environments through the products and services they offer. While some commercial actors do provide products and services that can support health, their primary goal is usually to generate profit rather than to promote public wellbeing. As a result, many companies may not prioritise health and wellbeing, and in some cases, their practices harm public health. A 2024 WHO report on the commercial determinants of health argues that harmful industries often collaborate to exploit regulatory gaps, political influence, and media control to protect their profits and shape policy in ways that are often harmful to public health. The report estimates that such commercial practices account for up to 90% of deaths from non-communicable diseases in the WHO region.[36] It warns that governments have frequently been unwilling or unable to respond effectively to corporate pressure.

Economic and social policies, governance, and cultural and societal norms can also interact to generate, maintain or exacerbate structural discrimination. These systems have, for example, historically devalued care work, such as child-rearing, care of older people and domestic labour, most of which is undertaken by women. This reflects entrenched patterns of gender discrimination, where the unequal division of labour and prevailing social norms contribute to economic insecurity, reduced access to social protection, and worse health outcomes for women and caregivers. Similarly, different racial and ethnic groups in society can also suffer from structural discrimination that is perpetuated by weak anti-discrimination laws, which subsequently affect the quality of education, work and housing that those who are affected have access to.

Such structural factors affect the conditions in which different groups in society live, which in turn determine their health outcomes, such as morbidity, mortality, and life expectancy, through various pathways discussed below.

WHO World Report (2025), which is a follow-up report to the WHO CSDH final report, includes a simplified version of the original framework shown below:

Figure 41: WHO's conceptual framework on the social determinants of health[37]



2.2 Social determinants of health

Addressing the structural or root causes of health inequalities as set out above is the most effective way to reduce them. However, doing so often requires confronting deeply embedded political, social, and institutional norms. These norms are frequently reinforced by powerful vested interests, making meaningful structural change difficult to achieve. While it is essential to keep the structural determinants of health in view, focusing on the social determinants can produce more immediate improvements in the daily living conditions of groups facing relative disadvantage.

Multiple factors affect the conditions of daily life, providing pathways to improve them. The most obvious are **material factors such as income, housing quality, environmental conditions, and food security**, all of which directly affect a person's ability to maintain or improve their health.

Occupational factors, such as employment status, are closely linked to these material conditions, as stable employment typically provides a reliable income needed to meet basic needs. In many countries, employment grants access to health-related benefits, including health

insurance, social protection, and paid leave.

Beyond material security, employment influences health in other ways, too. Work can provide structure, social identity, purpose, and social connections, all of which contribute positively to mental and emotional wellbeing. However, employment alone does not guarantee good health. Insecure contracts and precarious work can generate chronic stress, while hazardous working conditions may expose individuals to physical risks.

Crucially, the level of **job control, the degree to which individuals can influence when, where, and how they work,** has a significant impact on health. Job control tends to be limited in lower-paid employment and is strongly linked to poorer health outcomes, including higher risks of cardiovascular disease, mental illness, and burnout.

Psychosocial factors are a key pathway through which poor social conditions can lead to poor health. These factors relate to **how a person's position on the social hierarchy affects their psychological state**, such as stress levels, sense of control, and self-esteem, as well as the quality of their social environment.

Living in poverty is not only about lacking money; it often creates a chronically stressful psychosocial environment. Constant uncertainty about food, housing, and safety, experiences of social exclusion or stigma, and the daily pressures of low income or poor working conditions can all contribute to psychological strain. These stresses can lead to social conflict, limit participation in social or community activities, and foster feelings of shame and low self-worth.

Such psychosocial stressors are especially harmful when experienced in early childhood, a critical period for brain development and the formation of stress regulation systems. Early exposure to financial hardship or family conflict has been linked to long-term impacts on behaviour and mental health, including higher risks of depression, anxiety, cardiovascular disease, substance use, and reduced life expectancy in adulthood.[38]

Levels of s**ocial cohesion, social connectedness and social capital are also crucial to how living conditions affect health, positively or negatively.** These terms refer to the degree of trust and solidarity amongst members of a society, as well as how well they cooperate, and the public resources that communities can access through their social networks. They can mitigate the impact of structural and social factors on health. Whether or not people have social networks, feel safe in their communities and can access collective resources influences their sense of control and support, as well as trust. This can explain why people facing similar kinds of structural disadvantage might experience different health outcomes. A recent report by the WHO Commission on Social Connection sets out how social connection has tangible health benefits. Strong social ties support health across the life course: they lower risks of serious illness, enhance mental health, and help prevent early death. Vulnerable groups face disproportionately higher rates of loneliness and isolation, compounding preexisting social and health disadvantages.[39] Hence, addressing social connections becomes essential to reducing social inequalities in health.

Root causes do not simply affect factors like income and the material and social conditions in which people live; they also affect how they behave. **Behavioural determinants refer to whether people habitually engage in health-enhancing behaviours, like socialising, physical activity and healthy eating, or in health-damaging behaviours like smoking, alcohol use and abuse of digital devices or food.** However, the behaviour is strongly determined by a range of other factors. Disadvantaged communities, for example, are disproportionately exposed to commercial practices that harm health, with less access to healthy foods or green environments in which they feel safe. They may also experience more stress and seek to self-medicate through health-harming behaviours.

People's social position often shapes how they experience health systems, not only in terms of access, but also the quality, continuity, and responsiveness of care they receive. Individuals from marginalised or disadvantaged groups may face barriers such as discrimination, stigma, language obstacles, or a lack of cultural competence among providers, which can result in delayed diagnoses, poorer treatment outcomes, and lower levels of trust in the health system itself. These unequal experiences are not just consequences of health disparities; they actively reinforce and reproduce them, **making healthcare access and quality an essential social determinant of health.**

Life-course or fundamental cause theories emphasise how all these different biological, social, material and psychological factors interact and compound over time. They also consider how different aspects of people's identities and social positions, such as group, ethnicity, age, gender, sexual orientation, disability, where they live, their education, or income, interact with each other. The way different forms of social inequality, such as racism, sexism, classism, and others, interact and overlap to create unique experiences of discrimination or privilege for individuals or groups is referred to as 'intersectionality'.[40]

2.2.1 Which are most important?

Despite the many different, interacting factors that lead to and compound inequities, including health inequities, efforts to address equity in health become conflated with equity in health care. The Health Equity Report,[41] published by WHO Europe in 2019, for example, found a statistical association of only 10% between health inequalities in self-reported health care and quality of health care, versus a statistical association of 35% with financial insecurity and 29% with poor quality housing and neighbourhood environment. Other studies have confirmed that health care systems, particularly those with universal health coverage, drive approximately 10-20% of socioeconomic health inequalities. Material conditions (income, housing, employment) as well as psychosocial factors[42] are generally far stronger contributors, as our study found, too.

Equity in health, and equity in healthcare are different. Equity in health aims to eliminate all systemic differences in health status between socioeconomic groups. The goal of equity in health care is to match services to the level of need closely.[xlii]

2.2.2 Key actions

The final report of the WHO Commission on Social Determinants of Health (2008) issued three main recommendations: 1) improve living conditions, and ensure healthy environments from birth to old age; 2) tackle inequities in power, money and resources, by promoting fairer social and economic policies; 3) measure and understand the problem, by strengthening data, research and accountability.[43] The report also included three global targets, to be achieve between 2000-2040: 1) Halve the gap in life expectancy between the richest and the poorest countries, and between social groups within countries; 2) Halve the adult mortality rates (probability of dying between the age of 15 and 60) in all countries and social groups within countries; 3) Achieve 90% and 95% reductions in child and maternal mortality, respectively.

In 2025, the WHO recently published a **World Report on the Social Determinants of Health Equity**[44] that assessed progress towards these targets and issued new recommendations in four strategic areas for action. The overall results of this report, based on the European Social Survey data as presented in section 1, of a slight overall increase in social inequalities in self-reported health across the 17 European countries analysed, suggest that, like other regions of the world, the EU is not making progress in achieving the objectives set by the CSDH in 2008.

Overarching recommendations from the WHO World Report on Social Determinants of Health Equity (2025)[44]

I. Address economic inequality and invest in universal public services.

II. Tackle structural discrimination and the determinants and impacts of conflicts, emergencies and migration.

III. Steer mega-trends towards health equity: climate change and digitalisation.

IV. Bring about change through new governance approaches (equip local governments, support community engagement, universal health coverage, health workforce, focus on social determinants of health, monitor social determinants of health equity).

Since a wide range of policy sectors shape the structural and social determinants that generate health and its distribution, addressing these requires a 'whole-of-government' commitment and action, to level up the social gradient in health. Achieving greater health equity should be a standard indicator of progress across policy areas, which is regularly monitored to ensure that it is being achieved by levelling up. What, specifically, can and is being done to improve health and reduce social inequalities in health across Europe, and implement the WHO recommendations, is discussed in more detail below.

2.3 Reducing social inequalities in health, with examples from the EuroHealthNet partnership

The following sets out the different measures needed to level up health across Europe. We drew from examples from the EuroHealthNet partnership[45] of (sub)national health authorities to illustrate how these approaches are being implemented.

2.3.1 The role of the health sector and its health systems

While the health sector alone lacks the power and resources to address all structural and social determinants of health, it plays a critical policy role in advocating for health, wellbeing, and health equity as essential outcomes of good governance, outcomes that all sectors must help achieve. **This leadership role includes raising awareness of the broader socioeconomic factors that shape health and challenging narrow views that reduce health outcomes to individual behaviours or lifestyle choices.** Instead, the health sector can help highlight how wider social, economic, and environmental conditions deeply influence such behaviours.

Doctors and scientists are the most trusted professionals in society, with the capacity to 'speak truth to power' by providing knowledge and evidence in relation to levels of health and their distribution across society.[46] Such analyses can focus on health outcomes. However, they should also consider the underlying social and economic outcomes of epidemiological patterns.

Poland - System-level public health transformation

National and Regional Transformation Plan (KPT and WPT) in Poland (2022) set out system-level priorities for public health, focusing on demography, epidemiology, prevention, and primary care. This plan provided a national framework for improving population health and reducing inequalities, shaping the direction of public health action across the country.

In 2024, the National Institute of Public Health NIH-NRI took this forward by convening an expert group to develop national standards for planning and evaluating public health programs. These standards represent a milestone in systematic and evidence-based health promotion and disease prevention, ensuring that interventions are more solution-focused, effective, sustainable, and equitable.

Another key development is the establishment of the first Polish Behavioural Science Team in Public Health. This team applies behavioural science insights to understand how and why people adopt certain health-related behaviours, and how these choices can either reduce or reinforce inequalities. The aim is to help policymakers, researchers, and practitioners deliver interventions that enable people to live healthy and reflect the real needs of diverse communities.

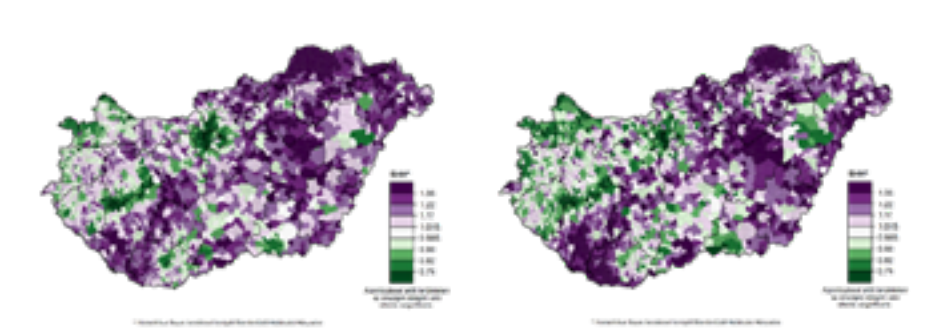
Hungary - Using data to guide local health strategies

In Hungary, the Centre for Epidemiology and Surveillance at Semmelweis University developed the Spatial-EPI IT tool[47] to map population health and its determinants at high resolution. It supports the investigation of health inequalities, prioritisation of public health needs, and local health planning.

The tool provides standardised, annually updated indicators on mortality, demographics, and socioeconomic disparities, with data available from national to municipal levels for trend analysis and comparison. Upcoming updates will add morbidity data and composite indicators.

Accessible to all users after registration, the system guides evidence-based local health strategies by pinpointing areas most affected by avoidable mortality and highlighting vulnerable populations. Its adaptable design makes it applicable beyond Hungary.

Map of preventable-avoidable-mortality among the 0-74-year-old population, in Hungary, at the settlement level, 2019-2023 [48]



Source: SPATIAL-EPI system (2025)

Norway - Holistic governance for better health

The Norwegian Public Health Act (2012) gives municipalities, counties, and the central government responsibility to promote public health, prevent disease, and level out social inequalities in health. It is known for its holistic approach to public health work at all governance levels. Under the act, national authorities provide municipalities with Public Health Profiles and Childhood Profiles, based on the public health statistics database.[49] The act has already inspired several other countries' legislation, among them Ukraine and Denmark.

Source: Norwegian Department of Health

Denmark – Monitoring health to guide policy and practice

Denmark has a long-standing tradition of monitoring population health through nationwide surveys and publishing health profiles at national, regional, and municipal levels. These profiles serve multiple purposes: nationally, they inform health legislation, recommendations, and strategic interventions; regionally and locally, they are used to identify public health challenges and vulnerable groups, guide priority-setting, and support cross-sector policy development and evaluation.

The Danish National Health Survey[50] is a collaborative effort between the National Institute of Public Health, the Danish Health Authority, and the five administrative regions. Since 2010, the survey has been conducted every four years, covering approximately 300,000 randomly selected individuals in each round. Results are published as national and regional health profiles and are actively used in local planning and prevention work, including in municipal health dialogues. The data also provide a strong foundation for public health research with a clear focus on reducing health inequalities.

Access to and quality of health services are significant determinants of health, and health professionals also play a critical role in designing and implementing universal health systems that reach all people and reduce rather than exacerbate health inequalities. To ensure cost-effectiveness and efficiency, this means strengthening primary health care and improving investments in health promotion and disease prevention. These efforts should not, however, focus on changing health-related behaviours and put the onus on the agency of individuals, the so-called lifestyle-drift. Allocating scarce resources for health promotion and disease prevention to efforts that change health behaviours risks exacerbating inequitable health outcomes, as those who are better off have the resources to benefit from such interventions.

Denmark - Social vulnerability index

DEFACTUM, a research department on social and health services within the Central Denmark Region, is developing a social vulnerability index that provides prospective health data that reflects citizens' social situations, in a non-stigmatising way.

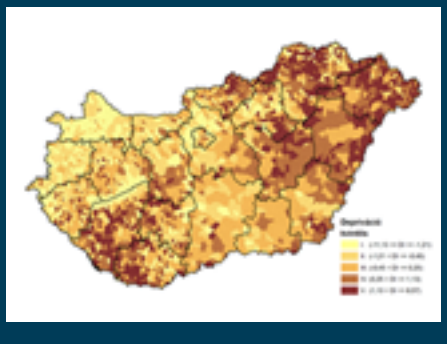
The index will generate personal data to enable health practitioners and policymakers to provide immediate support to patients while also driving the systemic and structural changes needed to improve patients' access to health services, as well as the social conditions in which they live. This approach offers an opportunity to improve trust in health systems as it better responds to individual needs.

Hungary – Deprivation index

In Hungary, the GIS-based Spatial-EPI system, as described above, now incorporates the Deprivation Index (DI), designed to measure socioeconomic inequalities at the municipal level. The DI is based on seven indicators: income, educational attainment, unemployment rate, proportion of one-parent families, proportion of large families, housing density, and car ownership.[51]

The DI was first calculated from the 2001 and 2011 censuses and updated in 2022 by the Centre for Epidemiology and Surveillance at Semmelweis University, allowing a three-decade analysis of deprivation trends. The index also identifies geographic areas with vulnerable populations, including an additional indicator mapping the distribution of the Roma population at the municipal level.

By linking deprivation to health outcomes, the system supports health assessments, local planning, and programme evaluations, guiding action to reduce inequalities.



Source: SPATIAL-EPI system (2025)

Belgium - Health literate organisations in primary care

In Flanders, Belgium, a comprehensive toolkit was developed to help primary care services become health-literate organisations, making it easier for people to access, understand, and use health information and services.

The toolkit is built around a compass that guides organisations to reflect on policies, communication, accessibility, and patient involvement. It includes practical tools such as a self-assessment questionnaire to identify areas for improvement.

Several organisations are receiving tailored guidance to implement the compass and ensure equitable, understandable, and accessible care, including reviewing patient materials, involving patients in decisions, using visual aids, and embedding health literacy into organisational missions.

Swiss-Slovak Health Programme – Reducing health inequalities

The Swiss-Slovak Health Programme, strengthening social systems, is managed by the Ministry of Investment, Regional Development and Informatisation of the Slovak Republic in cooperation with the Ministry of Health. It aims to reduce health inequalities in Slovakia by focusing on the prevention of non-communicable diseases, especially in marginalised communities.

The programme implements coordinated actions at national, regional, and local levels to reach diverse and underserved populations. A central element is strengthening health governance through cross-sector collaboration and improved stakeholder coordination, making prevention efforts more equitable and effective.

It also enhances health literacy and system capacity to address inequalities, supporting data-driven decision-making and more targeted, efficient public health interventions.

2.3.2 Universal approaches

To date, the stronger emphasis on improving health and equity through a socioeconomic conceptualisation has focused on addressing the conditions of daily life. Doing so requires a mix of universal and targeted approaches.

The principle of **proportionate universalism**, introduced by Professor Sir Michael Marmot, is key to reducing social inequalities in health. This means **resourcing and delivering universal services at a scale and intensity proportionate to the degree of need.**[I] Proportionate universal responses entail ensuring universal access to health and education systems. At the same time, they provide extra resources where they are needed most. This can be achieved through additional services in schools and medical centres, especially those located in deprived or hard-to-reach areas.

Some universal policies or initiatives that are designed for the entire population can have a more substantial proportional effect among lower socioeconomic groups. Such universal responses help to avoid 'poor services for the poor'. They also help to tackle the social gradient in health.

Poland – Sugar tax

In Poland, a sugar tax was introduced in 2021 through an amendment to the 2015 Public Health Act. The tax applies to beverages containing sugar, sweeteners, or caffeine. The measure aims to reduce consumption of sugary drinks by discouraging purchases and encouraging producers to reformulate products with lower sugar content.

The tax represents a population-wide approach to addressing diet-related health risks, particularly among lower-income groups who are disproportionately affected by unhealthy food environments.

Scotland – Minimum unit pricing

In Scotland, Minimum Unit Pricing was introduced in 2018 to set a minimum price of 50 pence per standard unit of alcohol. The goal is to reduce the consumption of cheap, high-strength alcohol, often favoured by heavy drinkers and more prevalent amongst lower socioeconomic groups.[52]

Spain – Health-promoting schools

Schools shape not only what children learn but how they live and thrive. Across Europe, school systems are struggling to respond to the growing challenges that students are facing: declining academic results, mental health concerns, physical inactivity, and widening inequality. Health Promoting School (HPS)[53] approach is a crucial and cost-effective strategy to create healthier learning environments.

In Spain, the Ministry of Education and the Ministry of Health collaborate to implement a comprehensive school health approach covering physical, psychological, social, and environmental aspects.[54] The government supports initiatives through micro-training programs for teachers, a 'Health Promoting School Guide' developed by an intersectoral working group, and various funding lines, awards, and recognition schemes. A network of regional health-promoting schools is also coordinated to strengthen implementation.

These measures aim to improve student health, wellbeing, and equity, fostering a whole-school approach that addresses multiple determinants of health.

Proportionate universal responses can be more politically sustainable than targeted ones, as they reduce stigma by being available to everyone, thereby lowering the costs associated with a lack of trust in public services and social instability.

A failure to apply proportionate universalism has been referred to as the **inverse care law**, whereby the availability of good (medical and social) care and services tends to be lower where the need for it in the population served is greater.[55] The inverse care law can apply to all public services, widening health inequalities.

Belgium - Inspiring and supporting prevention work to apply proportionate universalism

The Flemish Institute of Healthy Living, Belgium, actively supports organisations in the prevention sector in applying the principle of **proportionate universalism (PU), an approach that combines universal interventions with additional intensity for groups experiencing greater disadvantage.**

To operationalise this principle, the institute has developed several practical tools, including a five-step guide for developing a PU strategy and an inspirational guide featuring ten concrete PU practices with real-world examples. In addition, a PU attachment has been created for prevention programmes and methodologies. This form helps developers clearly articulate how they address the needs of vulnerable target groups and what additional efforts are made to reach and support them.

The institute also facilitates knowledge exchange by sharing good practices through webinars and interviews, and by convening partners in a network focused on health inequality. Furthermore, organisations can access training, e-learning modules, and free tailored advice on proportionate universalism and reducing health inequalities.

Source: Flemish Institute for Healthy Living (Gezond Leven): Illustration of proportionate universalism in Flemish.

It has been noted that proportional universal responses are not always efficient, since they may come at the cost of improvements in the health of the whole population.[56] A counterargument is that the resources needed to apply proportionate universal approaches can be offset by improving efficiencies in other parts of the system.[57] The costs of providing more and better early childhood interventions in deprived areas can, for example, reduce downstream costs like chronic disease, unemployment, and criminal justice involvement. **The expenses of targeted interventions can also be recuperated by improving the integration of otherwise siloed systems and by applying data systems and digital tools to enable more intelligent resource allocation within a universal framework.**

Italy – Network of Marmot cities

In a recent iteration, the National Institute of Health in Italy (ISS) has established an Italian Network of Marmot Cities, to tackle health inequalities at the local level. The network will empower cities and communities to address social determinants of health. Local governments, universities, organisations, and communities are invited to join forces to design and implement Health Equity Plans, share best practices, and collaborate on evidence-based solutions. The initiative is supported by the Institute of Health Equity and key Italian health networks.

Several other countries in Europe, like Sweden, Denmark, Slovenia and Norway, have undertaken 'reviews' of health inequalities in their countries and what can be done, based on the work of the WHO Commission on the Social Determinants of Health and following the first review in England, undertaken in 2010. Many cities across the UK have committed to addressing health inequalities by implementing the principles outlined in the initial Marmot Review. This work is coordinated by the Institute of Health Equity (IHE).[58]

Germany - Health Equity Network

The National Collaborative Network for Equity in Health[59] in Germany, which brings together more than 75 partner organisations, including ministries, municipal representatives, insurance funds, welfare organisations, and research centres, to provide health services to socially disadvantaged populations.

The network has developed a framework with 12 Good Practice Criteria[60] to guide planning and implementing health promotion interventions, covering areas such as empowerment, participation, accessibility, sustainability, integrated action, and evaluation.

These criteria support institutions, associations, and professionals in childcare centres, schools, social services, and funding or training organisations to improve the quality and reach of health promotion efforts, ultimately reducing social disadvantage and health inequalities.

2.3.3 Targeted approaches

Because certain groups nevertheless suffer from structural disadvantage, often compounded over time, more targeted approaches are also required. Targeted measures can then be tailored to meet the needs of specific vulnerable groups and communities, to improve conditions of daily life.

Germany – early support during pregnancy and childhood

In Germany, the Federal Ministry for Family Affairs, Senior Citizens, Women and Youth launched a system of early support during pregnancy and early childhood[61] in 2006 to ensure a coordinated approach across governance levels.

Initially, 10 pilot projects were implemented across the federal states and scientifically monitored.

The system was legally established through the Federal Child Protection Act, which came into force in 2012, providing a framework for early interventions to improve child and family health outcomes.

Austria - regional family support networks

In Austria, early childhood interventions (Frühe-Hilfen-Netzwerke in German[62] were launched in 2015 as regional networks providing multi-professional support for parents and young children, inspired by the German model. By 2023, the networks were rolled out to all Austrian districts.[63]

The networks offer low-threshold, voluntary services free of charge, aiming to support families facing difficulties and promote healthy child development. They are coordinated by the Austrian National Public Health Institute (GÖG) and guided by concepts such as the life course approach and proportionate universalism.

The programme has been evaluated as effective in improving family living conditions, includes mental health data, and has been recognised as EU best practice. Legal anchoring since 1 January 2024 ensures sustainable, nationwide, needs-based, and quality-assured services in partnership with the federal government, provinces, and social insurance institutions.

Finland – addressing undetected and untreated health problems of prisoners

Finland is facing increasing levels of poor mental health amongst all social groups.[64] People living in prison are a particularly disadvantaged social group, as they have disproportionate rates of mental illness compared to the general population, in addition to being beset by physical health problems and obstacles to employment. They often grew up in families that experienced financial difficulties or violence during their childhood[65]. Crimes can be a result of undetected and untreated mental health conditions, such as gambling problems, leading to property crimes.[66]

Investing in programmes to support young families and especially children in schools can be cost-effective, over the long term, to avoid the suffering of individuals and prevent adverse social consequences such as higher crime rates.[67]

When this fails, the incarceration period can also provide a rare opportunity that is not often considered to investigate complex problems, such as untreated illnesses, social exclusion or mental health. It offers a unique opportunity to treat individuals and to learn from the circumstances that brought them there, to strengthen interventions aimed at reducing health inequalities in whole the society. EuroHealthNet's member, the Finnish Institute for Health and Welfare (THL) is active in this area, manages health services for prisoners, and promotes inequality-related research.

Prisonner experiencing pain (68%)

Very poor sense of inclusion (21%)

Source: The Finnish Institute for Health and Welfare (THL)

Greece – Improving the health of Roma women

In Greece, the Prolepsis Institute in Athens implements a Comprehensive Health Promotion and Prevention Programme[68] to improve the health of Roma women, addressing maternal complications, chronic conditions, and mental health issues.

The programme is participatory and culturally sensitive, involving Roma women, local mediators, and health communities. It provides education on sexual and reproductive health, cancer prevention, lifestyle behaviours, and vaccination, as well as preventive screenings through a Mobile Unit or local health services.

These measures aim to increase agency, improve health literacy and behaviours, and reduce health inequalities among Roma women

Slovakia – Healthy communities for Roma women

In Slovakia, the Zdravé regióny Healthy Communities[69] initiative under the Ministry of Health works in segregated Roma settlements to reduce cultural, social, and systemic barriers to healthcare.

The initiative builds trust and health literacy through locally recruited culturally sensitive mediators[70] and increases participation in preventive care and vaccinations. Over 250 trained health assistants and laypersons operate across 262 localities and 11 hospitals, reaching around 50,000 clients monthly in collaboration with 1,300 healthcare professionals.

These efforts aim to improve health outcomes and reduce health inequalities in marginalised Roma communities.

Belgium - Empowering vulnerable unemployed individuals

In Flanders, Belgium, 'Krachtboom!'[71] is a toolkit for employment and social work professionals that supports vulnerable unemployed individuals and NEET youth in building resilience and mental wellbeing on their path to work.

The toolkit uses the 'Tree of Life' method to help participants explore their life stories and strengths, and provides handbooks, guidelines, reflection tools, and ready-to-use exercises for short interventions, standalone sessions, or extended programs.

The initiative aims to enhance coping skills, tackle barriers, and improve mental wellbeing, enabling participants to progress toward employment while supporting professionals to integrate wellbeing approaches into their work.

Belgium – Promoting physical activity for vulnerable groups

In Flanders, Belgium, Physical Activity on Referral[72] is a universal programme promoting physical activity, especially among socially vulnerable groups. Health or social workers refer patients to a coach, who develops a personalised activity plan, monitors progress, and adjusts it as needed.

Local networks implement the programme using proportionate universalism, offering income-adjusted rates, personalised support, and barrier removal to ensure inclusion. About 30–40% of participants receive extra medical cost reimbursement, compared to about 15% in the general population.

The programme aims to increase physical activity, reach socially vulnerable populations, and improve health outcomes, while providing tailored support for those most in need.

Social participation

Participation is key to ensuring that the experiences and voices of people in positions of relative inequity inform policies and actions designed to improve this. Policies and interventions should also be developed with the input of communities themselves to enhance the likelihood that they meet real needs and have an impact.[73]

Additionally, it is essential to note that effective measures to reduce social inequalities must, on the one hand, empower people to act on their own behalf, while on the other hand, not require too much self-directed action on the part of the target groups or professional leadership. Navigating life with few resources is a complex and stressful experience. Even highly educated individuals with strong social networks often struggle to navigate bureaucratic layers and access public services. As these structures become even more complex and digitalised, the challenges of navigating them compound for those with fewer (digital) skills and support networks for help. If accessing these grants and services demands excessive initiative and numerous skills from people facing socioeconomic adversity, those individuals are less likely to benefit from them, which reduces the programs' effectiveness and worsens health inequalities.

2.3.4 Governance for health equity

While proportionately universal and targeted policies can address underlying conditions that contribute to poor health, **policies alone are unlikely to deliver the comprehensive and lasting change required to reduce health inequalities.** Their impact is often limited by short legislative cycles and shifts in government priorities. More sustainable progress depends on strengthening governance processes that embed equity as a core principle.[74] This means developing mechanisms that enhance accountability for health and health equity, assigning clear mandates and responsibilities across government, and institutionalising the tools and structures needed to integrate equity into all relevant policies and activities. Systematic use of policy instruments such as distributional and health impact assessments is essential to ensure that equity considerations are consistently applied and sustained.[75] This calls for the systematic implementation of policy tools, like distributional and health impact assessments.

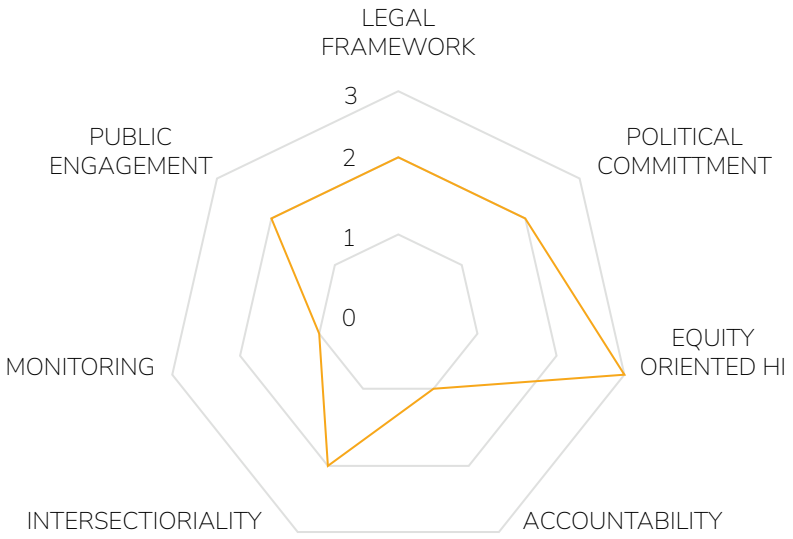
There is also a need for **policy coherence across levels and areas of governance, so actions across government reinforce rather than counteract one another.** For example, new environmental policies aimed at tackling climate change and restoring nature have raised costs for many households, with a disproportionate burden on those with lower incomes. Redistribution measures are therefore essential, not only to ease these impacts, but also to secure public support and ensure that all share the co-benefits of these policies to health.

Seven dimensions of health inequality governance

Model developed by the Joint Action on Health Inequalities Europe (JAHEE)

- **Legal framework, strategies and policies to tackle health inequalities/ social determinants of health** (approaches, vertical level, targets on health inequalities)
- **Sustained political commitment** (agenda, mechanisms to protect commitment, funding)
- **Role and equity of the health system** (access, health care, prevention, skills and resources on health inequalities, advocacy)
- **Accountability on health inequalities and on the social determinants of health** (who is responsible and how)
- **Active intersectoral working and health in all policies** (institutions & experiences)
- **Monitoring of system performance and evaluation** (tools and report mechanisms on progress)
- **Communication, public engagement and community participation** (mechanisms which promote involvement of local people to give them a stake in problem definition and solution development)

According to this model and based on its analyses of the 24 European countries that participated in this Joint Action on Health Inequalities Europe (JAHEE)[76] in 2022, three countries (Finland, Norway and Wales) had sound governance systems in place to reduce health inequalities, 12 countries had something in place, and nine countries could do more.



Spain - Health equity checklist

In 2022, the Ministry of Health in Spain published an updated checklist for analysing equity in health strategies, programmes and activities,[77] as part of the Methodological Guide to Integrate Equity into Health Strategies, Programmes and Activities.[78]

The tool targets professionals and decision-makers, supporting the integration of equity during planning, implementation, and evaluation. It has already been applied to different strategies and accompanied by two training sessions on its use.

Learnings from the checklist are also being used to strengthen Health Impact Assessment in Spain, embedding equity systematically into health policy and practice.

2.3.5 Wellbeing approaches

The Wellbeing Economy approach is a comprehensive governance approach that orients all sectors towards the common goal of generating wellbeing for everyone. The approach can be implemented at all levels of governance and ideally connects them through a collectively developed definition and vision of wellbeing, involving all sectors in society: public, private, civil society.

The approach drives all actors to look and work beyond their specific sector to maximise win-wins, and negotiate tensions or trade-offs, to achieve societal-level wellbeing goals.[79] This approach has been gaining traction in some countries, subject to political change.

Wales – wellbeing and equity through future generations

In 2015, Wales introduced the Wellbeing of Future Generations Act,[80] embedded in the constitution, to improve decision-making towards seven wellbeing goals, including prosperity, equality, health, resilience, and thriving communities. The Act requires public bodies to consider the long-term impact of their actions, collaborate across sectors, and involve communities. It has succeeded in changing the way Wales evaluates progress and success, which are now based on wellbeing rather than GDP.

A Future Generations Commissioner monitors progress, with the 2020 Future Generations Report assessing achievements towards these goals. Since 2016, the Public Health Outcomes Framework Reporting Tool has been used to track the outcomes of services, programmes, and policies on health and wellbeing in Wales. The tool underpins the national indicators[81] for the Act by providing a detailed set of measures on the wider determinants of health, including education, employment, housing, and community cohesion. This makes it possible to assess not only health outcomes but also the broader social and environmental conditions that shape wellbeing.

In addition, Public Health Wales evidence maps[82] provide structured access to high-quality evidence on effective interventions in areas such as health behaviours, mental wellbeing, and social determinants, helping ensure that policy and practice are evidence-based and equity-focused.

Finland - Wellbeing Economy approaches

In 2023–2025, Finland launched its National Action Plan for the Economy of Wellbeing,[83] aiming to create a common definition of social sustainability, develop indicators, and design impact assessment tools that integrate wellbeing. These tools allow policymakers to assess the social, environmental, and economic consequences of policies in a balanced way, supporting cross-sectoral monitoring, resource allocation, and priority setting.

Finland also placed the Economy of Wellbeing on the EU agenda during its 2019 Council Presidency, leading to the adoption of Council conclusions stressing that GDP alone cannot capture people's wellbeing.

The Finnish Federation for Social Affairs and Health (SOSTE) uses the comparison between GDP and Genuine Progress Indicator (GPI) per capita between 1960 and 2017 in Finland to argue for a more holistic approach combining economic performance with social and health equity. The GPI includes economic, but also environmental and social

factors, such as 'cost of water pollution' or 'value of volunteer work'. In SOSTE's view, adopting a wellbeing economy framework could help the EU align its fiscal policy with broader EU social, health and environmental goals.[84] As the graph below shows, even though GDP grew steadily until the financial crisis in 2008, Genuine Progress has declined considerably since the 1990s. Changes in government and legislative priorities have, however, reduced attention and support for the Wellbeing approach in Finland and at the EU level.

EuroHealthNet's work on the Wellbeing Economy

EuroHealthNet has published on the wellbeing economy approach in cooperation with the Institute of Public Health in Ireland. The report on a reimagined economic system (2024) explains and sets out concrete steps to measure a Wellbeing Economy's impact and benefits, and how to implement them and overcome challenges along the way[85]

EuroHealthNet members contributed and co-authored a new WHO report on policy pathways to a wellbeing society (2025),[86] providing practical guidance to ministries of health on how to translate the vision of wellbeing societies into concrete action across five policy areas.

The Nordic Wellbeing Academy[87] is involved in the development of a new model to assess the impact of public/private/people partnerships and their performance regarding the ability to build trust and cooperation across stakeholders and organisations to improve health and wellbeing.

2.4 Summary and conclusions

Social inequalities in health across Europe remain persistent; they are either 'levelling down' or are widening. Evidence shows that poor health outcomes are driven by structural and social determinants, such as income, housing, education, employment, discrimination, and social connection, rather than healthcare access alone.

The WHO Commission on Social Determinants of Health (2008) identified three central priorities: improving daily living conditions, addressing inequities in power, money and resources, and strengthening data and accountability. Its 2025 follow-up report recommends addressing economic inequality, structural discrimination, and global mega-trends such as climate change and digitalisation, alongside governance reforms.

This section sets out concrete examples from the EuroHealthNet partnership of how to reduce social inequalities in health by applying universal and proportionate universal approaches, which ensure equitable access to health and education services, combined with targeted interventions for vulnerable groups such as children, Roma communities, and prisoners. National and regional initiatives across Europe, ranging from sugar and alcohol policies in Poland and Scotland to school-based health promotion in Spain, data-driven planning in Hungary, and wellbeing economy frameworks in Wales and Finland, illustrate how these approaches can be implemented.

The health sector plays a critical role in advocacy, monitoring, and cross-sector collaboration, though it cannot alone resolve inequalities. **Achieving health equity requires a whole-of-society and whole-of-government commitment, embedding equity into policies, governance structures, and accountability systems.**

Progress on reducing social inequalities of health in EU Member States will depend on the political willingness, professional capacities and public resources to tackle the root causes of inequality, strengthening social and community cohesion, and reorienting policies towards wellbeing as a collective societal goal.

3. EU-level action to reduce social inequalities in health

As set out in earlier chapters of this report, the European Union (EU) has every interest in implementing policies and encouraging and enabling actions to reduce social inequalities in health between and within its Member States. Doing so aligns with its aims and objectives, as set out in Articles 2 and 3 of the EU treaties, which include both equality and wellbeing. Reducing social and health inequalities also strengthens social cohesion, trust in society, resilience, innovation and productivity across the Union.

However, the situation in the 17 European countries examined in this report is concerning. Only two countries showed clear signs of 'levelling up' in self-reported health. The other 15 countries failed to improve self-reported health and/or to reduce social inequalities in health. Such trends risk undermining the efforts of EU Member States to achieve their common priorities and objectives.

This chapter reviews the actions taken by EU institutions to reduce health inequalities across the Union, and where further progress is needed. It sets out that explicit efforts at the EU level to reduce health inequalities have been concentrated within the health sector, where progress has been made to raise awareness, promote knowledge exchange among Member States, and improve measurement tools. However, what is still lacking is recognition across all policy areas that promoting health equity is a shared goal that generates mutual benefits. The EU has yet to develop a truly comprehensive, balanced, cross-sectoral strategy, underpinned by effective governance tools, to ensure a more consistent implementation of measures that can reduce social and health inequalities by 'levelling up' health.

As will be set out, progress has nevertheless been made through measures addressing key structural and social determinants of health. One of the most important developments is the creation of the European Pillar of Social Rights and the reinforcement of the social dimension within the European Semester process. However, these advances remain fragile. **To prevent further stagnation, deteriorating health outcomes, and widening inequalities across Europe, it is crucial to ensure a balance between economic and public health, social and environmental goals, and consistently integrate an equity perspective.**

3.1 General considerations

Any discussion of the role of the European Union in reducing health inequalities must begin with an understanding that the EU institutions govern based on shared agreement amongst its Member States, and that it only has powers to legislate in those areas where Members have allowed it to. The EU institutions, therefore, carefully balance shared sovereignty

with respect for national competencies. The foundational structures of the EU were laid after the first two World Wars and built on a conviction that countries bound together by a common market, underpinned by shared laws and values, would be more prosperous than they could be alone, and more likely to remain at peace. The founding Member States wanted to maintain their national identity and sovereignty but agreed to cede power to the EU institutions in some areas to establish a common market. The European Social Model, developed early in the European project, is based on the idea that economic growth should serve social wellbeing, with Member States leading social protection within a framework that ensures cohesion and common standards.[88]

The EU's principal competences, as defined in the Treaties, therefore lie in ensuring the smooth functioning of the single market. This gives the EU the power to regulate in areas such as the customs union, competition rules, and monetary policy within the Eurozone. In other policy domains, including employment, social affairs, and the environment, competences are shared with the Member States. **Much of the power to address key structural and social determinants, like the redistribution of income and wealth, or those that affect health and education systems, and broader social policy, remains primarily with national governments. The EU can legislate in areas when there is consensus or majority agreement amongst EU Member States and their representatives.**

In policy fields where it only has supporting competence, the EU institutions exercise what is often referred to as 'soft power', meaning, for example, shared indicators and targets, or financial instruments steering progress towards common norms and standards.

3.2 EU-level policy initiatives with an explicit focus on social inequalities in health

The publication of the WHO report on the Social Determinants of Health (2008) raised awareness of how factors beyond the health sector shape health and health inequities. In the wake of its publication, the European Commission released the Communication on Solidarity in Health in 2009, and the European Council adopted Conclusions on Equity and Health in All Policies in 2010. While European Commission Communications, Council Conclusions, and its recommendations are non-binding, they carry important 'soft power', shaping policy priorities both at the EU and member state levels. They also influence the design and conditions of EU funding programmes, guiding how resources are allocated to support EU objectives. To date, these two documents remain the only EU-level policy initiatives to focus on health inequalities explicitly.

The 2009 **Communication on Solidarity in Health** included recommendations on ensuring regular statistics and reporting on the size of health inequalities in the EU, as well as the identification of successful strategies to reduce them. It also called for better information on EU funding to help national authorities and other bodies reduce them.

The 2010 **Council Conclusions on Equity and Health in All Policies** invited the European Commission and EU Member States to promote training on and gradually incorporate the equity in health approach, to advance in the development of new methodologies and tools for information exchange across sectors. EU Member States were also invited to assess the health impact of their policies and improve the use of integrated impact assessment from a health equity point of view.

Both the Commission Communication and the Council Conclusions emphasised the need to implement policies aimed at ensuring a good start to life for all children and the right to universal access to healthcare, including health promotion and disease prevention services.

3.3 EU-level actions on health equity driven by DG SANTE

When the Directorate-General for Health and Food Safety (DG SANTE) of the European Commission became involved in developing the Communication on Solidarity in Health and the subsequent Council Conclusions, it was still relatively new. Established in 1999 in response to major public health crises such as BSE (mad cow disease), its initial mandate was to strengthen the EU's role in health policy and ensure high standards for health and food safety across Member States. At the outset, DG SANTE operated from a predominantly biomedical perspective and with a relatively limited role, given the EU's restricted powers in the field of health. For example, **the first Public Health Programme (2003–2008)** did not explicitly include health inequalities as an objective, although it did fund related initiatives. Over time, DG SANTE's mandate has expanded to adopt a more holistic view of health, even though it continues to have a strong bio-medical orientation, given its regulatory roles in areas like food and safety, pharmaceuticals and infectious disease control.

The work of the WHO Commission of the Social Determinants of Health nevertheless contributed to widening DG's approach to health and the scope of its work. This was reflected in the main objectives of the **EU's Second Health Programme (2008–2013),** which included promoting health and reducing health inequalities. This commitment resulted in increased funding for initiatives relating to the reduction of health inequalities, and to the first Joint Action among national Ministries of Health on this topic (see Text Box 3.1). DG SANTE also facilitated an expert group among national health authorities to exchange experience.

The Third Health Programme (2014–2020) and the current **EU4Health Programme (2021–2027)** deepened the EU's commitment; health inequalities remain a specific objective, which is framed both in terms of improving and promoting health, and strengthening health systems, with particular emphasis on equity in access to care.

The COVID-19 pandemic prompted a significant increase in health budgets at the EU level. **The EU4Health programme (2021-2027)** budget of €5.3 billion represents a more than tenfold increase from the previous programme's €450 million budget. However, this was subsequently reduced by 20% in 2022, due to the Russian war against Ukraine. Part of the ten-

fold increase in the EU's budget for Public Health is being used to fund large-scale Joint Actions that strengthen cooperation amongst national governments around topics like non-communicable diseases. These Joint Actions build on the work of their predecessors, and some include social and health inequalities as a cross-cutting theme.

The first general objective of the EU4Health programme (2021-2027) is to improve and foster health in the Union to reduce the burden of communicable and non-communicable diseases, by supporting health promotion and disease prevention, by reducing health inequalities, by fostering healthy lifestyles and by promoting access to healthcare.[89] Other priorities are increasing crisis preparedness for cross-border threats, ensuring access to medicines and medical devices, and modernising and reinforcing health systems through digital innovation and better healthcare workforce capacity. The Programme also includes the One Health approach, which means a multisectoral approach which recognises that human health is connected to animal health and to the environment, and that actions to tackle health threats must consider all three dimensions.

The EU4Health programme offers essential opportunities to reduce social inequalities in health. It nevertheless risks reinforcing inequalities if it continues to focus too narrowly on individual behaviours, rather than on the wider structural and systemic factors that shape them. To reduce social inequalities in health, it is critical to move beyond informing people about what they should do to protect and promote their health, to creating the conditions that enable them to do so. Strengthening the health sector's engagement in 'Health (Equity) in All Policies' (HEIAP) can support collaboration with other sectors to address these underlying determinants. This involves collaboration with, for example, the education, housing, transportation, and social policy sectors, to make the case that they also shape health and health equity, and work with them to optimise these impacts. It also involves working with, for example, the agricultural, internal market, and competitiveness sectors to develop policies that can reduce alcohol and tobacco use, regulate food marketing, promote healthy urban design, ensure the safety of the digital environment, and support health-promoting schools. A HIA and HIEAP involve helping other sectors identify the impacts of policies on health and health equity, fostering shared objectives, and negotiating tensions and trade-offs between public health goals and other policy aims.

Article 5 of the regulation establishing the EU4Health programme[90] states that a minimum of 20% of its budget 'shall be reserved for health promotion and disease prevention'. It is unclear whether this percentage of the budget is currently being allocated to these areas, but it is unlikely. In addition, a large proportion of the spending on health promotion and disease prevention is on interventions provided within the healthcare system, such as screenings, vaccinations, clinical counselling, and medical risk assessment. A much smaller proportion is going to actions that strengthen collaboration with other sectors, via HEIAP approaches.

Health across all levels of government is still often considered a cost rather than an investment. Consequently, economic and financial considerations tend to take precedence over health-related goals, to ensure that health-care related interventions can be financed; this is especially the case at the EU level, where the EU's powers in health are limited. This limits DG SANTE's

influence over other sectors in advancing better health outcomes. Although the EU holds strong legislative powers to regulate commercial determinants of health, **such as reducing tobacco and alcohol consumption, promoting the consumption of healthier and more sustainable food, and addressing addictive algorithms in social media and digital technologies,** commercial interests frequently prevail over health and equity concerns. The delays in adopting key legislation during the previous von der Leyen Commission (2019-2024), aimed at reducing tobacco and alcohol consumption and fostering sustainable food systems, illustrate this challenge. **These delays may reflect a lack of resources and capacity, as well as a lack of political willingness at the EU-level to prioritise measures that address the structural and social determinants of health more effectively.**

Despite the broad ambitions of the EU4Health programme, the health services at the EU level continue to operate from a relatively narrow conceptualisation of health. This is evident in the plans for the European Health Union (EHU),[91] a flagship initiative championed by Commission President Ursula von der Leyen in the wake of the Covid-19 pandemic. The European Commission Communication on the EHU emphasises health inequalities primarily through the lens of equity in healthcare as a fundamental human right, notably in relation to Europe's Beating Cancer Plan.[92] However, the EC vision for the EHU does not extend to mobilising other sectors to contribute towards improving health and health equity across the EU. This limits the scope of the Union's efforts to address the broader structural and social determinants that influence health outcomes.

The new mandate of DG SANTE includes the development of a **Cardiovascular Health Plan**. EuroHealthNet has set out its vision for this plan, as a comprehensive one that addresses the root causes of cardiovascular diseases, with health equity and prevention at the centre of all actions.[93] This in turn means that DG SANTE must engage more strongly with other policy areas that affect such underlying structural and social determinants, like social policy, food systems, work environments, environmental policies and urban development, to ensure proportionally universal responses that promote health and reduce social inequalities in health.

EU-funded projects and initiatives, focusing on health equity

The Joint Action 'Equity Action' (2011-2014), led by EuroHealthNet, focused on building capacities and implementing Health Equity Audits, including at the EU level. It strengthened the use of stakeholder engagement for health equity, as well as using EU Structural Funds to reduce health inequalities.[94]

The European Parliament also co-funded three projects that focused on reducing health inequalities and improving the health of vulnerable groups,[95] including the Health Equity Pilot Project (2016-2018)[96] with the participation of EuroHealthNet.

The EC staff working document on **Health Inequalities in the European Union** (2013)[97] was based on the research led by Professor Sir Michael Marmot and with the contribution of EuroHealthNet.

The Joint Action Health Equity Europe (JAHEE) (2018-2021) identified the criteria of a good response to health inequalities as the ability to monitor these and the existence of a legal framework, policy commitment and governance structures to act on health inequalities.[98] These criteria enable policy makers to screen relevant policies through an 'equity lens', e.g., by applying health equity audits or equity-focused health impact assessments. This in turn necessitates timely data and the right governance tools to assess levels of health inequalities, and the coverage, uptake and effectiveness of relevant policies to address health inequalities.

The ongoing **Joint Action Cardiovascular Diseases and Diabetes (JACARDI)**[99] (2023-2027) and **Joint Action PreventNCDs (2024-2027)**[100] build on the work of their predecessors and include work to mainstream health inequalities as a cross-cutting theme.

3.3.1 Data on health equity

An area in which DG SANTE, as well as other EU Services, has made considerable progress to enable action on health inequalities is to ensure **more harmonised and disaggregated health data at the EU level and across EU Member States**, to measure the situation. This includes the development of the European Core Health Indicators (ECHI) in early 2000 by DG SANTE, as well as the EU SILK (European Union Statistics on Income and Living Conditions) survey, which provides data on underlying determinants of health. The EU also collaborates with WHO-Europe on the European Health Information Initiative (EHI) to ensure methodological alignment on health inequalities indicators.

The first **Health at a Glance: Europe publication**, issued by the European Union in collaboration with the OECD, was published in November 2016.[101] This report marked the start of the European Commission's State of Health in the EU knowledge cycle. It was the initial step in their partnership with the OECD to analyse the health status of EU citizens and health system performance across EU countries. This publication does not include regular sections on the underlying determinants of health, but there has been a focus on health inequalities in some issues (e.g., 2021). Where the publication does highlight disaggregated data, however, it tends to be on gender inequalities.

Most recently, an important initiative in relation to social and health inequalities was the establishment of a **European Cancer Inequalities Registry**, as part of Europe's Beating Cancer Plan, launched in 2020.[102] The registry presents data on cancer prevention and care to identify trends, disparities and inequalities between Member States and regions. The European Commission has, as part of this initiative, developed fact sheets on specific cancer-related inequalities (e.g., environmental factors in cancer, inequalities in screening for breast cancer and in childhood cancers). It also produced analytical reports to examine policies and actions to tackle cancer

trends and inequalities across the EU. The impact of the registry depends on EU Member States' contributions and on the extent to which they take up and act on this information.

While progress has been made on the harmonised collection of disaggregated data at the EU level, there continue to be big discrepancies in efforts to collect and compare administrative data across countries and in Member States' ability to disaggregate data. Further measures can be taken to **improve the granularity of existing data to ensure it captures vulnerable groups across Europe and to improve the timeliness of data collection processes to provide a better understanding of how policy measures are impacting health and wellbeing, across the European Union.**[103]

EU Multidimensional Inequality Monitoring Framework

The European Joint Research Council has also developed an EU Multidimensional Inequality Monitoring Framework (MIMF) that aims to broaden and deepen the scope of inequality monitoring frameworks at the EU level.[104] The MIMF covers a comprehensive set of 346 indicators across 10 life domains related to inequality and wellbeing, including many social and labour market indicators that have strong links to those in the European Social Scoreboard.

The MIMF offers a detailed dashboard of indicators measuring inequality, allowing nuanced country rankings and identification of specific areas needing policy focus. The Framework enhances understanding of inequalities beyond single-dimension metrics.

3.4 EU-level actions that contribute indirectly to reducing social inequalities in health

Overall, policy initiatives that are explicitly designed to reduce health inequalities at the EU level have been taken in the context of the European Public Health Programmes. There have been few explicit policy efforts to encourage and enable other policy sectors to contribute to the goal of improving health and wellbeing. In recent years, there have nevertheless been developments at the EU level that can have a positive impact on reducing socioeconomic inequalities in health by addressing underlying social determinants. These include the development of the European Pillar of Social Rights, as well as the 'broadening and softening' of the European Semester process, which is a governance tool that has been designed to coordinate policies at EU level and amongst EU Member States, and can help to mainstream the European Pillar of Social Rights as well as the UN Sustainable Development Goals. These developments will be discussed below.

The EU came close to making health inequalities a strategic priority under the **EU 2020 Strategy (2010-2020)** that brought together all EU policy priorities relating to employment, research and development, climate change and energy, education, and poverty and social exclusion. The EC Communication setting out the Strategy made a direct reference to health inequalities, framing their reduction as essential to economic growth:

The need to **combat poverty and social exclusion and reduce health inequalities is a prerequisite for economic growth.** A major effort will be needed to combat poverty and social exclusion and reduce health inequalities to ensure that everybody can benefit from growth. **Equally important will be our ability to meet the challenge of promoting a healthy and active ageing population to allow for social cohesion and higher productivity.**[105]

The EU 2020 Strategy did not include any targets and indicators related to health inequalities specifically. Still, it aimed to lift at least 20 million people out of the risk of poverty or social exclusion by 2020.[civ] The EU and its Member States, however, fell short of meeting this poverty reduction target. This was, in part, due to a general tendency for the European Commission and Member States to take a siloed rather than more integrated approach to achieving different policy goals.[106]

EU Member States also failed to meet the poverty reduction target in the EU 2020 Strategy, since it coincided with the 2008 financial crisis. Many of the actions taken at the EU level in response to the crisis were inconsistent with and undermined measures needed to achieve these targets. Many EU Member States imposed austerity measures in the wake of the crisis, which exacerbated poverty and social exclusion and widened social and health inequalities.

The European Semester process was first initiated in 2010 to strengthen EU economic governance in the aftermath of the financial and sovereign debt crisis, in response to the need that it revealed for stronger coordination to avoid future crises. The EU Member States, therefore, set up an annual policy coordination cycle to review developments and progress in various thematic areas using jointly formulated indicators and benchmarks. While the focus was primarily on Member States' economic and fiscal policies, it was also intended to coordinate their policies towards the achievement of the overarching Europe 2020 Strategy, including its social and environmental objectives.

The European Semester Process

The European Semester is the EU's annual cycle of economic and social policy coordination.

The process is guided each year by the Annual Sustainable Growth Strategy (ASGS), which sets out the EU's economic and social priorities for that year. This information is included in Country Reports, setting out EU Member States' performance across a wide range of indicators related to the EU's economic, fiscal, social, and environmental policy objectives. The EU institutions and Member States jointly review Country reports. The EU institutions, in negotiation with the Member States, then issue **country-specific recommendations (CSRs)** for reforms that EU Member States will make, to improve their performance against specific indicators.

The indicators include those from the European Pillar of Social Rights Social Scoreboard (see below) to align Member States' policies not only with economic growth and environmental goals but also to achieve social wellbeing and reduce inequalities, to reinforce the Semester's broader agenda of sustainable and inclusive development.

The United Nations Sustainable Development Goals (SDGs) were formally integrated into the European Semester process starting with the 2020 cycle, also to monitor progress towards the broader and long-term sustainability objectives of the SDGs.

3.4.1 European Pillar of Social Rights

The austerity measures imposed on several European countries following the 2008 financial crisis led to a dramatic increase in unemployment, reduced wages, and cuts in social services, especially in Greece, Italy, Portugal, and Spain. These measures undermined social cohesion and led to an increase in poverty and inequality in these countries.

In response, the European Commission developed and launched the **European Pillar of Social Rights** (EPSR) in 2017 as a comprehensive framework aimed at restoring the social dimension of the European Union. It consists of 20 principles, in three categories: 1) equal opportunities and access to the labour markets; 2) fair working conditions; and 3) social protection and inclusion. It also includes one principle directly related to the right to health care: **Principle 16: Everyone has the right to timely access to affordable, preventive and curative health care of good quality.**[107]

The Pillar serves as a compass for EU policy and is implemented through a combination of EU legislation, policy coordination between Member States, funding from the EU budget, and national reforms by Member States. The EU can incentivise Member States to act, for example, by benchmarking their performance in different areas via the Social Scoreboard (refer to Section 4.1) as part of the European Semester Process.

In 2021, the EU adopted the first European Pillar of Social Rights Action Plan as a roadmap to implement the principles of the European Pillar of Social Rights. The Action Plan calls for a strong social Europe that ensures

that the green and digital transitions are fair. It also emphasises job creation, fair working conditions, and upskilling/reskilling, as well as improved access to quality services like childcare, healthcare, and housing. EU institutions, Member States, social partners, and civil society are all responsible for taking the actions outlined, with the support of EU funding instruments, such as the Recovery and Resilience Facility, the European Social Fund, the Social Climate Fund and other funds.

Since all 20 principles of the EPSR reflect key social determinants of health, it can also be considered a **European Pillar for Health Equity.** EuroHealthNet has developed a European Pillar of Social Rights Flashcard tool, where every principle is translated to health and efforts to address social inequalities in health.[108]

Source: EuroHealthNet

In line with the new political guidelines, the European Commission aims to put new impetus in areas where more progress is needed and will frame its work in a **new Action Plan on the implementation of the European Pillar of Social Rights.** It will include initiatives looking at how digitalisation is impacting the world of work, from AI management to telework and the impact of an 'always on' culture on people's mental health. Namely, Principle 9 and the 'right to disconnect'. The new Action Plan will also focus on a just transition for all, supporting fair wages, good working conditions, training and fair jobs. The Plan will moreover include initiatives to strengthen the European Child Guarantee (see below) and to prevent social exclusion through education, healthcare and other essential public services.

The European Child Guarantee

An important EU instrument with strong potential to promote health equity is the European Child Guarantee,[109] which was adopted in 2021, based on a European Council Recommendation.[110]

It is linked to Principle 11 of the EPSR and aims to prevent and combat social exclusion by guaranteeing effective access of children in need to a set of key services. Those services address key determinants of health and include:

- free early childhood education and care
- free education (including school-based activities and at least one healthy meal each school day)
- free healthcare
- healthy nutrition, and
- adequate housing

As part of the European Child Guarantee, Member States must produce national action plans that set out the concrete actions that they will take to improve the wellbeing of children, and appoint national Child Guarantee coordinators who can monitor the implementation process. To date, however, these action plans differ significantly in terms of the quality and innovative nature of the actions proposed, and efforts to strengthen the EU Child Guarantee will be welcome.

The European Commission's new political guidelines for 2024-2029 include several initiatives that aim to contribute to the implementation of the European Pillar of Social Rights, like the announced first-ever European Anti-Poverty Strategy and a European Affordable Housing Plan, discussed below.

European Anti-Poverty Strategy - under discussion

The current European Commission's new political guidelines stress the importance of a strong social Europe that leaves no one behind. Poverty remains a significant issue across the EU, exacerbated by crises such as the pandemic, the rising cost-of-living, climate and geopolitical instability, which disproportionately impact vulnerable groups.

The announced EU Anti-Poverty Strategy, which shall be published in 2026, will aim to address the multi-dimensional nature of poverty through a life cycle perspective and build on the social investment approach. It envisages supporting Member States in addressing the root causes of poverty, strengthening access to adequate income and essential services, promoting inclusive labour markets, and reinforcing social protection systems. In addition, the strategy envisages improving monitoring and analysis of poverty, exchange of best practices and coordination mechanisms while ensuring meaningful stakeholder involvement. **The findings of this report demonstrate that poverty and health are interlinked and indicate that health equity should be a core concern and part of the EU Anti-Poverty Strategy.**

European Affordable Housing Plan - under discussion

The European Commission is planning to address the housing crisis facing millions of families and young people and will put forward a European Affordable Housing Plan in 2026. As indicated in the analysis of the European Social Survey Data, Europeans have more housing problems than they did ten years ago. In addition, housing is a significant determinant of health, playing a critical role in social equity. Access to social housing or housing assistance of good quality should be provided for those in need. The Affordable Housing Plan will help implement Principle 19 of the European Pillar of Social Rights, on housing and assistance for the homeless.

Unaffordable housing contributes to housing insecurity, financial strain, and, at worst, homelessness, disproportionately affecting vulnerable groups. Poor housing conditions, such as overcrowding, exposure to pollutants, inadequate ventilation, and limited access to green spaces, are linked to chronic health issues, including respiratory diseases, cardiovascular problems, and mental health disorders. **The new European Affordable Housing Plan must focus not only on affordability but also on ensuring that living spaces, their environments, and the communities in which they are situated are conducive to good health.** For example, mainstreaming the use of indicators for healthy, sustainable and resilient buildings, developed by the Buildings Performance Institute Europe, can contribute to achieving this.[111]

More broadly, if the EPSR Action Plan, European Anti-Poverty Strategy and the European Affordable Housing Plan are to be successful, the EU Institutions and EU Member States must see them as part of a more holistic strategy to improve the wellbeing of all Europeans, rather than considering them, more narrowly, as the responsibility of the social, health or housing sectors only. The broader underlying structural and social determinants that generate poverty and social exclusion must be acknowledged and addressed in both the EPSR Action Plan and the Anti-Poverty Strategy. A failure to do so means that, as in the past, broader macro-economic developments may undermine progress towards the targets and objectives set out in these policy initiatives.

3.4.2 Other EU policies and programmes that address underlying structural and social determinants

In addition to broader policy developments set out above, there is a wide range of specific policies and programmes at the EU level that can contribute to addressing key structural and social determinants of health, and to reducing social inequalities in health. Some of these EU policies were designed in the first mandate of Commission President von der Leyen (2019-2024) and are being taken forward during the second mandate, under the new EU Strategic Priorities 2024-2029, in addition to new upcoming initiatives.

Examples of EU policies and legislation with strong potential to contribute to the reduction of health inequalities

Structural, macro-economic determinants

- Unfair Commercial Practices Directive (2005, amended in 2019)
- Audio-visual Media Services Directive (2010, amended in 2018)
- Capital Markets Union (2015) & Action Plan (2020)
- Tax transparency and anti-tax avoidance directives (2016)
- Digital Services Act (2022)

Structural determinants for equal opportunities

- Non-discrimination and equal opportunities in the European Union (2008)
- Council recommendation on lifelong learning (2018)
- EU Youth Strategy (2019-2027) (2018)
- EU Pact for Skills (2020)
- EU Anti-racism Action Plan (2020-2025) (2020)
- EU strategy for Roma equality, inclusion and participation (2020-2030) (2020)

- European Declaration on Digital Rights and Principles (2022)
- European Strategy for a better internet for kids (2022)

Material and psychosocial determinants

- European Child Guarantee (2021)
- Directive on Minimum Wages (2022)
- European Care Strategy (2022)
- Council Recommendation on adequate minimum income (2023)
- Pay Transparency Directive (2023)
- Platform Work Directive (2024)
- Platform Work Directive (2024)
- EU Affordable Housing Plan (upcoming)
- EU Anti-Poverty Plan (upcoming)

Occupational determinants

- Posting of Workers Directive (1996, amended in 2018)
- European Employment Strategy (1997, integrated in European Semester since 2011)
- EU Working Time Directive (2003)
- Directive on Temporary Agency Work (2008)
- Work-life balance directive (2019)
- European Platform for enhancing cooperation in tackling undeclared work (2020)
- Gender equality strategy (2020-2025) (2020)
- Strategic Framework on Health and Safety at Work (2021-2027) (2021)
- Roadmap for Women's Rights (2025)
- Quality Jobs Roadmap (upcoming)

Health and behavioural determinants:

- Europe's Beating Cancer Plan (2021)
- EU Comprehensive Approach to Mental Health (2024)

- EU Vision for Agriculture and Food (2025)
- EU agricultural policy – strategy to promote generational renewal (upcoming)

Environmental determinants:

- EU biodiversity strategy for 2030 (2020)
- Urban Agenda for the EU (initiative launched in 2016 and reconfirmed in 2021)EU Adaptation strategy (2021)
- 8th Environment Action Programme to 2030 (2022)
- Energy Performance of Buildings Directive (2024)
- EU Nature Restoration Regulation (2024)
- European Water Resilience Strategy (2025)
- European Climate Adaptation Plan (upcoming)

3.4.3 Funding programmes

The EU institutions exercise substantial soft power among Member States by tying funding instruments to programme objectives and core EU values such as solidarity, inclusion, and social rights. Just as funding opportunities are made available under the EU4Health budget to encourage stakeholders to take forward its objectives, a wide range of other funding opportunities also exist to incentivise national governments and other actors to take actions that drive common objectives and thereby address key structural and social determinants of health. These financial incentives are reinforced by monitoring, technical assistance, and opportunities for knowledge exchange, facilitated by the EU institutions.

The multi-annual Financial Framework programme of the EU (2021-2027) includes various funding programmes that provide financial resources to address social inequalities in health.

Perhaps the most notable example is the **EU's Cohesion Policy**, which allocates around one-third of the EU budget to reducing economic, social and territorial disparities across EU regions. Decisions on how to use these funds are made jointly by Member States and the European Commission, ensuring that EU resources can be directed toward objectives that contribute, at least indirectly, to reducing health inequalities across Europe.

The European Social Fund Plus (ESF+), the European Regional Development Fund (ERDF) and the Cohesion Fund (CF) all fall under the umbrella of **Cohesion Policy**. ESF+ funds support social inclusion and poverty reduction, combating unemployment, developing human capital, and promoting equal opportunities. ERDF funds target regional imbalances by supporting economic development in less developed and transition regions and promoting social inclusion and sustainable urban development. Cohesion Funds focus on Member States with lower GDP per capita, and finance large-scale infrastructure projects related to the environment, transport, energy, and social sectors, contributing to reducing disparities.

The European Just Transition Fund was established in 2021 under the previous Von der Leyen Commission to support regions most affected by the transition to a climate-neutral economy, addressing social and economic costs to prevent widening inequalities.

Additionally, following the COVID-19 pandemic, around €43 billion from the EU's Resilience and Recovery Fund was dedicated to health-related projects.[112] This includes investments in healthcare infrastructure, digitalisation, and system improvements across EU member-states, with countries like France and Belgium, prioritising digital health and Spain and Greece focusing on workforce reforms.

Refer to **Annex IX** for a list of current EU funding programmes that provide opportunities to reduce health inequalities (2021 -2027).

The European Parliament has also published a study on 'policy instruments to tackle social inequalities related to climate change' that elaborates on selected EU Funds and instruments to ensure a Just Transition.[113]

As discussed below, however, the governance mechanisms to ensure these funds are allocated to address pressing social and health-related needs as efficiently and effectively as possible are weak.

The **new Multiannual Financial Framework (MFF) for the European Union, or its long-term budget, covering the period 2028–2034, reflects a shift in strategic priorities shaped by recent geopolitical, economic, and security challenges.** As Member States face growing demands on national budgets, the EU is likely to concentrate its resources on defence and security, energy independence, climate action, and digital innovation, seen as essential for strengthening Europe's resilience and competitiveness. This shift in focus is likely to affect funding for health and social priorities. While health gained prominence during the COVID-19 pandemic, financing for health is unlikely to remain stable under the new MFF, and there may only be modest support for targeted initiatives like cross-border data systems, cardiovascular health or antimicrobial resistance.

3.4.4 The European Semester process and other governance tools

As set out above, EU institutions strike a careful balance between shared sovereignty and respect for national competencies. An important governance tool to achieve this balance and make joint progress towards commonly established goals and priorities is the European Semester process. The process helps to identify where EU Member States are underperforming in areas that are key to meeting the EU's common priorities, norms and standards. EU Member States then receive recommendations on reforms needed. In the area of economic and fiscal policy, the EU can exercise 'hard power' to ensure countries comply with reforms; in areas of social policy and health, countries are incentivised to reform through soft measures like funding opportunities.

The European Semester process has and continues to receive criticism for its inconsistent approach across policy priorities. A report by the European Court of Auditors (2020), for example, raised the lack of a strategic focus of the CSRs, since it was unclear how they contributed to the Annual Growth Survey and the Europe 2020 Strategy. It was also unclear how progress towards the implementation of the CSRs would be evaluated. The report also raised the lack of clear links between the EU's priorities of the European Semester at the time, and the EU's funding programmes.[78]

The European Semester has been reformed over the past ten years to include a stronger focus on social, health and environmental policy. However, inconsistencies like those raised by the European Court of Auditors in 2020 remain. The EU remains a predominantly economic project; the EU's institutional powers and expertise are primarily oriented towards strengthening financial performance. As a result, the resources that the EC makes available to ensure compliance with social and public health-related norms and standards are generally much weaker. This has led the European Economic and Social Committee (EESC) to note, for example, that:

Unless funding mechanisms like the Just Transition Fund, Social Climate Fund, Resilience and Recovery, and Cohesion Funds are specifically earmarked for vulnerable groups, the EU Semester guidelines are insufficiently strong to ensure spending is directed towards these groups.[114]

The EESC therefore concludes that there is a need for even more policy coherence and accountability measures across different policy areas at the EU level, to ensure the balanced delivery of all EU objectives, including the cross-cutting objective of a just transition.[115]

One suggestion related to EU level funding opportunities is, for example, to use **disaggregated data at sub-national levels on health outcomes to determine where to invest funds to reduce poverty, social exclusion and health inequalities**. Currently, the EU tends to use GDP per inhabitant at the EU level as the primary indicator to allocate funds. They could, consequently, be missing pockets of inequalities within countries or regions where GDP is relatively high.[116]

Authors have argued that, although the EU lacks strong enforcement powers to ensure Member States implement recommended reforms in health or social policy, mechanisms like the Country-Specific Recommendations (CSRs) still help strengthen Member States' institutional capacity. This concept refers to their ability to influence policy outcomes through expertise and political arguments, shaping the development of reform advice and the interpretation of data. In other words, while EU institutions may not be able to guarantee compliance with their recommendations, they do play an essential role in setting norms and standards. These encourage economic growth that supports health, health equity, and wellbeing, rather than allowing growth to occur at their expense.

While there is still much scope for improvement in EU governance mechanisms like the European Semester process to ensure a stronger balance between fiscal and economic, and social, health and environmental considerations, positive steps are being taken to do so. The ('hard') EU fiscal rules, for example, set limits to deficits and public debt to ensure economic stability, but these limits often force countries to restrict social spending, such as on pensions, healthcare, and long-term care. Concerns about budget debts and deficits led to a re-tightening of debt and deficit limits after the COVID-19 pandemic. **Nevertheless, the new fiscal rules also allow Member States that make reforms in areas that are deemed to generate high economic and social returns to benefit from an extended fiscal adjustment period of up to seven years.** This allows countries to take measures that support underlying structural and social determinants of health, without the risk that their debt is deemed unsustainable under the fiscal rules.

Another positive new development is the introduction of the Social Convergence Framework in 2023, which was piloted during the 2024 Semester cycle. This framework aims to deepen the analysis of EU Member States' performance in social policy, ensuring they uphold the principles of the European Pillar of Social Rights.[117] Countries demonstrating potential risks during the first stage of monitoring via the Social Scoreboard undergo a second stage of analysis to improve understanding of the scope and distribution of the risks. In 2024, this secondary analysis focused on countries like Bulgaria, Estonia, Greece, Spain, Croatia, Italy, Lithuania, Luxembourg, Hungary, and Romania. **The framework produces a Social Imbalances Report and informs the Country-Specific Recommendations (CSRs) in the employment, skills, and social policy domains, so that the findings are considered in context alongside other economic and fiscal assessments.** While this does not guarantee that countries will receive CSR relating to their social imbalances, it does strengthen the social dimension of EU policy coordination and supports upward social convergence across Member States.

The Better Regulation Initiative

Another key approach to reducing health inequalities is to mainstream a focus on the distributional impact of policies and programmes across sectors. Another key EU level governance mechanism that contributes to ensuring such a focus on distributive impacts and to more integrated policymaking is the EC's Better Regulation Initiative.[118] This initiative was established to ensure that EU regulations are evidence-based, made transparently and inclusively, and are as simple and targeted as possible to reduce unnecessary burdens. Implementation of the regulation is supported by the **EC's extensive Better Regulation Unit Tool Kit**,[119] which includes 69 tools, including one on employment, working conditions, income distribution, social protection and inclusion (Tool #30). The toolkit also includes one on **how to conduct health impact assessments, which emphasises health inequalities (Tool #32)**. Health falls under social impact assessments.

However, the scope of the EC's Better Regulation Toolkit, and irregularities in data collection processes across the EU, particularly relating to disaggregated data, raise questions about the extent to which EC and Member States have the resources and political will to undertake distributive impact assessments more frequently, and why this information is not more broadly accessible and communicated. An EC Communication on better assessing the distributional aspects of Member State policies[120] notes that while the EC encourages Member States to analyse the distributional impact of their budgetary measures (EU Regulation on Member States' draft budgetary plans), this is rarely provided to the EC, for example as part of the European Semester process. The document refers to a background study for the EC Communication on distributional aspects, which confirms that EU Member States rarely included DIA's in draft budgetary plans for organisational reasons, like lack of time and no specific request from the ministerial hierarchy. It also notes that **'the results of distributional analyses, when communicated in an accessible manner to the media and public, could be used to nurture public debate and help to gain acceptance of reforms.'**[121]

The OECD has, in the past, reviewed and praised the EU's efforts on 'better regulation', but noted in a report that **makers tend to focus on costs when**

developing regulation, rather than benefits, which can result in regulation that is not in the best interests of the community. The report also notes that **stronger efforts are needed to involve stakeholders, citizens, businesses, NGO's and others, who have direct experience regarding the actual impacts of rules.**[122]

The European Union Competitiveness Compass

Progress has been made, but more is still needed to balance economic, fiscal, social, health, and environmental priorities. However, this progress risks being derailed by the current Competitive Compass, which is actively shaping the current European Commission's policy agenda.[123]

The Competitive Compass was launched in early 2025 as a strategic framework to make the EU more dynamic, commercially, in the face of current geopolitical and economic tensions. It aims to strengthen technological development (AI, robotics, biotech, etc) across the EU, and to continue to take forward efforts to decarbonise economies, in ways that strengthen the EU's competitiveness. The initiative is paired with a strong focus on simplification of the rules and reducing administrative burdens, particularly for small and medium-sized enterprises, to make them more competitive. It is also paired with efforts to establish a 'Union of Skills', to ensure lifelong learning and stimulate and retain talent, in the EU. The European institutions will align their actions and encourage EU Member States to achieve competitiveness as their primary goal. **There is a danger that the strong focus on competitiveness and simplification, paired with the emphasis on security and defence, will come at the cost of health and social reforms and distributional considerations, thereby driving up (health) inequalities across the European Union.**

A more balanced approach, Resilience 2.0, is outlined in the EU's 2025 Strategic Foresight Report. It builds on the recent European Preparedness Strategy to ensure that the EU thrives in turbulent times through 2040 and beyond. Amongst the areas for action are strengthening long-term economic resilience: increasing the ability to deliver sustainable and inclusive growth, and supporting sustainable and inclusive wellbeing: supporting a social market economy and a just transition to a clean economy.[124] The report stresses that the EU and EU Member States should work toward a renewed social contract that strengthens trust by improving welfare, reducing disparities, and ensuring access to high-quality public services. This includes expanding preventive and affordable healthcare, tackling health inequalities, and promoting healthier lifestyles through new technologies.

3.5 Summary and conclusions

While there is an awareness of and some explicit action around the issue of health inequalities within the health sector at the EU level, a whole-of-government approach to addressing them is missing. At the same time, equity, fairness and justice are essential values at the EU level, which received more attention in recent years, due to the fallout of austerity measures taken by some EU Member States after the 2008 financial crisis, the COVID-19 pandemic and in the face of the green and digital transitions, disrupting societies. These crises also raised the need for better

coordination and integration of EU and EU Member State policies, and the development and reform of the European Semester process. The crisis shed light on the importance of social policy to maintain social cohesion and led to the development of the European Pillar of Social Rights. This chapter also highlighted other policies and mechanisms developed at the EU level that address the key structural and social determinants and can thereby contribute to a reduction in social inequalities in health.

The **EU can develop binding legislation** in employment policy, where it has taken necessary measures around, for example, working time, minimum wages, health and safety at work, etc. The EU nevertheless has limited power to enforce social rights, and many of these actions are supporting policies, which means that the **EU can monitor, benchmark, analyse, support mutual learning and channel funds.** Their real impact, however, will depend on the extent to which EU Member States take them up. The main leverage that the EU has to influence reforms and measures to reorient health systems and progress social rights is through its funding programmes. However, this leverage will likely decrease rather than increase. This is because the new Multiannual Financial Framework (2028-2034) will reflect the new Political Priorities, such as competitiveness, preparedness, and security, with less attention to health and social goals.

There is scope to **mainstream a stronger focus on distributional impacts across policies and programmes through governance mechanisms like distributional impact assessment (DIA) and health (equity) impact assessments (HEIA), to ensure that they reach those in more, or most need.** Again, however, the EU's current emphasis on simplification, in the context of its Competitive Compass, makes it unlikely that there will be a stronger emphasis on such tools at the EU level in the current legislative period.

Although EU Treaties state that economic growth should support wellbeing, in practice, **economic and fiscal goals usually take priority over health and social goals,** which are still regarded as costs rather than investments. As a result, policy tends to focus on creating the right conditions for economic growth to fund these expenditures. This means economic and fiscal interests, often championed by commercial actors, frequently also overshadow the voices of those in non-commercial sectors. The gap in available resources between private and public interests gives large commercial groups significant political influence. While this report did not focus extensively on EU-level social policies that shape wider economic factors affecting health, it is important to note that policies on the internal market, taxation, and competition have major impacts on funding, the design of social and health policies, and levels of health inequality within and between Member States.

Although EU institutions have contributed to advancing (health) equity and fairness within and between Member States, much more remains to be done. The rightward shift in the EU's political mandate following the 2024 elections, combined with ongoing geopolitical upheavals and a strong focus on security and competitiveness, risks diverting attention away from these

issues. **Yet deprioritising health, wellbeing, and their fair distribution will not only fuel the lack of progress in most EU Member States in relation to health and the reduction of health inequalities, but it will also undermine the very priorities—security, stability, and prosperity—that such trade-offs are intended to protect.**

This underscores the urgent need to act on the recommendations of the WHO Commission on Social Determinants of Health (CSDH, 2008) and the updated World Report on the Social Determinants of Health (2025). Achieving the EU's overarching objective of wellbeing, rooted in the shared values of peace, democracy, and equality, requires tackling imbalances in power, resources, and money that shape people's daily lives. Addressing these inequities is essential to preserve and strengthen the European social model while fostering healthier, more resilient, and more productive societies. Governance frameworks such as the European Semester can help clarify common objectives, assess Member States' progress, identify potential synergies across sectors, and manage the trade-offs required. Initiatives such as JA PreventNCD and work through the EuroHealthNet Partnership can contribute to defining the path forward.

4. The Social Scoreboard and the need for disaggregated indicators

The previous chapter highlighted the European Pillar of Social Rights (EPSR) as one of the most important initiatives at the EU level to reduce social inequalities in health. The EPSR sets out 20 principles and rights, in the areas of equal opportunities, fair working conditions and social protection, that EU Member States have committed to. These rights and principles can help to ensure that economic growth occurs in ways that support, rather than undermine, wellbeing for everyone. The EPSR addresses key structural and social determinants of health, making the Pillar of Social Rights a Pillar for Health, too.

The main tool to help ensure EU Member States respect and progress the principles in the Pillar is the Social Scoreboard, which includes tools to monitor and benchmark EU Member State performance across key indicators.

The Social Scoreboard provides precise, structured monitoring of social rights and progress across EU Member States aligned with the European Pillar of Social Rights. It helps identify countries with social policy challenges and areas needing targeted actions, to inform analysis and policy discussions within the EU framework, such as the European Semester. Most data in the Socia Scoreboard, however, is not disaggregated across different social groups.[125,126] Differentiated outcomes are only presented for specific indicators like the employment gender gap, severe housing deprivation by owner status, and healthy life years at 65 by sex. For other indicators, disaggregation by different social groups is limited by data availability at the national level, sample size or harmonisation issues. As the analysis into levels of self-reported poor (mental) health in Chapter 1 revealed, disaggregating data by socioeconomic groups can generate important insights into who is benefiting and who is being left behind, in relation to different rights and principles. **The omission of disaggregated outcomes impedes a more nuanced understanding of what is happening across social groups that can allow for more effective measures to reduce social and health inequalities.**

The purpose of this chapter is to demonstrate further the relevance and importance of presenting more scoreboard outcomes in ways that enhance understanding of a country's performance in relation to the EPSR delivery, as well as how that performance is distributed across different population groups. This knowledge is important to developing effective and efficient policy responses that can reduce social inequalities in health and thereby improve social cohesion, resilience and competitiveness.

To demonstrate the value of this, data has been disaggregated for one indicator per category of principles and rights in the Pillar, namely:

- **Early school leavers**, under the category of equal opportunities.
- **Employment gap and gender employment gap**, under fair working conditions.
- **Unmet medical needs**, under social protection and inclusion.

The analysis is based on the data from the European Social Survey, rather than data from Eurostat. We selected indicators from the ESS that correspond to those used in the Social Scoreboard and followed the definition and methodology applied for the Social Scoreboard indicators, although the latter are not habitually disaggregated by socioeconomic level. See Annex for all data from ESS Rounds 7 (2014) and 11 (2024) addressed in this chapter.

These indicators were disaggregated by **educational level: secondary, as low-education; upper secondary/vocational, as mid-education; and tertiary, as high-education.**

The following sections present the results of these analyses, illustrated through graphs that demonstrate the impact of early school leaving, the employment gap, and unmet medical needs on different educational groups, as well as trends over the past 10 years.

The European Social Pillar and the Social Scoreboard – a recap

As set out previously, the **European Pillar of Social Rights** was launched by the European Commission in 2017 to strengthen the social dimension of the EU, rebalance economic policies with social considerations, and promote higher social standards. The Pillar is a recommendation by the European Commission and is not legally binding; its implementation is a joint responsibility of Member States, social partners, and the EU.

The European Pillar of Social Rights comprises 20 principles grouped into the following categories:

I. Equal opportunities and access to the labour market (e.g., gender equality)
II. Fair working conditions (e.g., secure and adaptable employment, and wages that ensure a decent standard of living)
III. Social protection and inclusion (e.g., access to childcare and healthcare)

EuroHealthNet's European Pillar of Social Rights Flashcard tool illustrates its 20 principles, which address key underlying socioeconomic determinants of health, making it a Pillar for Health.[107]

The **Social Scoreboard** is a monitoring tool accompanying the EPSR. It includes 14 primary indicators and 31 secondary indicators that cover different aspects, to measure EU Member States' progress towards principles in the European Pillar of Social Rights.

The Scoreboard does not include an indicator on health inequalities, but it consists of some indicators that are directly related to health; **self-reported**

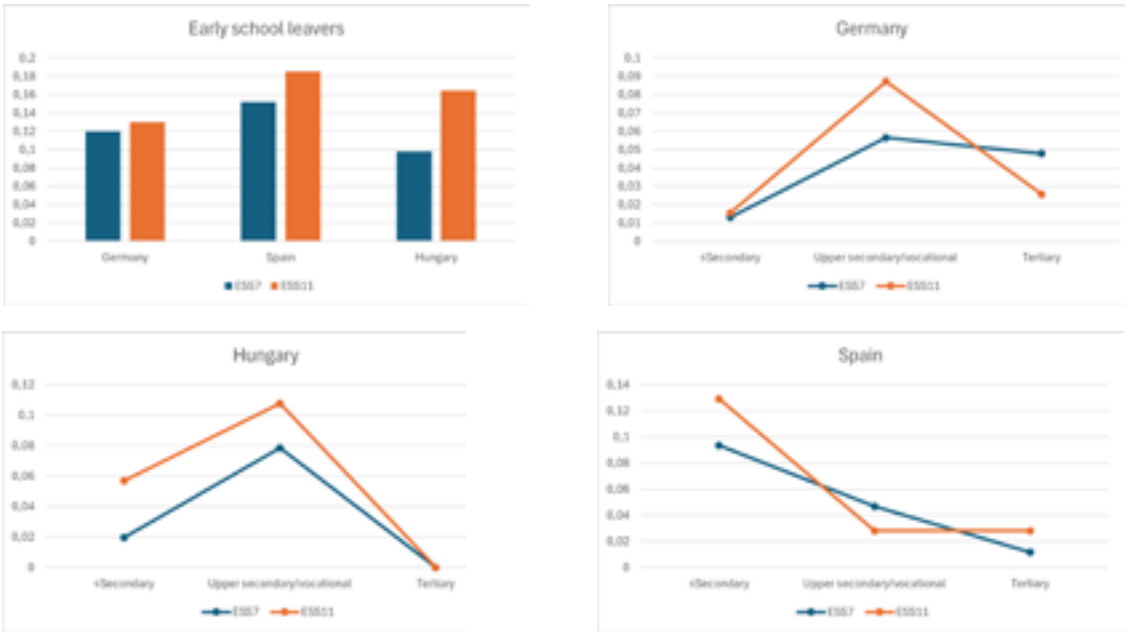
unmet need for medical care is a headline indicator, while healthy life years at 65 for men and women, levels of standardised preventable and treatable mortality, and out-of-pocket expenditure for healthcare are secondary indicators. Amongst other highly relevant indicators are, for example, income quintile share ratio, housing cost overburden, and at-risk-of-poverty and social inclusion rate.

Besides assessments that the Scoreboard does not present more disaggregated data, there has also been a critique that EU Member States and the EU Institutions have not set explicit targets in relation to the indicators in the social scoreboard, so that progress is monitored towards these targets. Instead, the Social Scoreboard shows the current state and trends but lacks a clear framework for assessing whether countries are meeting agreed social objectives or progressing sufficiently towards these targets.[127,128]

As set out in Chapter 3, the Social Convergence Framework (SCF) is a new tool applied in the context of the European Semester process that builds on and goes beyond the Social Scoreboard, by providing a more in-depth analysis of social imbalances and progress on implementing the principles of the European Pillar of Social Rights. The process only concerns countries that are performing poorly in areas reflected by the Social Scoreboard.

4.1 Early leavers from education and training

Figure 42: Differences and changes in early school leaving, 2014-2024



In the Scoreboard, early school leaving is defined as the percentage of young people aged 18 to 24 who have attained a lower secondary education, and who are not participating in further education or training, neither formal nor non-formal, during the four weeks preceding the Survey measurement. The ESS indicator for early school leavers defines participation in education or training during the last seven days.

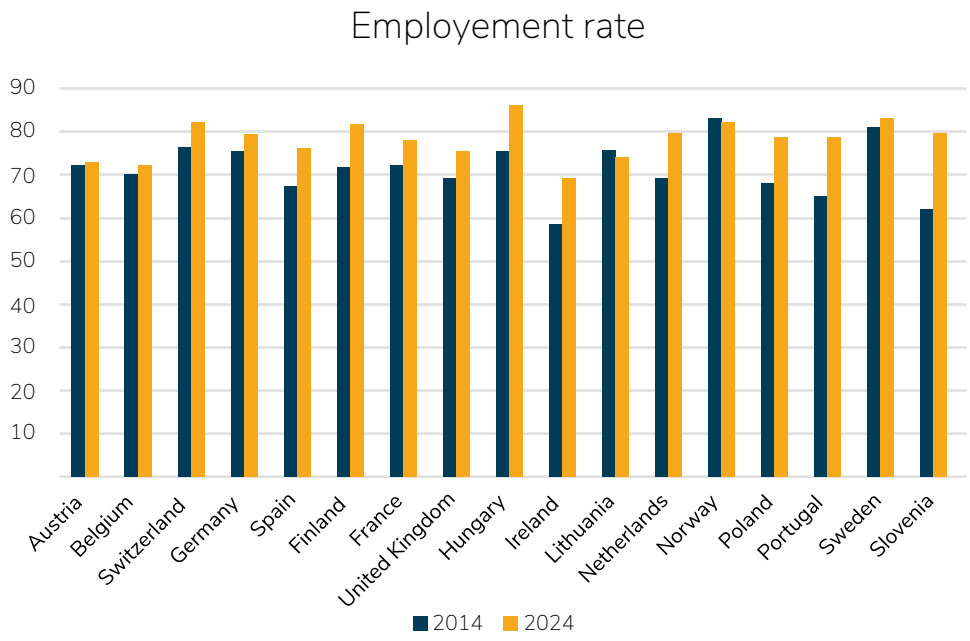
The figure above reflects that approximately 13% of youth left school early in Germany in 2024, compared to 18% in Spain and 16% in Hungary. Early school leaving is going up in all three countries examined, with the highest rates in Spain, from 15% in 2014 to 18% in 2024. The largest percentage increase in early school leaving was in Hungary (by approximately 6%).

Early school leaving, disaggregated by parents' education, differs considerably among countries. In **Hungary,** the rise is mainly amongst students of parents with lower secondary school, the low-education group (4%). However, it also increased amongst students of parents with upper secondary and vocational schools, the mid-education groups (by less than 2%). In **Spain**, there was also an increase amongst students from parents with a lower secondary background, mid-education (approximately 3%). There was also an increase in those with a tertiary background, a high-education (approximately 2%), but a decrease in early school leaving amongst children from parents with secondary and vocational education, mid-education. (approximately 2%). In **Germany**, early school leaving remained the same amongst students of parents with lower secondary between 2014 and 2024. Still, there was an increase in early school leaving amongst children of parents with upper secondary and vocational schools, mid-education (3%), and a decrease amongst those children from parents with tertiary education, high-education (2%).

The results of this analysis illustrate **how the drivers of early school leaving not only differ per country but also among different socioeconomic groups within countries. Governments must understand the specific patterns in their country, region and/or locality, to develop better-tailored, evidence-based responses** to prevent vulnerable youth from leaving education prematurely and thereby reduce their risk of poverty and social exclusion. Single policy approaches are unlikely to address the diverse realities that young people across different socioeconomic groups face.

4.2 Employment rate

Figure 43: Employment rates between 2014 and 2024

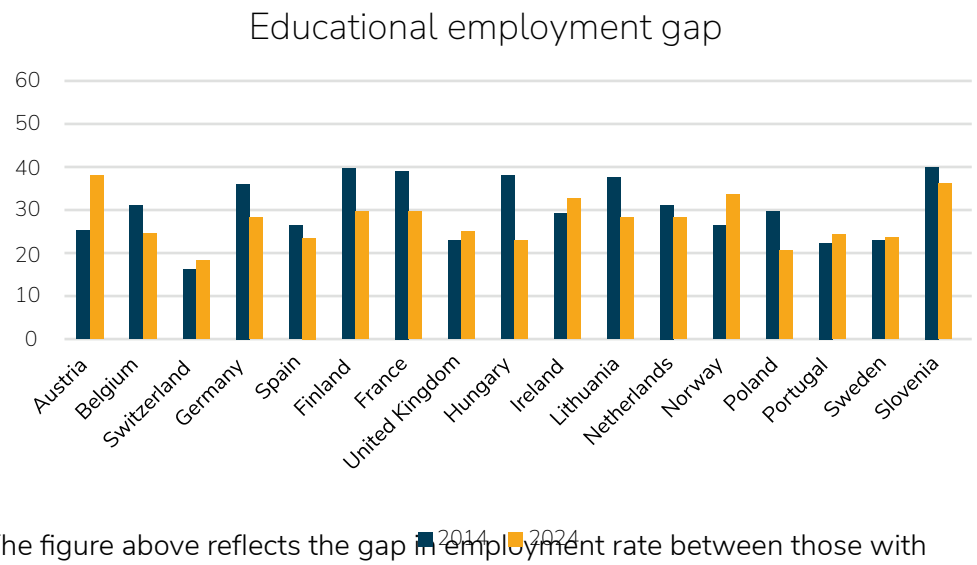


Employment rate is defined as the proportion of the population aged 20 to 64 years that is in employment. The employment rate includes all employed persons, both employees and self-employed, who have worked for at least one hour during the reference week for pay or profit and excludes those outside the labour market (such as the unemployed and inactive population).

Overall trends in employment were positive between 2014 and 2024, with average rates ranging from 67.8% in Ireland to 85.4% in Hungary. Lithuania was the only country that experienced a slight decline in employment rates between 2014 and 2024.

Employment rate broken down by education.

Figure 44: Gap in employment rates, secondary versus tertiary educated



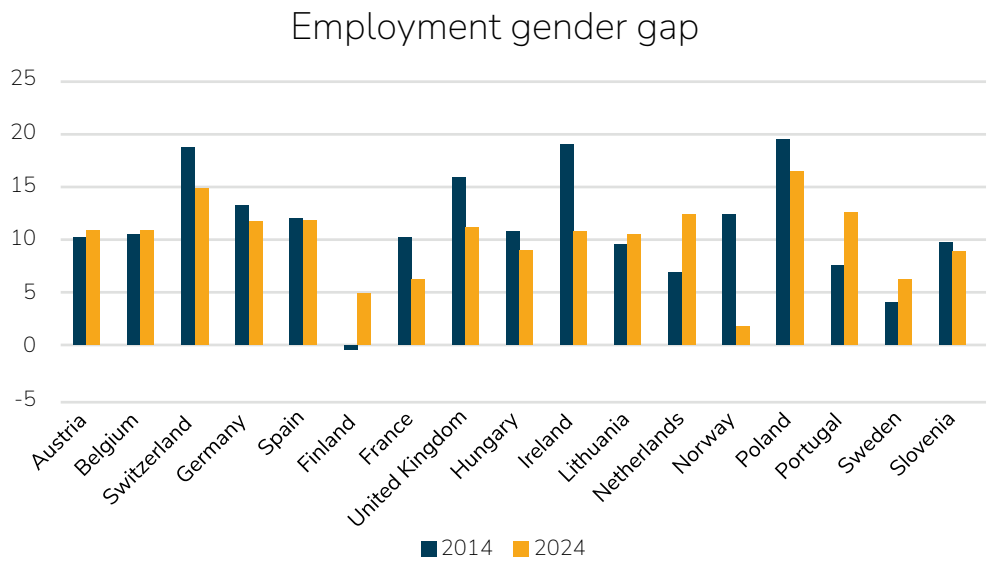
The figure above reflects the gap in employment rate between those with just lower secondary and those with tertiary education. In 2024, 81-91% of the high-education group in Europe reported being in employment, while this fell to 53-70% for the low-education group. In all countries studied, except for Switzerland, the gap in labour market participation between the high- and low-education was above 20% both in 2014 and 2024.

The gap between the percentage of people in the low-education groups, vis-à-vis those in the high-education groups who were employed, increased in six of the 17 European countries studied over the past ten years, namely Austria, Ireland, the United Kingdom, Switzerland, Portugal and Norway. The gap grew the most in Austria, by 12.1%.

The biggest decrease in the gap was in Slovenia, by 18.1%, although the overall gap remains amongst the highest of the 17 countries.

4.3. Employment gender gap

Figure 45: Gender employment gap between 2014 and 2024



The employment gender gap is the difference between the employment rates of males and females aged 20 to 64 years, expressed in percentage points (indicating absolute difference in percentages), serving as a key measure for gender equality in labour market participation.

The figure above demonstrates that in Poland, for example, in 2024, males had an employment rate that was 17 p.p. higher than that of females. In comparison, this was approximately 11 p.p. in Austria and Belgium, 5 p.p. in Finland, and 1 p.p. in Norway.

The gender employment gap grew slightly in Austria, Belgium, Lithuania, and most significantly in the Netherlands, Portugal and, to a lesser extent, Sweden.

Figure 46 below shows the **employment gender gap in the high-education group** across 17 countries. In 2024, in Hungary, for example, males in this group were 13 p.p. more active in the labour market than females. In Sweden and Slovenia, this was approximately 2 p.p. **The gender employment gap amongst highly educated males and females grew in 10 of the 17 countries** examined, namely Austria, Spain, Finland, Hungary, Lithuania, the Netherlands, Poland, Portugal, Sweden and Slovenia.

Figure 46 presents the **employment gender gap in the low-education group across 17** countries. In 2024, it shows that in Sweden, for example, males have a higher participation rate in the labour market by 49 p.p. compared to women in the low-education group. In the Netherlands and Lithuania, males in this group were 28 p.p. more employed than females, while in Hungary and Norway, this was 1% and 2%. **The gender employment gap amongst the low-education group also increased in 10 countries**: Austria, Belgium, Switzerland, Spain, Lithuania, the Netherlands, Poland, Portugal, and Sweden, and remained the same in Slovenia.

Figure 46: Gender employment gap amongst the highly educated

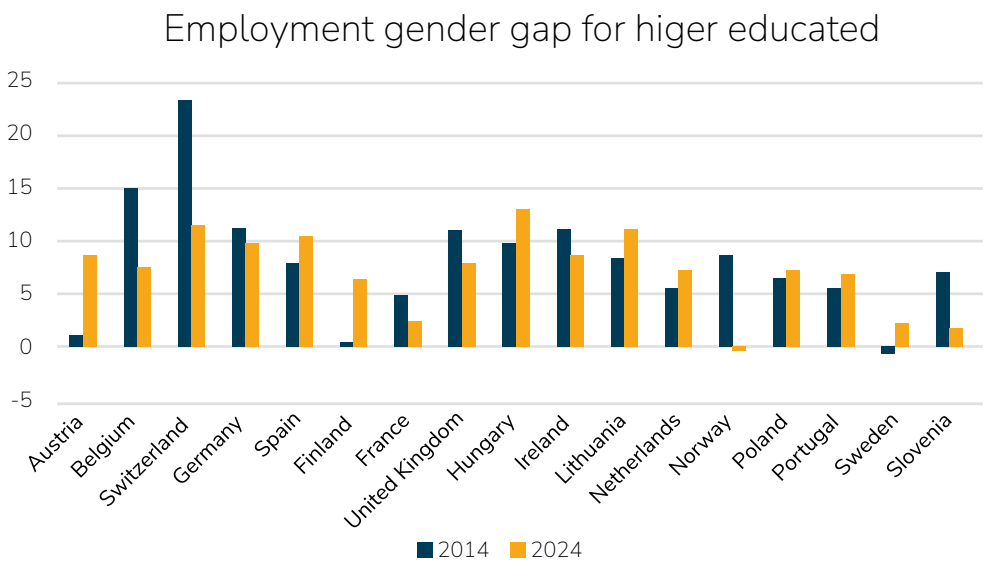
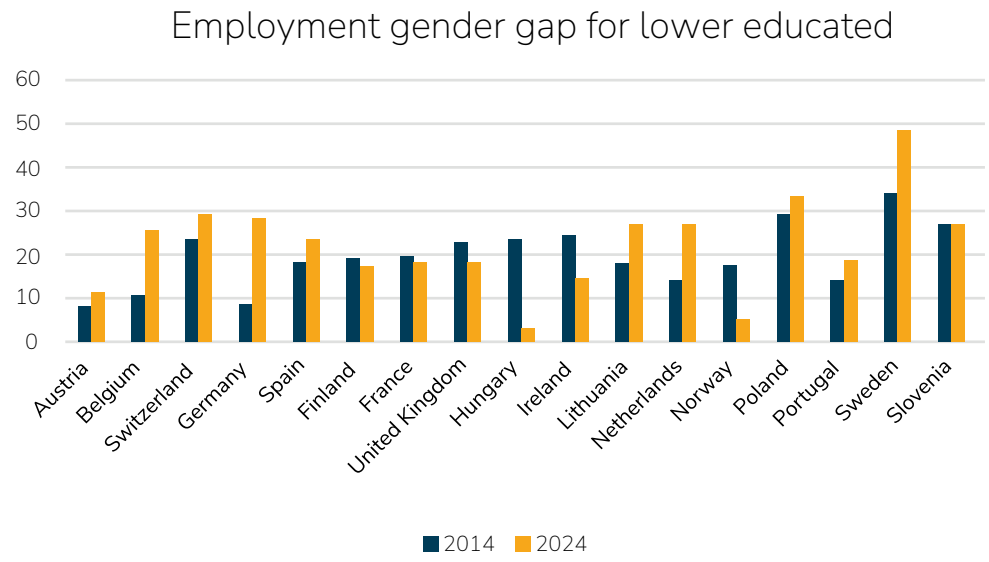


Figure 47: Gender employment gap amongst the lower educated



Per country, the situation was very different, depending on whether employment rates were increasing or decreasing for different genders, within different socioeconomic groups (refer to Annex for a complete overview). In Austria, Finland and Lithuania, for example, the gender employment gap increased considerably amongst the high-education group. However, while in Finland this was due to an unequal increase in labour market participation, in Lithuania both genders were substantially less active in the labour market, but high-educated women even more so. In contrast, the increase in gender employment gap amongst high-educated in Austria, derived from opposing gender trends in labour market participation. Compared to a decade ago, in Austria there is higher participation in the labour market of males with a high education and lower participation for females with higher education. In addition, the employment gap for the low-educated widened in Austria and Lithuania. In Austria, both genders were substantially less active in the labour market, with a stronger loss for lower-educated women. In Lithuania, the only group with higher participation on the labour market compared to a decade ago was the low-educated men, with low-educated women losing

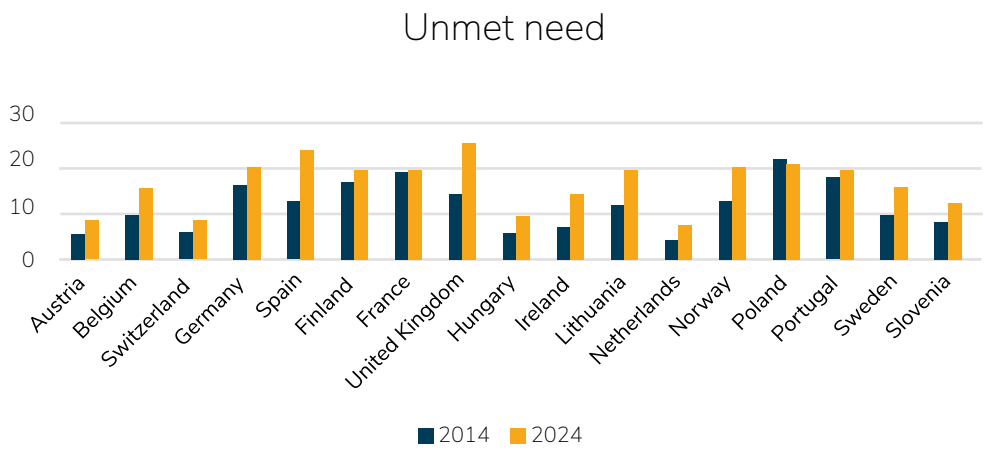
further ground, with approximately only a third of the low-educated women active in the labour market in 2024. In a similar vein, Sweden experienced the largest increase in the gender employment gap for the low-educated. In 2024 only a quarter of Swedish low-educated women reported being part of the labour market, a drop of over 17 percentage points compared to 2014. In Hungary, on the contrary, the gender gap for the low-educated decreased because the employment of low-educated females increased by 29 p.p.

The examples show the markedly different trends behind the gender employment gap, both across countries and across socioeconomic groups within countries, again **highlighting the importance of analysing disaggregated data per locality, to understand specific trends per group.** The results for Sweden for example, reflect that the focus must be on what is causing such a large gap in the low-education group and what can be done to narrow it, to ensure women in this group are not left behind even further, financially. **Labour market participation is crucial not only for reducing social inequalities in health and wellbeing but also for the economic and competitiveness objectives of the EU.**

4.4 Unmet medical needs

The European Social Scoreboard defines unmet medical needs as the percentage of the population aged 16 years and over who report that they needed medical examination or treatment within the previous 12 months but did not receive it, specifying at least one main reason: cost, distance, or waiting time. The ESS unmet medical needs indicator also includes respondents who could not access healthcare for other reasons, such as not being able to take time off work, or the service not being available in the area.

Figure 48: Changes in unmet medical needs 25–75-year-olds, 2014-2024



The figure above demonstrates that unmet medical needs increased in all 17 countries examined, except in Poland, where they decreased very slightly. Respondents in the Netherlands and Austria reported the lowest levels of unmet medical needs in 2024 (7.2% and 8.4% respectively). The United Kingdom and Spain reported the highest levels of unmet medical needs (25.9% and 24.3% respectively).

Figure 49: Changes in unmet medical needs by education, 2014-2024

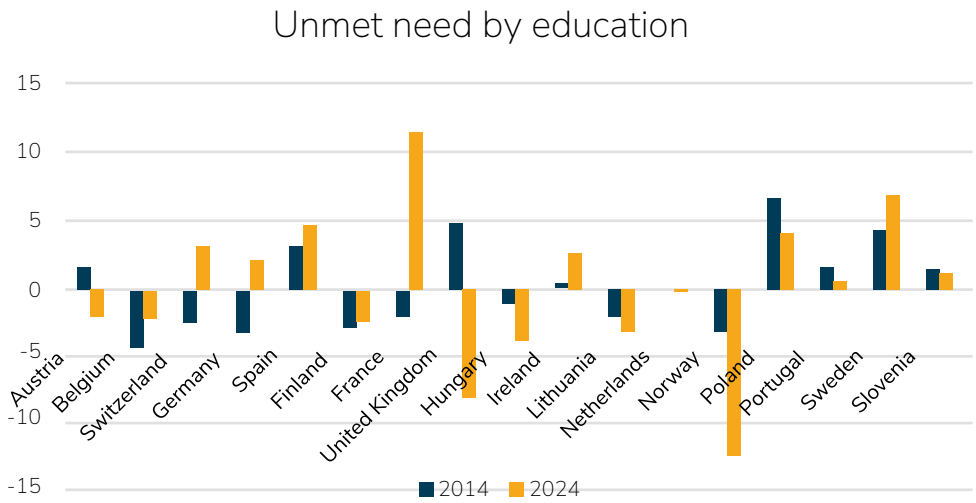


Figure 49 demonstrates the percentage difference in the level of unmet need reported by the lower educational group versus the higher educational group. The graph shows, for example, that in France, in 2014, the lower-educated group reported 2 p.p. more unmet need, while in 2024, this changed considerably, and the high-education group reported 12 p.p. more unmet need. In Norway, the low-education group had 3 p.p. more unmet need in 2014, and this increased to 13 p.p. in 2024.

Highly educated people in all European countries studied – except for Poland and Portugal- report higher rates of unmet medical needs, compared to a decade ago. Similarly, the low-education group also reported higher rates of unmet medical needs, except for in Poland and Portugal, where they were stable, and for France, where the low-education group reported less unmet need than a decade ago. In this context, **changes to the magnitude of inequalities represent deterioration of access to healthcare at an uneven pace among social groups.**

The graph depicts that in eight of the 17 countries (Austria, Belgium Switzerland, Finland, the United Kingdom, Hungary, Lithuania, Norway) respondents with a high education reported higher levels of unmet need than those with mid-education. This finding appears paradoxical, since problems with access to healthcare (such as cost, distance, and long waits) generally disproportionally affect low socioeconomic groups. Nevertheless, in some countries high-educatION groups may report more unmet medical needs due to higher expectations, different barriers, like time and convenience, and greater levels of health literacy, which may make them more aware of delays and likely to report unmet needs.

These variations underscore once again that without disaggregated data, faulty interpretations can be made based «on average» outcomes or important nuances can be masked, leading to less effective policy responses.

4.5 Summary and conclusions

This chapter has demonstrated how disaggregating European Social Scoreboard indicators can generate important insights into which specific groups are most affected by broader trends that are masked by population-level averages. This has implications for the design of effective policy responses to address specific problems.

For example, the analysis reveals that levels of **early school leaving have increased over the past ten years in Spain (18%), Hungary (16%) and Germany (13%)**. In Hungary and Germany, the problem is increasing most amongst youth with parents of mid-education level, rather than the low or high level. On the other hand, in Spain, it is decreasing amongst this mid-level group, but increasing amongst youth with parents in the low- and high-education groups. Another example from the analysis that reflects the importance of going beyond averages is from Sweden, where men are on average 21% more likely to be employed than women. A closer look into how this is distributed across educational groups reveals that **males in the low-education group are 49 p.p. more likely to be employed than females in these groups**. In comparison, this is only 2 p.p. amongst the high-education group. This knowledge can affect where and how governments in these countries take measures to reduce early school leaving and close the gender employment gap.

This reveals that different countries should monitor more closely access issues for different groups. For instance, in the **United Kingdom and Norway**, an urgent action is necessary to improve health care access for the low-education groups, while countries like **Germany and France** should explore the substantial rise of unmet medical needs by the high-education groups.

It is also useful to compare the outcomes of different analyses to see to what extent they correspond and inform one another. The study found that between 2014 and 2024, there was a significant increase in health inequalities in Austria. This corresponds with the analysis in this chapter of an increase in the employment gap between low- and high- education groups during this time. The study also confirms that 'feeling of income' is an important causal factor in Austria for inequalities in poor self-reported health and mental health, suggesting that actions to improve employment amongst low-socioeconomic groups in Austria are a key priority for action to reduce health inequalities. Another revealing case is Hungary, which saw the largest improvements in self-reported health over the last decade. The disaggregated analysis of the employment gender gap by education reveals that low-educated women have entered the labour market by almost 30 p.p. more than a decade ago.

The European Union's **new Social Convergence Framework (SCF) will lead to more detailed and in-depth analysis of the social situation in certain Member States** identified as having potential risks to upward social convergence. The first stage analysis applies harmonised data based on social scoreboard indicators. The secondary analysis uses a broader set of quantitative and qualitative evidence than the initial stage and can incorporate national data, which can provide additional important insights. The secondary stage analysis may therefore apply more disaggregate data

than is possible in the first stage, to reveal deeper challenges and to better assess the policy responses of Member States and make them more efficient and effective.

This new process is, however, primarily focused on countries that have been identified as facing potential risks to upward social convergence. Overall national figures in countries that appear to be performing well can, however, mask vulnerable subpopulations. In addition, countries may not have national (or regional, or local level) data or the resources to make further disaggregation of health and social outcomes amongst different population groups possible.

Further EU-wide investments in resources and capacities to harmonise data collection and disaggregation processes would make more detailed data widely available for policymaking. This improved data granularity would support the design of more effective, proportionally universal, and targeted policies, enabling better support for specific, often unseen groups that may be falling behind despite positive national averages. More effective policies would, in turn, improve progress towards achieving upward convergence in health and social outcomes as well as other common EU-level policy objectives.

5.Conclusion and recommendations

This report has set out why improving health and its distribution across Europe is key to securing the EU's current policy priorities (competitiveness, security, preparedness) and longer-term aims and objectives (peace, our values and wellbeing), as described in Articles 2 and 3 of the Treaty of the European Union. **Health inequalities are not only the most poignant manifestation of the consequences of social disadvantage, but they also represent a loss to society of human and material resources, due to unnecessary public costs incurred and contributions foregone.**

Our study shows that, on average, one in three people between 25–75-year-olds reported poor health, and more than 10% of people aged 25–75 report poor mental health in 2024, with some countries approaching one in four (25%). People from lower socioeconomic groups report being in poor health or mental health twice as often as people from high socioeconomic groups.

Have health outcomes improved in the EU?

Over the past ten years, inequalities in health between EU Member States have shown a trend of convergence in health outcomes between EU Member States. However, this is not purely a case of 'upward convergence'; instead, they are 'meeting in the middle'. Self-reported health declined in many Northern and Western European countries, such as Belgium, the UK, Sweden, and Finland. In contrast, several Central, Eastern and some Southern European countries with historically lower levels of health, demonstrated notable improvements over the past decade (2014-2024). However, the decline occurred at a much slower rate than improvements in countries like Poland, Hungary and Slovenia. Overall levels of self-reported mental health remained stagnant across the seventeen countries studied, but this masked varying patterns of change across socioeconomic groups in these countries.

Have social inequalities in health reduced in the EU?

This study found that across the countries studied, there was a small increase in social inequalities in poor self-reported health over the past decade, reflecting that slightly more people in lower socioeconomic groups reported poor health. Across the countries, there was a small decrease in social inequalities in self-reported poor mental health. However, such averages conceal a wide range of different situations, per country. In addition, where health gaps between lower and higher socioeconomic groups narrowed, for both self-reported health and self-reported mental health, this was not, in most cases, because the health of lower socioeconomic groups improved, but because the health of higher socioeconomic groups declined somewhat. Only two of the seventeen countries studied clearly levelled up health, as was the case for mental health.

Many of the countries examined showed trends of increasing social inequalities in health or of levelling down the social gradient in health and mental health. This confirms a stagnation in overall health outcomes across the EU. It reflects that many Europeans are unable to reach their full health potential and that quality of life is suffering and lives are being cut short, for avoidable reasons.

How can we reduce socioeconomic inequalities in health?

This report also demonstrated how some essential underlying determinants of social inequalities in health, namely early school leaving, gender employment rates, and unmet medical needs, can vary greatly per country, so it is important to tailor policy responses to the specific situation in each country.

This report turned to the question of what can be done to improve this situation, to strengthen progress towards the EU's priorities in ways that align with European values. There is a stubborn perception that it is solely the role of health systems to improve health. This overlooks the fact that health and social inequalities in health stem from various structural and social factors that affect the conditions of daily life. This makes health inequalities a good indicator of how societies are doing in terms of achieving wellbeing. It also means that while it is the role of health systems to address ill health, a wide range of sectors must be engaged in creating conditions that promote good health for all.

This means that reducing social inequalities in health requires a whole-of-government approach and cannot be achieved by the health sector alone. Health sectors play an essential role in measuring and highlighting the problem, identifying key underlying causes, such as financial difficulties, as this report has done, and in taking leadership to ensure that economic, social, environmental, and health policy objectives and measures are aligned.

To do so, health sectors must themselves embrace a broader conceptualisation of health and move beyond a strictly biomedical approach. While health systems and public health programmes have adopted the language of a more holistic approach to health, resources and actions have not adequately followed suit. **Efforts to reorient health systems towards a stronger focus on health promotion and disease prevention, which involves strengthening the contributions that other sectors can make to improving health and reducing social inequalities in health, remain undervalued and underfunded,** also at the EU-level.

The report nevertheless highlighted **numerous encouraging initiatives by public health authorities across different levels of governance in Europe to reduce social inequalities in health between and within countries. It showed that progress can be achieved through both proportional universalism and targeted measures, as well as through more holistic, cross-government strategies**. At the EU level, the report noted positive steps to address structural and social determinants of health. Recent efforts, such as the establishment of the European Pillar of Social Rights and greater attention to environmental and social issues in the European Semester

process, have brought some improvement. Yet, significant imbalances remain, preventing a fully integrated policy approach where economic targets and competitiveness goals also protect and improve the health and wellbeing of everyone in society. Moving forward, it is essential to prioritise closing the gaps in health by embedding a focus on this across policymaking. Doing so would not only advance social fairness but also the capacity of the EU and its Member States to build dynamic and resilient economies, aligned with their shared values and goals, as set out in the 'Resilience 2.0' approach, outlined in the recent EC 2025 Foresight Report.

The evidence in this report leads to two sets of recommendations.

I. The first set of recommendations relates to policy measures that can address the root causes of social inequalities in health that emerged from this study, at the EU level as well as at the (sub)national level. Because the analysis focused on 25–75-year-olds, these recommendations are most relevant to this group.

- **Guarantee adequate and accessible minimum income levels and social protection to ensure everyone can meet their essential needs, like housing, energy, and nutritious food and to prevent poverty and health risks.** Currently, levels of minimum income benefit in EU countries vary between 20% to 80% of the national poverty thresholds. Also, ensure adequate wage levels and enforce legislation to prevent in-work poverty.

- Ensure more coordinated action and joint accountability across all relevant sectors to design and implement the upcoming **EU Anti-Poverty Strategy**, including health, employment, finance and economics, education, environment, and civil society. Continuously ensure that policies and funding mechanisms are aligned to prevent conflicting objectives and to achieve impact.

- Ensure that the upcoming **EU Affordable Housing Plan** goes beyond affordability by prioritising healthy living environments and vibrant communities. For example, promote the use of harmonised indicators for healthy, sustainable, and resilient building, amongst all stakeholders involved in implementing the Plan. Such an approach will enhance wellbeing, environmental sustainability, and social cohesion alongside housing access.

- **Improve working conditions and strengthen job control.** Poor quality jobs and psychosocial environments at work contribute significantly to mental health inequalities. Establish an EU-level legal framework to reduce psychosocial risks and promote healthier, safer workplaces.

- **Investigate and respond to new, emerging drivers of non-communicable diseases (NCDs).** This study demonstrated that the rise in housing problems, unpaid caregiving responsibilities, and adverse childhood experiences is linked to higher disease burdens. These issues require a deeper understanding and targeted measures at both the EU and national levels.

- **Invest in mental health promotion and prevention** in the workplace, at schools, via the health-promoting school approach, and in communities, to provide accessible mental health services for everyone. This is crucial to reducing social inequalities in health and building a resilient population.

- **Prioritise action on the availability of healthy and sustainable food** as a key risk factor to social inequalities in health. Access to nutritious food, healthier dietary behaviours, and the prevention of overweight and obesity must be central to EU and national strategies. Cross-sector governance means that health and social objectives are part of food system policies.

- **Regulate commercial determinants of health.** Marketing, pricing, and availability of alcohol, tobacco, ultra-processed foods and other addictive products and technologies widen health inequalities. The EU should establish legal frameworks to restrict harmful industry practices and incentivise businesses that promote healthier choices.

- **Invest in research to understand what is causing stagnating or declining levels of health** amongst all groups along the social gradient. Any reversal in the health of groups higher on the social gradient may signal the emergence of new and powerful determinants of ill health that could eventually spread to other groups. Studying these patterns can make it easier to identify emerging risks and how to address them, to the benefit of everyone, with the greatest absolute gains for the most disadvantaged.

II. The second set of recommendations relates to strengthening the focus on social inequalities in health at the EU and (sub)national levels, in the context of broader governance mechanisms. This is needed to ensure that the more targeted measures set out above are implemented in an overall policy framework of reducing social inequalities in health.

1.Promote and apply a more holistic conception of health to mobilise action across policy sectors. Raise awareness that improving health and reducing social inequalities in health is a joint responsibility that reaps collective benefits, and that social inequalities in health is an important measure of how well sectors are working together to improve health and wellbeing.

The following are calls to action to achieve this:

- At the EU-level, seize the **renewal of the Action Plan of the European Pillar of Social Rights** to emphasise that while Principle 16 secures the right to 'timely access to affordable, preventive and curative health care of good quality', progress towards implementation of all principles in the Pillar will help to secure a broader right to health. Advocate for a stronger focus on distributional impacts and health equity across all Pillar principles and their implementation.

- Develop and implement a **dedicated indicator on health inequalities**, such as in self-reported health, in the Social Scoreboard and/or include this in the European Semester process, to ensure that social inequalities in health and whether EU Member States are levelling up health are adequately captured and monitored over time.

- **Integrate health and social objectives in the new EU policy initiatives** in the context of the EU Political Guidelines for 2024-2029. These include the new EU plan on Affordable Housing, the new EU Anti-Poverty Strategy, as set out above, as well as in the new EU Cardiovascular Health plan, and strengthening the focus on health in the European Child Guarantee.

- Set up a **high-level, cross-sectoral mechanism on social inequalities in health** at th Secretary General of the European Commission to generate more accountability and policy coherence across sectors like education, agriculture, trade, competition, economy, etc.

- Expand on health equity in the Social Protection Committee.

- Hold regular **Joint EU Council meetings** of ministers for employment, social affairs and health (EPSCO) and economic and finance ministers (ECFIN) to improve the integration of policy processes.

2. Make the reduction of social inequalities in health a policy priority within the health sector, to boost resources and capacities of (sub) national ministries of health and DG SANTE. This enables them to take a stronger leadership role in delivering health equity within but also beyond health systems, by working with other policy areas.

Calls for action include:

- **Reorient health systems towards prevention and equity.** Strengthening primary care, increasing access to general practitioners, reducing waiting times, and expanding community-based prevention and health promotion programmes—especially for disadvantaged groups—are vital steps in reducing social inequalities in health.

- Consolidate and strengthen the health sector's role in applying a **Health Equity in All Policies (HEiAP)** approach. Such an approach involves working with other sectors to examine how their policies affect health and equity, to leverage opportunities for mutual benefit, and to address tensions or trade-offs between health and wellbeing goals and the priorities of other policy areas.

- Strengthen mechanisms to **include the voices of less visible and less powerful stakeholders**, those least likely to be heard, by actively listening to what they say would help them most and using this input to shape relevant policies and programmes. Involve stakeholders, including citizens, businesses, NGOs, and others with direct experience of legislation and funding that affect people's social circumstances, in the development and implementation of health policies.

3. Invest in data collection processes at the EU level on social inequalities in health. Improve and harmonise approaches to measure health and wellbeing, and their distribution across different levels of government.

There are clear data needs that require action:

- While there are measurements at the EU level to reflect health inequalities within and between EU Member States, much of this data is **not collected frequently or disaggregated by socioeconomic status.** There are considerable time lags in efforts to collect comparable data from surveys. Improvements can also be made to the level of granularity of the data that is available from EU-level sources, which means they may not provide insight into the situation of specific groups facing disadvantage at the (sub) national level.

- Invest in initiatives to **reduce discrepancies in Member States' abilities to collect and compare administrative data** across countries, and their abilities to disaggregate data.

- There is not enough knowledge about longitudinal perspectives across Europe. ESS and other surveys, like SHARE, cover adult populations only. Efforts to **collect longitudinal comparative cross-national data from children** across Europe are urgently needed.

- The EC/OECD State of Health in the EU publication should report regularly on health inequalities and the underlying determinants within and between EU Member States

- The Health Inequalities Registry on Cancer reflects what can be done; this approach can be expanded to provide information on key underlying determinants of health, as well as other diseases, like cardiovascular disease.

4. Strengthen other governance tools and mechanisms that can further embed a focus on health equity in the European Semester process, the Social Scoreboard, the Social Convergence Framework, including impact assessments and the allocation of funding.

Calls for action include:

- **Disaggregate more Social Scoreboard indicators** as set out in this report, and make this information more broadly available, to help policy makers at (sub) national and national level develop more efficient and effective policies to address social imbalances.

- Integrate the evidence on health inequalities, and whether EU Member States are on a favourable or unfavourable trajectory, in terms of levelling-up, in the **Country Reports of the European Semester.**

- Also strengthen the **focus on health and health equity within the Social Convergence Framework,** a new Semester tool designed to identify countries at risk of insufficient upward social convergence in employment and social indicators and use it to guide reforms aimed at closing gaps that are critical for advancing health equity.

- Systematically apply tools like **distributional impact assessments and health (equity) impact assessments** to develop and evaluate major EU-level policies and programmes. Communicate the outcomes of these assessments clearly and compellingly, to improve cross-sectoral collaboration as well as public engagement, to help ensure policies reach those who need them most.

- Improve indicators and guidelines to **allocate EU funding**, to ensure sufficient funds address health and social needs, and that they reach underserved people and populations across Europe.

Annexes

Annex I: Overall number of respondents per country to ESS

Country	Freq	%	Cum.
AT	2,354	5.86	5.86
BE	1,594	3.97	9.83
CH	1,384	3.45	13.28
CY	685	1.71	14.98
DE	2,420	6.03	21.01
ES	1,844	4.59	25.60
FI	1,563	3.89	29.49
FR	1,771	4.41	33.91
GB	1,684	4.19	38.10
GR	2,757	6.87	44.96
HR	1,563	3.89	48.86
HU	2,118	5.27	54.13

Country	Freq	%	Cum.
IE	2,017	5.02	59.15
IS	842	2.10	61.25
IT	2,865	7.13	68.39
LT	1,365	3.40	71.79
NL	1,695	4.22	76.01
NO	1,337	3.33	79.34
PL	1,442	3.59	86.35
PT	1,373	3.42	90.24
RS	1,563	3.89	93.30
SE	1,230	3.06	96.30
SI	1,248	3.11	96.41
SK	1,442	3.59	100.00
Total	**40,156**		

Annex II: ESS survey questions analysed in this report

The full ESS Round 11 (2023/2024) source questionnaire, including card references, is available at: www.europeansocialsurvey.org/sites/default/files/2024-01/ESS%20Round%2011%20Source%20Questionnaire_FINAL_Alert%2004.pdf.

The visual showcards that interviewers used are available at: www.europeansocialsurvey.org/sites/default/files/2024-01/ESS%20Round%2011%20Source%20Showcards_FINAL_Alert%2002.pdf

Survey questions by health and social domains

Non-communicable diseases

- D28 CARD 46 Which of the health problems on this card have you had or experienced in the last 12 months, that is, since [month, year]
- D29 STILL CARD 46 And which of the health problems that you had or experienced in the last 12 months hampered you in your daily activities in any way? Again, just tell me which letters apply to you. PROBE: Which others?
- D30 CARD 47 Do you have or have you ever had any of the health problems listed on this card?

Self-reported health

- C7 How is your health in general? Would you say it is… very good, 1; good, 2; fair, 3; bad, 4 Or, very bad, 5? Refusal, 7; Don't know, 8

Self-reported mental health:

On a scale of 1-4: 1) None or almost none of the time; 2) Some of the time; 3) Most of the time; 4) All or almost all of the time; 7) Refusal; 8) Don't know.

- D20 …you felt depressed? 1 2 3 4 7 8
- D21 …you felt that everything you did was an effort? 1 2 3 4 7 8
- D22 …your sleep was restless? 1 2 3 4 7 8
- D23 …you were happy? 1 2 3 4 7 8
- D24 …you felt lonely? 1 2 3 4 7 8
- D25 …you enjoyed life? 1 2 3 4 7 8
- D26 …you felt sad? 1 2 3 4 7 8
- D27 …you could not get going (in the sense of 'felt lethargic and lacked motivation'). 1 2 3 4 7 8

Social determinants of health

Healthcare access

Access to GP and access to specialist care

D13 CARD 40 In the last 12 months, that is, since [MONTH, YEAR], with which of the health professionals on this card have you discussed your health? General Practitioner, Medical Specialist (excluding dentists).

Unmet need

- D14 CARD 41 In the last 12 months, that is, since [MONTH, YEAR], were you ever unable to get a medical consultation or the treatment you needed for any of the reasons listed on this card?
- D15 STILL CARD 41 Which of the reasons on the card explains why you were unable to get this medical consultation or treatment? Could not pay for it; Could not take the time off work; had other commitments, etc.
- D16 Was that because ...1) you were able to get any medical consultation or treatment you needed; 2)
- you did not need a medical consultation or treatment in the last 12 months?

Unpaid Care

- D17 CARD 42 Do you spend any time looking after or giving help to family members, friends, neighbours, or others because of any of the reasons on this card? Do not count anything you do as part of your paid employment.
- D18 CARD 43 In general, how many hours a week do you spend doing this? E.g., Less than 1 hour a week; 1-10 hours a week; 11-20 hours a week (...) to More than 50 hours a week.

Access to alternative care

- ~D19 CARD 44 In the last 12 months, that is, since [MONTH, YEAR], which of the treatments on this card have you used for your own health? E.g., Acupuncture, Acupressure, Chinese medicine, Chiropractics, Osteopathy, Reflexology, Spiritual Healing.»

<u>Psychosocial determinants</u>

Sense of control

- D157 CARD 33 Using a scale of 0 to 10, where 0 means no control at all and 10 means complete control, how much control do you feel you have over your life in general nowadays?

Social network

- C2 CARD 21 Using this card, how often do you meet socially with friends, relatives or work colleagues? Never 01 Less than once a month 02 Once a month 03 Several times a month 04 Once a week 05 Several times a week 06 Every day 07 (Refusal) 77 (Don't know) 88.
- C3 CARD 22 How many people, if any, are there with whom you can discuss intimate24 and personal25 matters? Choose your answer from this card. None 00 1 01 2 02 3 03 4-6 04 7-9 05 10 or more 06
- (Refusal) 77 (Don't know) 88.
- C4 CARD 23 Compared to other people of your age, how often would you say you take part in social activities26? Please use this card. Much less than most 1 Less than most 2 About the same 3 More than most 4 Much more than most 5 (Refusal) 7 (Don't know) 8.

Conflict in childhood

- D32 CARD 49 Using this card, please tell me how often there was a serious conflict between the people living in your household when you were growing up? Always 1 Often 2 Sometimes 3 Hardly ever 4 Never 5 (Refusal) 7 (Don't know) 8.

Financial difficulty in childhood

- D33 STILL CARD 49 Using the same card, please tell me how often you and your family experienced severe financial difficulties when you were growing up? Always 1 Often 2 Sometimes 3 Hardly ever 4 Never 5 (Refusal) 7 (Don't know) 8.

Internet use

- A3 On a typical day, about how much time do you spend using the internet on a computer, tablet, smartphone or other device, whether for work or personal use? Please give your answer in hours and minutes.

Occupational determinants

Employment

- F17a CARD 74 Using this card, which of these descriptions applies to what you have been doing for the last 7 days? in paid work (or away temporarily) (employee, self-employed, 01 working for your family business) in education, (not paid for by employer) even if on vacation 02 unemployed and actively looking for a job 03 unemployed, wanting a job but not actively looking for a job 04 permanently sick or disabled 05 retired 06 in community or military service115 07 doing housework, looking after children or other persons 08 (other) 09 (Refusal) 77 (Don't know) 88.

Ergonomic hazard

- F35a119 CARD 77 In any of the jobs you have ever had, which of the things 120 on this card were you exposed to? Vibrations from hand tools or machinery 1 Tiring or painful positions 2 Manually lifting121 or moving people 3 Manually carrying122 or moving heavy loads 4 (None of these) 5 (Refusal) 7 (Don't know) 8.

Job control

- Please say how much the management at your work {allows/allowed} you:
  - F27 to decide how your own daily work {is/was} organised?
  - -F28 ...to influence policy decisions about the activities of the organisation?
  - 00 01 02 03 04 05 06 07 08 09 10 - I have/had no influence I have/had complete control (77 Refusal) (88
  - Don't know)

Material hazards

- F35b123 CARD 78 And in any of the jobs you have ever had, which of the things on this card were you exposed to? Very loud noise 01 Very hot temperatures 02 Very cold temperatures 03 Radiation such as X-rays 04 Handling, breathing in or being in contact with chemical products, vapours or substances 124 05 Breathing in other types of smoke, fumes125, powder or dust 06

Material factors

Feeling of income

- F42 (CARD 8) Which of the descriptions on this card comes closest to how you feel about your household's income nowadays? Living comfortably on present income 1 Coping on present income 2 Finding it difficult on present income 3 Finding it very difficult on present income 4 (Refusal) 7 (Don't know) 8.
- **Financial difficulty in childhood**
- D33 STILL CARD 49 Using the same card, please tell me how often you and your family experienced severe financial difficulties when you were growing up? Always 1 Often 2 Sometimes 3 Hardly ever 4 Never 5 (Refusal) 7 (Don't know) 8.

Housing problems

- F14a112113 CARD 72114 Do any of the problems listed on this card apply to your accommodation? Just tell me which letters apply to you. INTERVIEWER PROBE: Which others? INTERVIEWER NOTE: If the respondent has more than one home, they should think about the accommodation where they spend most of their time.

Behavioural determinants

Smoking

- D5 CARD 35 Now thinking about smoking cigarettes. Which of the descriptions on this card best describes your smoking behaviour? INTERVIEWER: Include rolled tobacco but not pipes, cigars or electronic cigarettes. I smoke daily, usually 10 or more cigarettes. 1 I smoke daily, usually nine or fewer cigarettes 2 I smoke but not every day 3 I don't smoke now, but I used to 4 I have only smoked a few times 5 I have never smoked 6 (Refusal) 7 (Don't Know) 8.

Fruit and vegetable consumption

- D2 I will now ask you some questions about your daily behaviour. Using this card, please tell me how often you eat fruit, excluding drinking juice? INTERVIEWER: Frozen fruit should be included. Three times or more a day 01 Twice a day 02 Once a day 03 Less than once a day but at least 4 times a week 04 Less than 4 times a week but at least once a week 05 Less than once a week 06 Never 07 (Refusal) 77 (Don't know) 88.

- D3 STILL CARD 34 Using the same card, please tell me how often you eat vegetables or salad, excluding potatoes? INTERVIEWER: Frozen vegetables should be included. Three times or more a day 01 Twice a day 02 Once a day 03 Less than once a day but at least 4 times a week 04 Less than 4 times a week but at least once a week 05 Less than once a week 06 Never 07 (Refusal) 77 (Don't know) 88.

Physical activity

- D4 On how many of the last 7 days did you walk quickly, do sports or other physical activity for 30 minutes or longer? (To be included, physical activity does not have to have been continuous.)

Skills

- F58 During the last twelve months, have you taken any course or attended any lecture or conference to improve your knowledge or skills for work? Yes 1 No 2 (Refusal) 7 (Don't know) 8.

Annex III: Scientific methodologies

Data preparation

In 2024, the sample size was first restricted to respondents aged 25 to 75 years old. From a total sample of 40,156, the respondents within this age group were 31,738.

To avoid losing more respondents, we recoded the education variable using information from both the education level and the years of education. Specifically, for all respondents who did not report their level of education but responded to the number of years of education, the responses were recoded into high school or less and more than high school, with 12 years of education as the cutoff. This way, we were able to retain in the study 128 respondents out of 169 who had not responded to the levels of education question. The total available sample after deleting respondents without information on education was 31,697 respondents.

Multiple imputation was performed to keep observations with missing information on BMI, PA, smoking, alcohol consumption, material and ergonomic hazards, financial difficulties, conflicts growing up and social control.

For the trend analysis, a similar data preparation was applied for wave 7 of ESS. The restricted sample of 25–75-year-olds was 31,971 from a total sample of 40,185. Twenty more observations were deleted due to missing information in both levels of education and years of education. Fifteen more observations were deleted due to missing information on gender. The final sample before multiple imputation was 31,936 respondents.

The merged files of waves 7 and 11 include 17 countries and 47,730 participants.»

Self-reported health analysis

Statistical Analysis

To examine changes in health inequalities by educational attainment across time, we conducted country-specific generalised linear models using data from the 2014 and 2024 waves of the European Social Survey (ESS). The dependent variable was poor self-rated health (binary), and the main exposure was educational attainment (three categories). Given the prevalence range of poor/fair health (14–35%) and the need to assess both relative and absolute inequalities across different countries and time points, the Modified Poisson Regression with Robust Error Variance is often the most practical and interpretable choice. It balances ease of implementation with reliable estimation of prevalence ratios, especially in cross-sectional studies with binary outcomes (doi: 10.1111/j.1751-7176.2010.00264.x). Models included gender, age, and permanent disability status as covariates and applied post-stratification weights (pspwght) to ensure national representativeness.

In addition, we perform the Normalised Residual Sum of Squares (NRSS) test for assessing the goodness-of-fit of the modified Poisson regression model with a binary outcome. We found an acceptable range (NRSS: 0.12-0.22 with differences between waves within the same country of 0.02) and consistency of NRSS values. Our modified Poisson regression model appears to fit the data well across different countries and waves.

To assess temporal trends in educational health inequalities, we included an interaction term between education and survey year (ESS). We used Wald tests (testparm) to evaluate whether these interactions were jointly significant, indicating a change in inequality over time. Differences in relative risk changes between educational groups were formally tested using linear combinations of interaction coefficients (lincom). This allowed us to test whether inequality changes for low- and medium-educated respondents differed significantly from those of the highly educated group.

In addition, we assessed absolute changes in the predicted probability of reporting poor health within each educational group between 2014 and 2024. This was done using further lincom tests combining education-by-wave interaction terms with the main ESS wave effect.

To enhance interpretability, we estimated marginal predicted probabilities of poor health for each educational level within each ESS wave using the margins command, with estimates exponentiated to represent probabilities on the original scale. These were visualised using marginsplot to compare changes across time and between educational groups.

Mental health analysis

Statistical approach

We conducted country-specific logistic regression analyses to examine the association between occupational class and the probability of reporting poor mental health (depression), and whether this association changed between the 2014 and 2024 waves of the European Social Survey (ESS). For each country, a separate logistic regression model was estimated with depression as the binary outcome and occupational class (eurosec), ESS wave, and their interaction as the key explanatory variables. Models controlled for gender and age (categorised) and incorporated post-stratification weights (pspwght) to adjust for sampling design. Robust standard errors were used to account for potential heteroskedasticity.

The interaction term between occupational class and survey wave was tested using Wald tests (testparm) to assess whether the strength of the class gradient in mental health changed over time. To further quantify differences in the evolution of inequalities, we used linear combinations of regression coefficients (lincom) to compare changes in relative risk between 2014 and 2024 for each occupational group relative to the salariat.

The interaction term between occupational class and survey wave was tested using Wald tests (testparm) to assess whether the strength of the class gradient in mental health changed over time. To further quantify differences in the evolution of inequalities, we used linear combinations of regression coefficients (lincom) to compare changes in relative risk between

2014 and 2024 for each occupational group relative to the salariat.

To aid interpretation, we computed predictive margins using the margins command to estimate the probability of depression for each occupational group within each ESS wave, adjusted for covariates. Country-specific visualisations of these adjusted probabilities were generated using marginsplot.

Finally, relative risks (RRs) for depression were calculated for each occupational group relative to the salariat, separately for 2014 and 2024. These were estimated by exponentiating the relevant logistic regression coefficients using the nlcom command. Confidence intervals were derived using the delta method to ensure appropriate transformation from the log-odds to the RR scale.

To identify the main contributors to poor mental health in each country we fitted for each of the 24 countries a baseline logistic regression for poor mental health adjusted for age, gender, and occupational group weighted using analysis weight (anweight) available in ESS 11 and robust standard errors. We sequentially added separately seventeen potential predictor (BMI, physical activity, smoking behaviour, alcohol consumption, material hazards, ergonomic hazards, job control, employment status, financial difficulties growing up, conflicts in household growing up, house problems, feeling of income, social network, sense of control over life, participation in training and internet use) in turn, creating one extended model per predictor. For each extended model, we recorded the change in model fit (Wald χ^2 increase), the change in McFadden's pseudo R^2 and the coefficient and 95% CI for the predictor. Predictors were ranked by the magnitude of their contribution (largest χ^2 and pseudo R^2 increases), using the coefficient as a tie-breaker. Larger Wald χ^{2+} and ΔR^2 indicate stronger predictors of poor mental health. We considered only predictors with significant coefficients ($p \leq 0.05$) and coefficients that were meaningful in magnitude. The final ranking thus reflects both statistical significance and substantive influence.

This method follows established protocols for comparing predictor importance in logistic regression through nested model comparisons via Wald tests and pseudo R^2 changes. While absolute pseudo R^2 values are not comparable across models, ΔR^2 within the same dataset is valid.

«The analysis of factors explaining occupational inequalities in mental health focused on 19 countries that showed occupational inequalities between the salariat and the working class. We fitted for each country separately a baseline logistic regression for poor mental health adjusted for age, gender, and occupational group, weighted using analysis weight available in ESS 11 (anweight) and robust standard errors. We sequentially added seventeen potential predictors, creating one extended model per predictor. Adjusted relative risk (ARR) for the working class vs. salariat groups were calculated using the adjusted relative risk post-estimation command, which estimates risk ratios and risk differences via delta-method standard errors. We assessed the relative explanatory power of each predictor by comparing the change in ARR following the formula: $(RR_{\text{model 1}} - RR\ e_{\text{xtended model}})/(RR_{\text{model 1}} - 1)$. Analysis was performed using STATA (19).»

Annex IV: Data points for scatter-graphs on paths to equity and inequity

Difference of poor self-reported health (SRH) and in changes in absolute difference of inequalities in SRH

Self-reported health	Prevalence difference	Absolute difference 2014	Absolute difference 2024.	Changes in absolute difference
Ireland	-3%	11.2	7.9	3%
Switzerland	0%	10.6	9.8	1%
Belgium	-6%	12	17.8	-6%
Sweden	-4%	14.2	6.9	7%
United Kingdom	-4%	11.9	12.4	0%
Austria	1%	13.1	25.1	-12%
Norway	-3%	17.7	27.8	-10%
Netherlands	-1%	13	12.2	1%
Europe	**2%**	**20**	**19.8**	**0%**
Finland	-4%	18.7	20.4	-2%
Spain	-2%	12.3	12.6	0%
France	1%	21.8	23.3	-2%
Poland	9%	26.7	16.1	11%
Germany	0%	20.1	27.6	-8%
Hungary	10%	22.5	24.6	-2%
Lithuania	-3%	17.8	29.1	-11%
Portugal	5%	29.7	28.5	1%
Slovenia	8%	31.2	22.6	9%

Difference of poor self-reported mental health (SRH) and in changes in absolute difference of inequalities in SMRH

Self-reported mental health	Prevalence change	Absolute difference 2014	Absolute difference 2024.	Changes in absolute difference
Norway	-0.7%	10.3%	3.6%	7%
Finland	-2.0%	3.1%	3.3%	0%
Switzerland	-1.0%	4.6%	6.1%	-2%
Netherlands	0.3%	12.1%	8.8%	3%
Sweden	-1.8%	7.3%	9.5%	-2%
Ireland	-0.2%	5.2%	4.3%	1%
Slovenia	2.1%	7.7%	5.3%	2%
Belgium	-3.6%	9.1%	7.0%	2%
France	-0.9%	7.3%	9.0%	-2%
Spain	2.6%	15.3%	7.7%	8%
Europe	**0.2**%	**9.7**%	**9.6**%	**0%**
Germany	-0.7%	8.2%	11.2%	-3%
United Kingdom	-2.5%	9.8%	8.7%	1%
Austria	1.9%	3.0%	5.1%	-2%
Portugal	1.2%	17.7%	10.7%	7%
Hungary	5.4%	15.9%	9.4%	7%
Poland	3.8%	6.6%	7.1%	0%
Lithuania	0.1%	12.8%	8.3%	5%

Annex V: Paths to equity and inequity in poor self-reported health (SRH), 25–75-year-olds, by education

Quadrant I: Countries on a favourable path where overall health is improving (poor SRH shifting down) and relative health inequalities are decreasing

Figure 1: Health trajectories by education in Poland

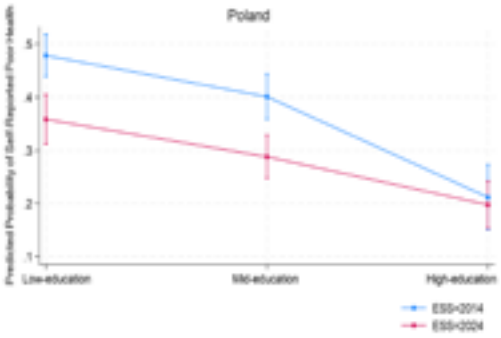


Figure 2: Health trajectories by education in Slovenia

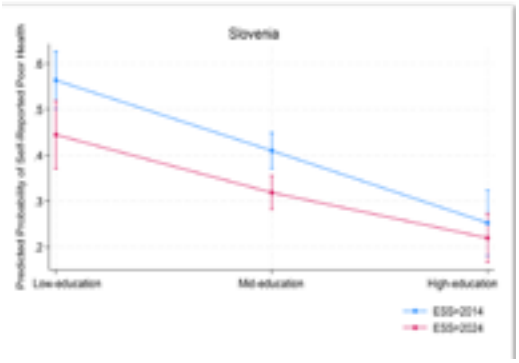


Figure 3: Health trajectories by education in Portugal

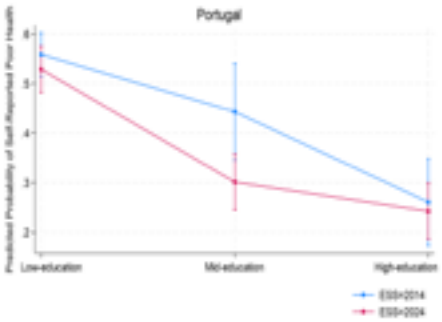
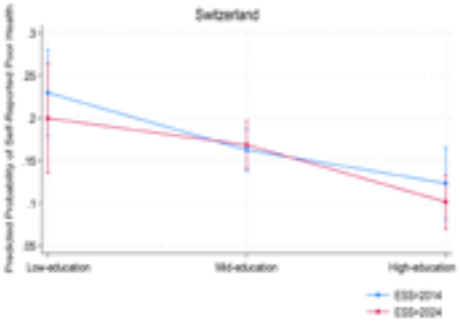


Figure 4: Health trajectories by education in Switzerland



Quadrant II: Countries on a path where relative health inequalities are decreasing, but overall health is getting poorer.

Figure 6: Health trajectory by education in Sweden

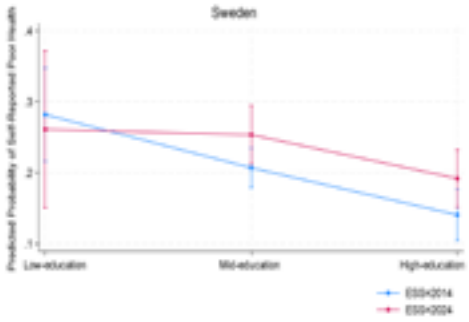
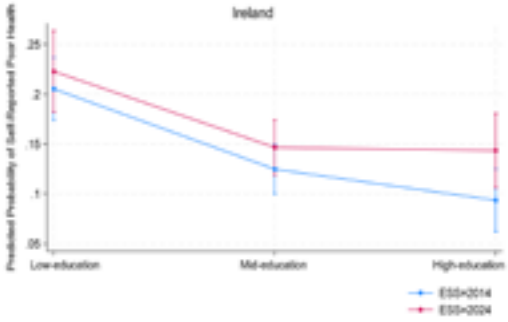
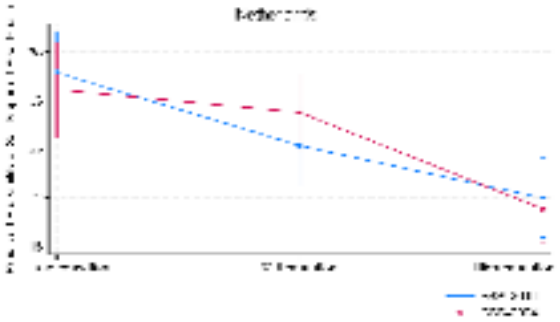


Figure 7: Health trajectories by education in Ireland



Figures 8: Health trajectories by education in the Netherlands



Quadrant III: Countries on a path where both overall health and relative health inequalities are getting worse, the most worrying path.

Figure 9: Health trajectories by education in Lithuania

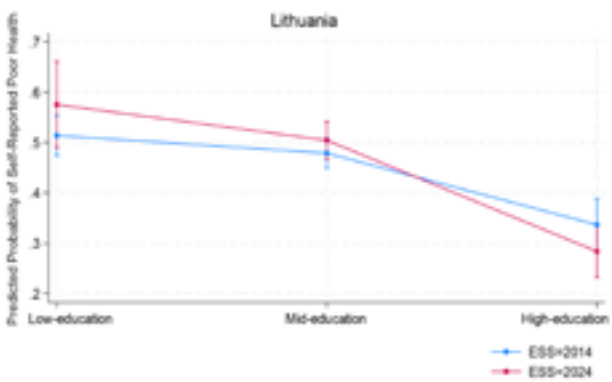


Figure 10: Health trajectories by education in Norway

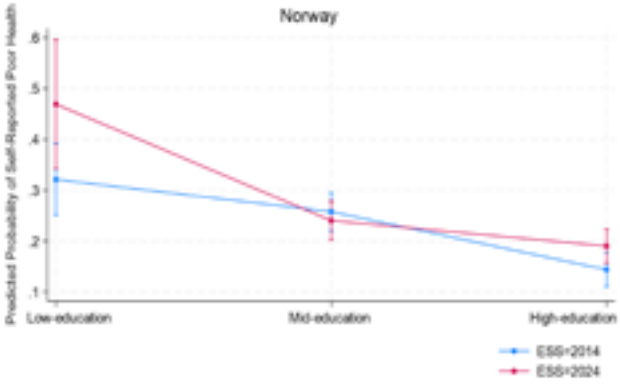


Figure 11: Health trajectories by education in Belgium

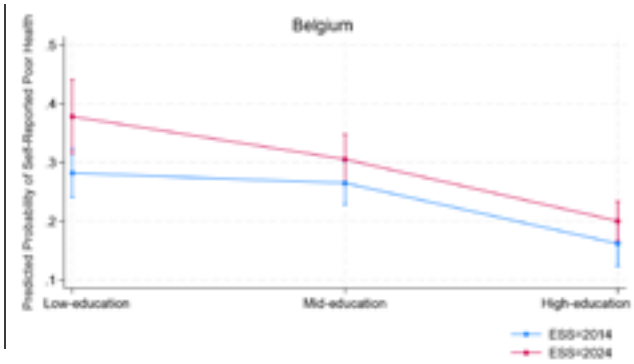


Figure 12: Health trajectories by education in Finland

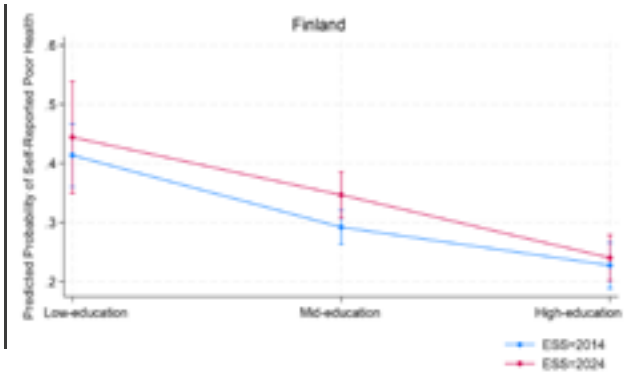


Figure 13: Health trajectories by education in United Kingdom

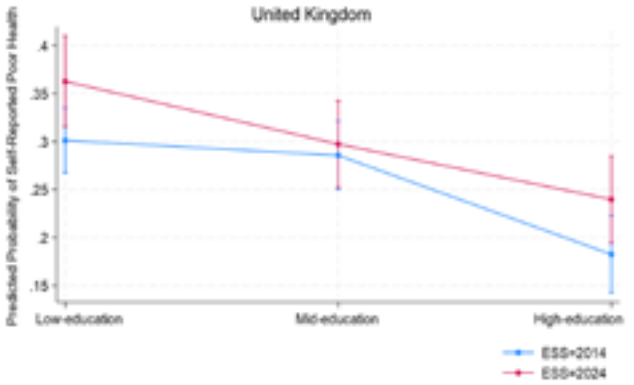
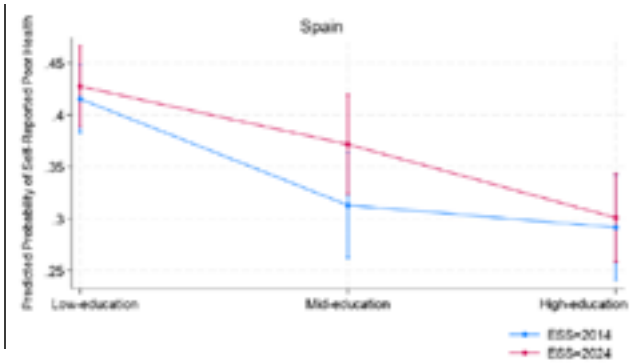


Figure 14: Health trajectories by education in Spain



Quadrant IV: Countries on a path where overall health is stable or improving, but relative health inequalities are increasing

Figure 15: Health trajectories by education in Austria

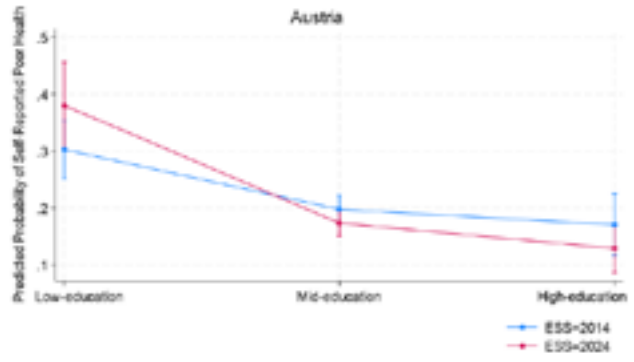


Figure 16: Health trajectories by education in Hungary

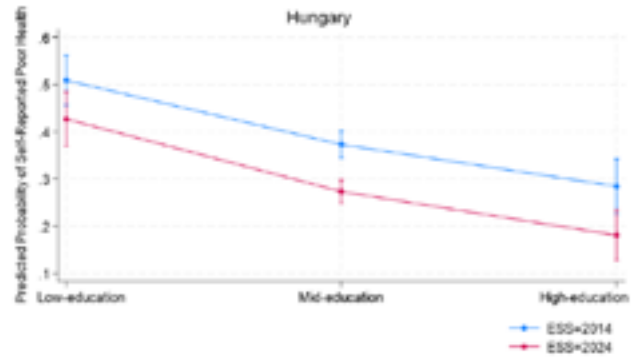


Figure 17: Health trajectories by education in Germany

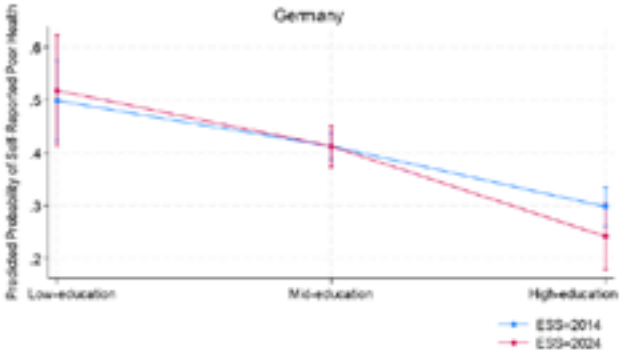
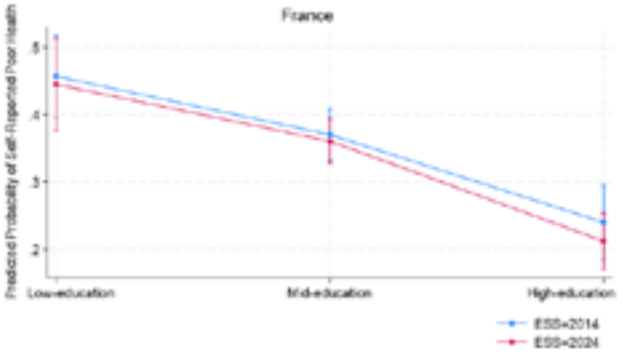


Figure 18: Health trajectories by education in Francet



Annex VI: Paths to equity and inequity in poor self-reported mental health (SRMH), 25–75-year-olds, by occupation

Quadrant I: Countries on favourable paths with overall improvements in mental health (poor SRMH shifting down) and declining levels of relative inequalities in mental health

Figure 19: Mental health trajectories by occupation in Hungary

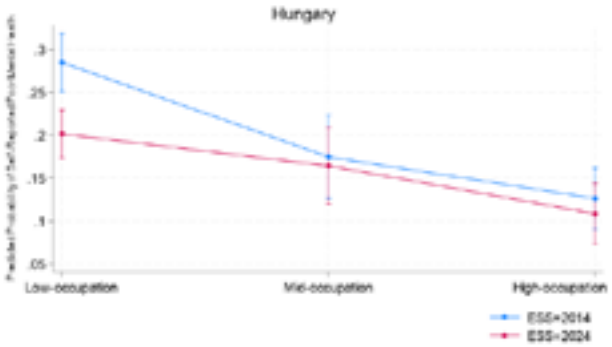


Figure 20: Mental health trajectories by occupation in Slovenia

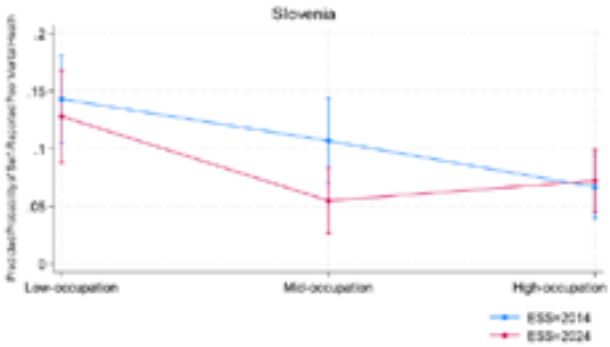


Figure 21: Mental health trajectories by occupation in Spain

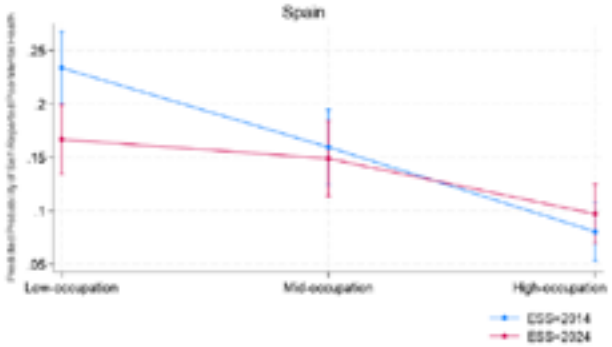


Figure 22: Mental health trajectories by occupation in Portugal

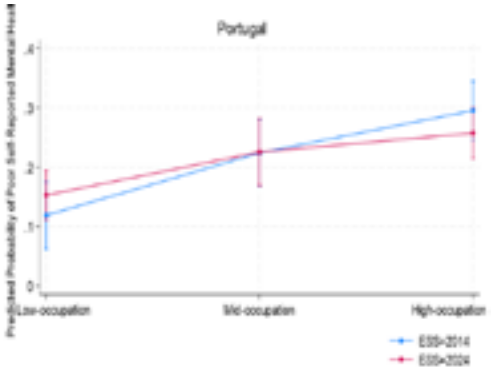


Figure 23: Mental health trajectories by occupation in Lithuania

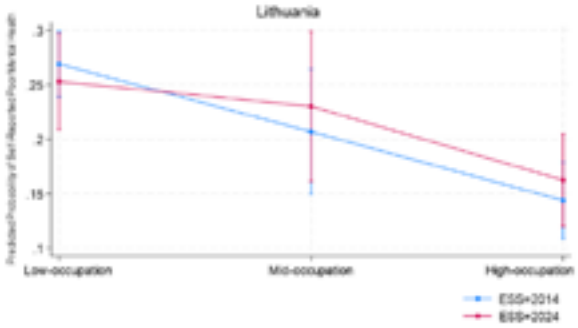
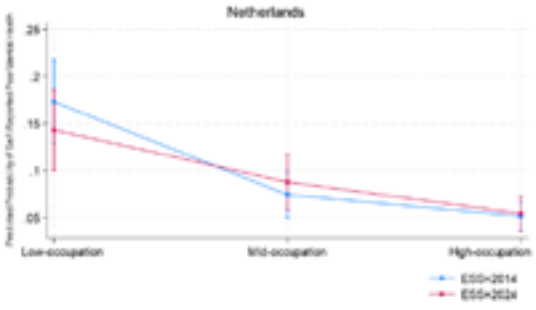


Figure 24: Mental health trajectories by occupation in the Netherlands



Quadrant II: Countries on a path where relative inequalities in mental health are decreasing, but overall mental health is getting poorer

Figure 25: Mental health trajectories by occupation in Norway

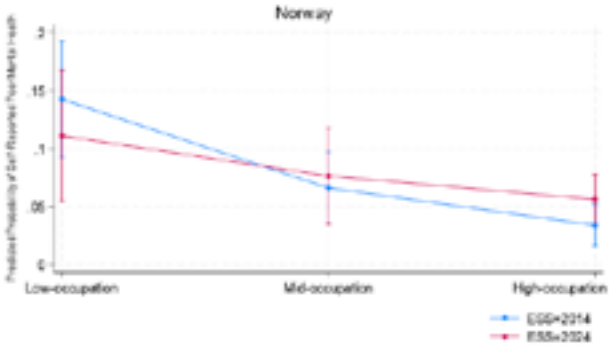


Figure 26: Mental health trajectories by occupation in Belgium

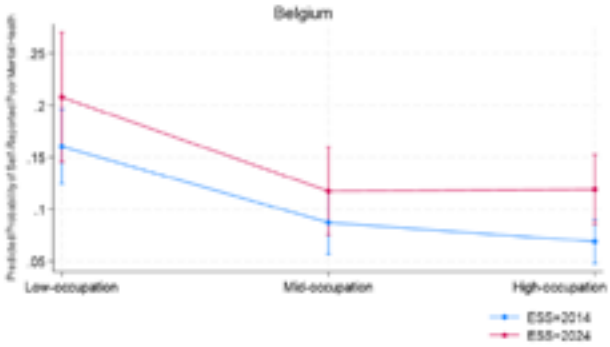


Figure 27: Mental health trajectories by occupation in the United Kingdom

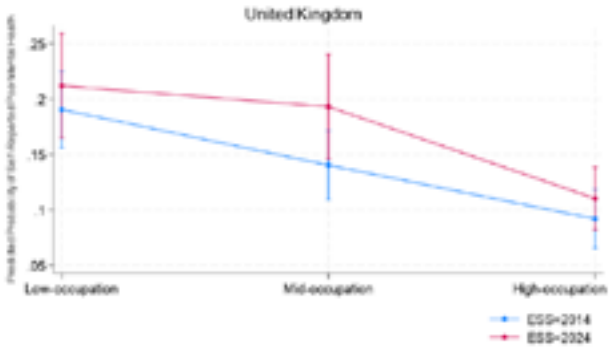


Figure 28: Mental health trajectories by occupation in Ireland

Quadrant III: Countries are on a path where both health and health inequalities are getting worse, the most worrying path.

Figure 29: Mental health trajectories by occupation in Germany

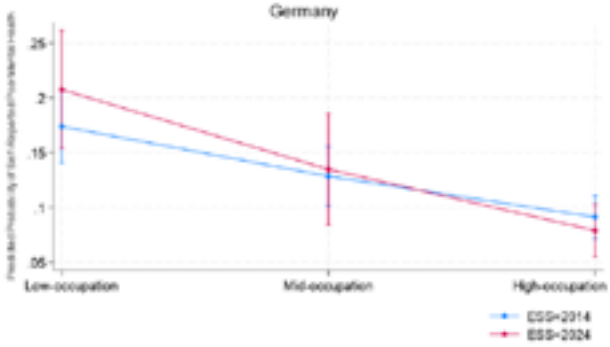


Figure 30: Mental health trajectories by occupation in Sweden

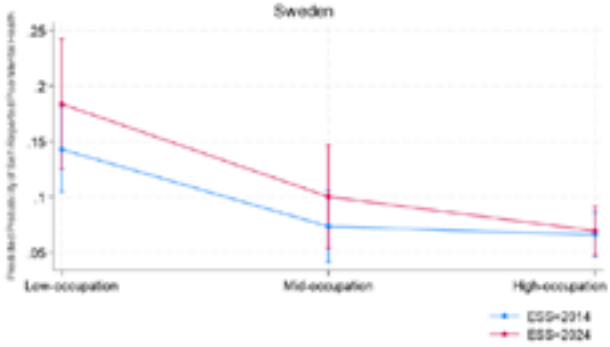


Figure 31: Mental health trajectories by occupation in France

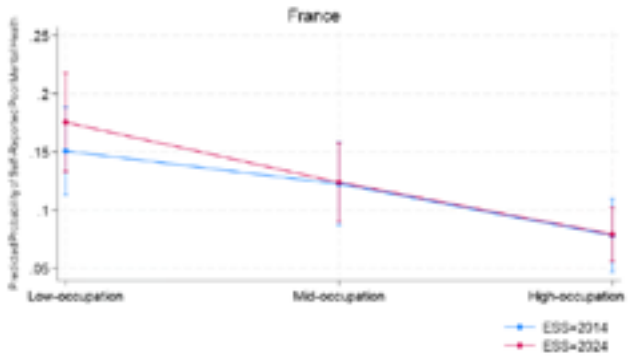


Figure 32: Mental health trajectories by occupation in Switzerland

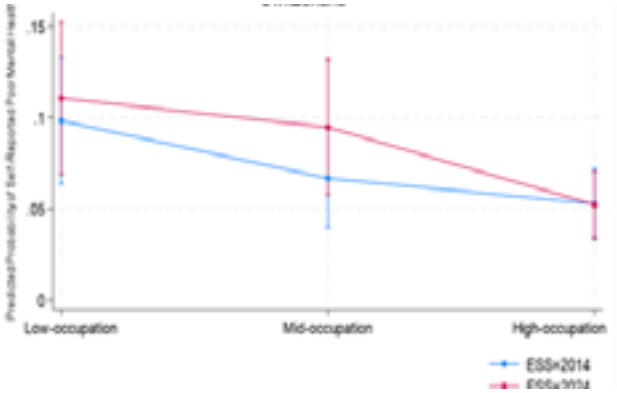
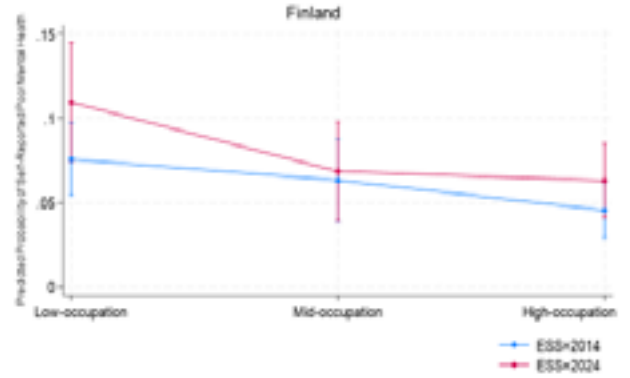


Figure 33: Mental health trajectories by occupation in Finland



Quadrant IV: Countries are on a path where health is stable or improving, but inequalities are increasing

Figure 34: Mental health trajectories by occupation in Austria

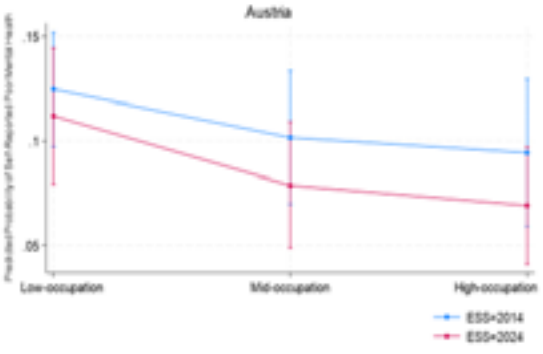
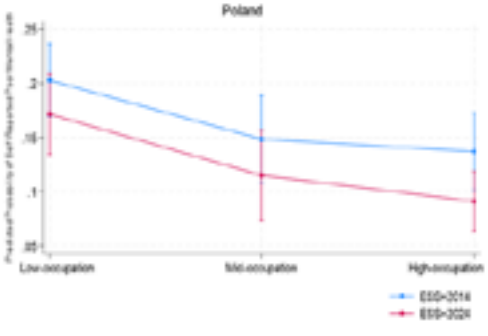


Figure 35: Mental health trajectories by occupation in Poland



Annex VII Prevalences of health problems, health care access and health behaviours and material and psychosocial determinants in 2014 and in 2024, per country and by male and female

This Annex will be added to this report by November 2025.

Annex VIII Data points for factors explaining SRH by education and SRMH by occupation in 2024, amongst 25–75-year-olds

Factors explaining poor mental health

Countries	Main explanation	Coefficient	Second explanation	Coefficient	Third explanation	Coefficient	Fourth explanation	Coefficient	Fifth explanation	Coefficient
Austria	Feeling of income	1.63	Ergonomic hazards	1.09	Sense of control	1.04	Conflict in childhood	0.99	Employment status	1.13
Belgium	Feeling of income	1.58	Social network	1.64	Employment status	1.15	Material hazards	1.12	Financial difficulties in childhood	1.02
Croatia	Conflicts in childhood	1.14	Social network	1.24	Sense of control	1.17	Employment status	2	Alcohol consumption	-0.91
Cyprus	House problems	1.35	Feeling of income	1.22	Employment status	1.19	Material hazards	1.02	Conflicts in childhood	0.76
Finland	Sense of control	2.06	Feeling of income	1.38	Job control	1.27	Internet use	1.1	Conflicts in childhood	0.87
France	Feeling of income	1.01	Conflicts in childhood	0.89	Financial difficulties in childhood	0.88	Sense of control	0.88	House problems	0.81
Germany	Feeling of income	1.49	Job control	1.19	Smoking	0.92	Social network	1.06	Sense of control	0.83
Greece	Conflicts in childhood	1.1	House problems	1.67	Sense of control	0.77	Financial difficulties in childhood	0.88	Financial difficulties in childhood	0.77
Hungary	Feeling of income	1.72	Financial difficulties in childhood	1.23	Sense of control	1.27	Conflicts in childhood	1.02	Ergonomic hazards	1.23
Iceland	Sense of control	1.2	Employment status	1.52	Social network	1.57	Smoking	1.48	Ergonomic hazard	1.42

Countries	Main explanation	Coefficient	Main explanation	Coefficient	Main explanation	Coefficient	Main explanation	Coefficient	Main explanation	Coefficient
Ireland	Sense of control	1.34	Conflicts in childhood	1.1	Physical activity	0.97	House problems	0.96	Feeling of income	0.87
Italy	Feeling of income	1.42	Conflicts in childhood	1.25	Financial difficulties in childhood	1.22	Sense of control	1.2	Fruits/ Vegetable consumption	1.23
Lithuania	Sense of control	1.14	Feeling of income	1.21	Social network	1.14	Fruits/ Vegetable consumption	0.85	Physical activity	0.63
Netherlands	Feeling of income	2.25	Sense of control	1.59	Physical activity	1.22	Job control	1.25	Employment status	1.22
Norway	Feeling of income	1.69	Sense of control	1.21	Financial difficulties in childhood	1.17	Social network	1.22	Smoking	1.13
Poland	Feeling of income	1.26	Sense of control	1	Conflicts in childhood	0.95	Financial difficulties in childhood	0.92	House problems	0.96
Portugal	Conflicts in childhood	1.1	Feeling of income	0.83	Sense of control	0.7	Social network	1.1	House problems	0.63
Serbia	Feeling of income	1.48	Sense of control	1.2	House problems	1.08	Job control	1.03	Conflicts in childhood	0.65
Slovenia	Feeling of income	1.24	Financial difficulties in childhood	0.85	House problems	0.98	Sense of control	0.67	Job control	0.85
Slovakia	Sense of control	1.82	Conflicts in childhood	1.61	Financial difficulties in childhood	1.59	House problems	1.39	Social network	1.03
Spain	Feeling of income	1.24	Sense of control	1.14	House problems	1.02	Material hazards	0.91	Physical activity	0.7
Sweden	Social network	2.28	Feeling of income	1.8	Sense of control	1.15	Job control	1.07	Conflicts in childhood	0.88
Switzerland	Feeling of income	1.68	Employment status	1.25	Sense of control	0.95	House problems	0.84	Social network	0.81
United Kingdom	Feeling of income	1.43	Sense of control	1.26	Physical activity	1.1	Smoking	1.32	Employment status	1

Factors explaining occupational inequalities in poor self-reported mental health

Countries	Main explanation	Coefficient	Second explanation	Coefficient	Third explanation	Coefficient	Fourth explanation	Coefficient
Austria	No occupational inequalities							
Belgium	Feeling of income	82	Job control	45	House problems	38	Employment status	35
Croatia	No occupational inequalities							
Cyprus	No occupational inequalities							
Finland	Job control	68	Employment status	39	Feeling of income	38	Sense of control	29
France	Job control	36	Feeling of income	35	Financial difficulties in childhood	19	Work training	12
Germany	Job control	44	Feeling of income	34	Smoking	30	Work training	22
Greece	No occupational inequalities							
Hungary	Feeling of income	73	Ergonomic hazard	59	Material hazard	37	Financial difficulties in childhood	34
Iceland	Job control	44	Smoking	27	Feeling of income	24	Sense of control	20
Ireland	Feeling of income	44	Employment status	27	Physical activity	24	Financial difficulties in childhood	21c
Italy	Feeling of income	72	Financial difficulties in childhood	56c	Ergonomic hazards	50	Material hazard	32
Lithuania	Job control	50	Ergonomic hazard	42	Sense of control	34	Internet use	32
Netherlands	Feeling of income	52	Job control	47	Employment status	26	Sense of control	24

Countries	Main explanation	Coefficient	Second explanation	Coefficient	Third explanation	Coefficient	Fourth explanation	Coefficient
Norway	Feeling of income	49	Smoking	35	Employment status	32	Job control	26
Poland	Feeling of income	42	Job control	34	Employment status	14	Smoking	10
Portugal	Feeling of income	52	Job control	40	Financial difficulties in childhood	31	Ergonomic hazards	26
Serbia	No occupational inequalities							
Slovenia	Feeling of income	51	Job control	38	Financial difficulties in childhood	14	Work training	11
Slovakia	Feeling of income	58	Financial difficulties in childhood	48	Job control	44	Sense of control	39
Spain	Feeling of income	58	Material hazard	35	Social network	30	Job control	28
Sweden	Social network	39	Feeling of income	30	Work training	27	Job control	26
Switzerland	Feeling of income	47	Work training	36	Job control	20	Social network	23
United Kingdom	Feeling of income	44	Job control	32	Smoking	31	Social network	24

Factors explaining educational inequalities in poor self-reported health

Countries	Main explanation	Coefficient	Main explanation	Coefficient	Main explanation	Coefficient	Main explanation	Coefficient
Austria	Financial difficulties in childhood	32	Feeling of income	23	Employment status	23	Ergonomic hazards	21
Belgium	Smoking	16	Fruit/vegetable consumption	15	BMI	13	Alcohol consumption	11
Cyprus	Feeling of income	12	House problems	11	Employment status	9	Sense of control	6
Finland	Feeling of income	18	Fruit/vegetable consumption	15	Smoking	14	Employment status	13
France	BMI	21	Feeling of income	18	Ergonomic hazards	15	Financial difficulties in childhood	12
Germany	Smoking	31	Feeling of income	25	Ergonomic hazards	21	Job control	19
Greece	Job control	22	Physical activity	21	Employment status	19	Feeling of income	19
Hungary	Feeling of income	48	Financial difficulties in childhood	25	Sense of control	23	Employment status	20
Iceland	BMI	16	Social network	13	Sense of control	13	Feeling of income	12
Ireland	Feeling of income	39	Physical activity	37	Employment status	33	Smoking	26
Italy	Feeling of income	35	Employment status	30	Sense of control	23	Financial difficulties in childhood	22
Lithuania	Financial difficulties in childhood	14	Ergonomic hazards	14	Material hazards	13	Feeling of income	10

Countries	Main explanation	Coefficient	Second explanation	Coefficient	Third explanation	Coefficient	Fourth explanation	Coefficient
Netherlands	BMI	30	Smoking	26	Physical activity	21	Feeling of income	20
Norway	BMI	26	Sense of control	19	Smoking	14	Ergonomic hazards	12
Poland	Feeling of income	19	Job control	15	Ergonomic hazards	13	Fruit/vegetable consumption	13
Portugal	Feeling of income	29	Financial difficulties in childhood	28	Ergonomic hazards	20	Material hazards	18
Serbia	Feeling of income	65	Employment status	41	BMI	32	Financial difficulties in childhood	22
Slovenia	Ergonomic hazards	25	BMI	19	Material hazards	16	Employment status	14
Slovakia	BMI	34	Feeling of income	25	Employment status	24	Ergonomic hazards	20
Spain	Social network	21	BMI	21	Feeling of income	19	Material hazards	17
Switzerland	BMI	23	Financial difficulties in childhood	21	Social network	17	Feeling of income	c
United Kingdom	Feeling of income	c	BMI	c	Physical activity	c	Financial difficulties in childhood	c

Annex IX: EU level funding programmes that provide opportunities to reduce health inequalities (2021-2027)

EU4Health programme 2021-2027

- The EU4Health programme was established during the COVID-19 pandemic, with a budget of €5.3 billion, of which €1 billion has been cut and re-allocated to other priorities.
- 20% of the programme's budget must be invested in initiatives that reduce the burden of non-communicable diseases in the EU.

Horizon Europe

- 95.5 billion EUR until 2027.
- This research and innovation programme addresses various areas, including tackling climate change, societal and technological challenges, boosting the EU's competitiveness and growth, while facilitating collaboration. I

InvestEU

- 372 billion EUR from 2021-2027.
- The programme is structured around four policy windows: sustainable infrastructure; research, innovation and digitisation; SMEs; Social investment and skills.

Single Market Programme

- 4.2 billion EUR.
- Focusing on higher consumer protection, high level of food safety, and improved competition policies.

European Regional Development Fund

- 226.05 billion EUR from 2021-2027.
- Investments in all EU regions to reduce economic, social and territorial disparities.
- Aiming to be more competitive and smarter, greener, more connected, more social and closer to citizens.

Cohesion Fund

- 48 billion EUR from 2021-2027.
- Providing support to EU Member States with a gross national income per capita below 90% to strengthen the economic, social and territorial cohesion of the EU.

Recovery and Resilience Facility

- 723.8 billion EUR from 2021-2027.
- Mitigating the economic and social impact of the coronavirus pandemic and making European economies and societies more sustainable, resilient and better prepared for challenges.

Technical Support Instrument

- 864 million EUR from 2021-2027.
- tSupport for Member States in designing and implementing resilience-

enhancing reforms by providing expertise.

EU Civil Protection Mechanism (rescEU)

- Strengthening European preparedness for disasters and allowing for a quicker reaction to health crises.

European Social Fund+

- 99.2 billion EUR from 2021-2027.
- Aims to tackle the crisis caused by the coronavirus pandemic, through achieving high employment levels and fair social protection as well as fostering a skilled and resilient workforce.

Erasmus+

- 26.5 billion EUR from 2021-2027.
- Aimed at supporting education, training, youth and sport in Europe and enhancing the Union's human and social capital.

Citizens, Equality, Rights and Values Programme

- 1.6 billion EUR from 2021-2027.
- Develop open, rights-based, democratic, equal and inclusive societies based on the rule of law, including the promotion of rights, non-discrimination, equality and advancing gender and non-discrimination mainstreaming.

European Agricultural Guarantee Fund

- 291.1 billion EUR from 2023-2027.
- Helping EU farmers to provide a secure supply of safe, healthy and affordable food.

European Agricultural Fund for Rural Development

- 95.5 billion EUR from 2023-2027.
- Improving the competitiveness of agriculture while encouraging sustainable management of natural resources and climate action.

European Maritime, Fisheries and Aquaculture Fund

- 6.1 billion EUR from 2021-2027.
- Helping fishers transition to sustainable fishing and supporting coastal communities.

Programme for the Environment and Climate Action

- 5.4 billion EUR from 2021-2027.
- Facilitating the shift towards a sustainable, circular, climate-neutral, and resilient economy, protecting, restoring and improving the quality of the environment, halting and reversing the biodiversity loss and tackling the degradation of ecosystems.

Just Transition Fund

- 19.3 billion EUR from 2021-2027.
- Supporting the economic diversification and reconversion for territories to be most negatively impacted by the transition towards climate neutrality.

Annex X: ESS data on employment rates, employment gender gaps, and unmet medical need for 2014 and 2024, by education group

This annex will be added in November 2025

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