INFRA4NEXTGEN

Data Summary

The Health and Well Being of People in Europe

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MAKE IT

GREEN

DIGITAL

HEALTHY

STRONG

EQUAL

Abstract

Background: Health inequalities remain a pressing concern across Europe, with clear disparities in outcomes based on social, economic, and geographic factors. These differences are not solely the result of individual practices or access to healthcare, but also reflect the broader conditions in which people live and work. The Social Determinants of Health (SDOH) framework provides a comprehensive lens to understand how such non-medical influences shape health across the life course.

Aim: This data summary examines the health and well-being of people in Europe, with a particular focus on young adults aged 15-34, in comparison to older age groups (35-54 and 55+). Drawing on the "Make it Healthy" framework, it explores four key areas influencing health: behavioural and psychosocial factors, material conditions, occupational factors, and access to healthcare. The report aims to support youth-oriented policy development by identifying disparities and emerging risks affecting younger generations.

Data: Data were drawn from three major cross-national surveys: the European Social Survey (ESS Round 11), the International Social Survey Programme (ISSP 2019 and 2021), and the European Quality of Life Survey (EQLS 2016). The report included 16-28 European countries per dataset, using recommended analysis weights to ensure comparability. Indicators covered domains such as self-rated health, physical activity, nutrition, BMI, trust, social contact, happiness, sense of control, housing problems, financial hardship, job quality, and access to healthcare.

Results: Young people generally reported good self-rated health and higher levels of physical activity than older adults. However, their average BMI values were close to the overweight threshold, and many reported financial constraints affecting food choices. Psychosocial outcomes such as trust, happiness, and sense of control varied by gender, age, and education, with young women and those with lower education reporting lower levels. Material conditions revealed higher rates of housing problems and financial insecurity among youth, especially in urban areas. Occupational indicators showed limited job control, higher exposure to hazards, and greater job insecurity among younger and female workers. Unmet medical needs were also highest among young adults, particularly women and urban residents.

Conclusion: Although many young Europeans report favourable health overall, their health and well-being are shaped by intersecting social, economic, and structural conditions. Addressing these social determinants is critical to promoting equitable opportunities, supporting resilience, and unlocking the full potential of Europe's younger generations.

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1 Introduction

Health inequalities continue to be a major concern across Europe, with noticeable differences in health outcomes between social groups, genders, and regions (Balaj et al., 2017; Mackenbach et al., 2017; Thomson et al., 2017). Studies have shown that people's life expectancy, overall physical and mental health, and rates of chronic illnesses can vary widely depending on their background and where they live. These persistent gaps highlight the importance of regularly monitoring health trends and developing policies aimed at reducing these inequalities and improving wellbeing for everyone.

This report looks at the current state of health and wellbeing in Europe, based on the well-established concept of the Social Determinants of Health (SDOH). This approach aligns with the World Health Organization's definition of health as a state of complete physical, mental, and social wellbeing – not merely the absence of disease.

Reflecting this comprehensive view, both academic research and international organisations increasingly recognise that health outcomes are shaped by the broader conditions in which people are born, grow, live, work, and age. The SDOH framework, as highlighted by the WHO's Commission on Social Determinants of Health (2008), provides a life course perspective that captures these influences and is essential for understanding and addressing health inequalities across populations.

We have brought together and summarised findings from a wide range of existing data to show the conditions that influence people's health throughout their lives. The information comes from a review of major cross-European surveys and studies, such as the European Social Survey (ESS), International Social Survey Programme (ISSP), and the European Quality of Life Survey (EQLS).

Since the Infra4NextGen project focuses on helping shape youth policies across Europe, particular attention is given to how the factors that influence health differ between younger Europeans (ages 15-34) and older age groups (ages 35-55 and 55+).

This focus is especially important because adolescence and young adulthood are critical periods filled with major life changes – starting higher education, entering the workforce, and building personal relationships (Arnett, 2000). These transitions can have a strong impact on health and wellbeing. Young adults, in particular, may face greater risks, such as poor dietary choices, substance use, or mental health challenges, often made worse by stress, uncertainty, and social isolation (Goldstein et al., 2013).

Research shows that early life experiences and behaviours are closely linked to health later in adulthood, and disadvantages can build up over time (Viner et al., 2012). Understanding and supporting young people's health today is essential for ensuring better health throughout their lives.

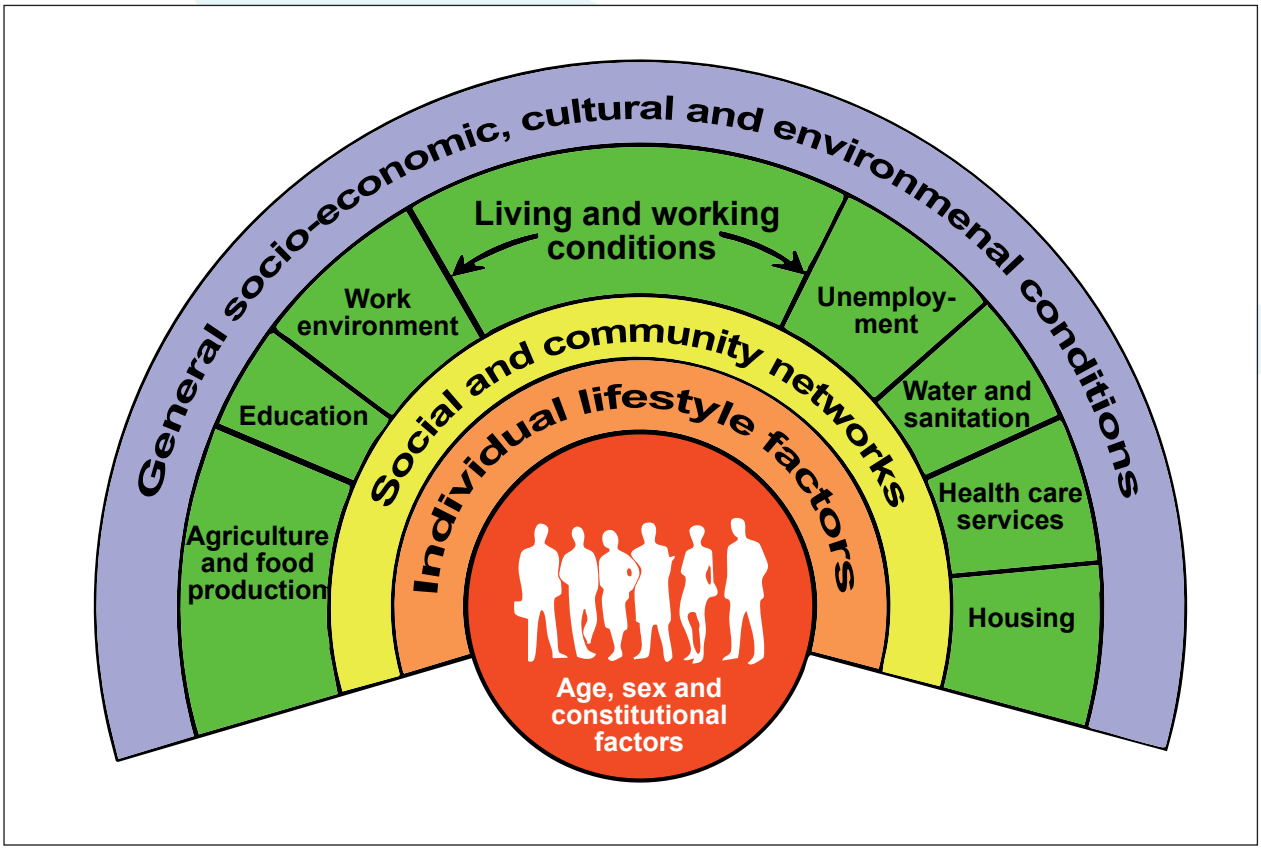
2 Theoretical model

The Social Determinants of Health (SDOH) refer to the social and environmental conditions in which individuals are born, grow up, live, work, and age, all of which play a major role in shaping their overall health and wellbeing.

These factors are non-medical influences that can impact health outcomes and contribute to differences in health between and within populations (see Figure 1).

Looking at health from the perspective of social determinants is essential because it offers a more complete view of how a range of social, economic, and environmental conditions shape health. The influence of these determinants can differ greatly from country to country, depending on variations in economic systems, cultural traditions, political structures, and social norms.

Figure 1. Model of the social determinants of health



Source: Dahlgren and Whitehead, 1991

To broaden the understanding provided by the Social Determinants of Health (SDOH) framework, the “Make it Healthy” framework organises the many influences on health into four main categories.

These categories are:

1. Behavioural and psychosocial factors, such as mental wellbeing and lifestyle practices;

2. Material conditions, including factors like housing quality and access to basic needs;

3. Occupational factors, meaning the influence of working conditions and job security on health; and

4. Access to healthcare services, covering whether people can easily reach and afford medical care when needed.

For each of these areas, there is strong scientific evidence showing clear links to different aspects of health and wellbeing. Recognising these connections is important for understanding how broader social and economic environments affect individual and population health.

3 Data and analytic strategy

This data summary report draws on multiple cross-national, population-based surveys that are recognised for their methodological rigour and rich coverage of social and health-related indicators across European countries. The aim of the analytic strategy is to provide a comprehensive yet accessible overview of the social determinants of health (SDOH) among young people in Europe, with comparative insights across age groups (15-34, 35-54, 55+), gender (male, female), education (lower secondary education or below, upper secondary or post-secondary education, tertiary or post-tertiary education), place of residence (urban [big city, suburbs or outskirts of big city, town or small city], rural [country village, farm or home in countryside]), and country-level contexts.

The selected data sources include the European Social Survey (ESS), the International Social Survey Programme (ISSP), and the European Quality of Life Survey (EQLS). These sources were chosen based on their thematic relevance, data availability across European countries, inclusion of youth populations, and their alignment with the conceptual framework of social determinants used in this report.

3.1 European Social Survey (ESS)

The European Social Survey (ESS) is a biennial cross-national study designed to capture the attitudes, beliefs, and behaviours of people living across Europe. For this report, data were drawn from ESS Round 11 (2023/24), which provided detailed insights into the social determinants of health.

The analysis included weighted data from 23 European countries: Austria, Belgium, Croatia, Cyprus, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Lithuania, the Netherlands, Norway, Poland, Portugal, Slovakia, Slovenia, Spain, Sweden, Switzerland, and the United Kingdom.

A wide array of variables were examined, including smoking habits and alcohol consumption to reflect health behaviours; trust in others, social interaction, and happiness to capture psychosocial indicators; and housing problems to assess material conditions. Additionally, occupational determinants such as material and ergonomic hazards in the workplace and job control, along with unmet medical needs representing healthcare access, were also explored.

To ensure comparability and representativeness across countries, all analyses employed the provided analysis weight (anweight). This weight adjusts for differential selection probabilities within each country based on sampling design, accounts for nonresponse and noncoverage, corrects for sampling error related to four post-stratification variables, and incorporates a population size adjustment for cross-national aggregation. Anweight is constructed through a three-step process involving the calculation of design weights, post-stratification adjustments, and a population size correction. Detailed documentation of the weight construction methodology is available in the round-specific ESS technical report.

3.2 The International Social Survey Programme (ISSP)

The International Social Survey Programme (ISSP) is a long-standing cross-national collaborative programme that has conducted annual surveys on topics of relevance to the social sciences since 1985. For this report, data from ISSP modules conducted in 2019 and 2021 were utilised to explore various

dimensions of social and health-related inequalities across European countries.

From the 2019 module, Social Inequality V, data from sixteen European countries were included in the analysis: Austria, Bulgaria, Croatia, Czech Republic, Denmark, Finland, France, Germany, Great Britain, Iceland, Italy, Lithuania, Norway, Sweden, Slovenia, and Switzerland. The variable used from this dataset focused on material hardship – specifically, the degree of difficulty respondents experienced in making ends meet based on their total household income.

Although no total weight was provided for international comparisons, the national weight variable available in the dataset was used. This weight compensates for unequal selection probabilities introduced by sampling design or nonresponse and may incorporate design, post-stratification, or nonresponse adjustment components.

From the 2021 module, Health and Healthcare II, data were analysed from sixteen European countries: Austria, Croatia, Czech Republic, Denmark, Finland, France, Germany, Hungary, Iceland, Italy, Netherlands, Norway, Poland, Slovakia, Slovenia, and Switzerland. Several variables from this module contributed to the assessment of health and health-related behaviours among younger and older European populations. These included self-rated health, daily consumption of fresh fruits and vegetables, levels of physical activity, body mass index (BMI), perceptions of healthcare system inefficiency, and beliefs about access to the best available treatment in the event of serious illness.

To ensure data quality and comparability, the combined weight variable WEIGHT_COM was used for the 2021 dataset. This comprehensive weight incorporates both design weights and adjustments for systematic sampling error. Design weights (DWEIGHT_HH and DWEIGHT_TS) address issues such as household-based sampling and intentional oversampling of certain regions or demographic groups. PSWEIGHT accounts for deviations in selection probabilities caused by real-world sampling imperfections. The use of WEIGHT_COM aligns with recommendations for achieving representative population estimates. Additional methodological details can be found in the ISSP Variable Report and national technical documentation.

3.3 European Quality of Life Survey (EQLS)

The European Quality of Life Survey (EQLS) is a cross-national survey conducted by the European Foundation for the Improvement of Living and Working Conditions (Eurofound). Launched in 2003, the EQLS is carried out periodically and aims to assess and monitor objective living conditions and subjective wellbeing across European countries. It explores multiple domains of life including income and financial situation, housing and environment, employment status and work-life balance, social relationships, perceived quality of public services, health, and overall life satisfaction.

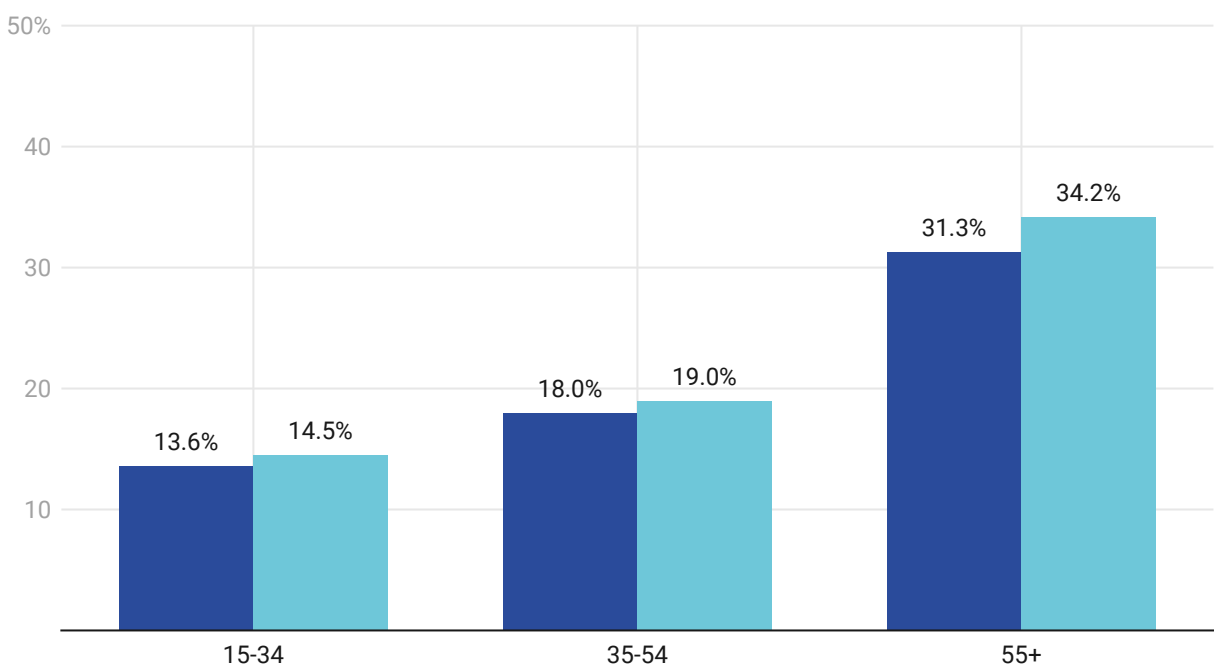
For this report, data from the 2016 wave were used, covering all EU-28 countries. The analysis focused on material determinants and inequalities in living conditions among youth, including indicators such as reduced spending on fresh fruit and vegetables or higher-quality meat, arrears in rent or utility bills, and younger respondents' perceptions of the quality of healthcare services. For all analyses, the WCalib_crossnational_EU28 weight was used. This standardised final calibration weight is specifically recommended for cross-national (multi-country) metrics within the EU and is suitable for both country-level and EU-level analyses.

4 Results

4.1 Self-rated health

People's personal evaluations of their health offer valuable insights into their overall physical and mental wellbeing. This self-perception adds an important layer to traditional measures like life expectancy and mortality, which focus only on how long people live rather than how well they live. Although self-assessments are subjective, research has consistently shown that they are strong indicators of future health outcomes and healthcare utilisation (OECD/ European Commission, 2024).

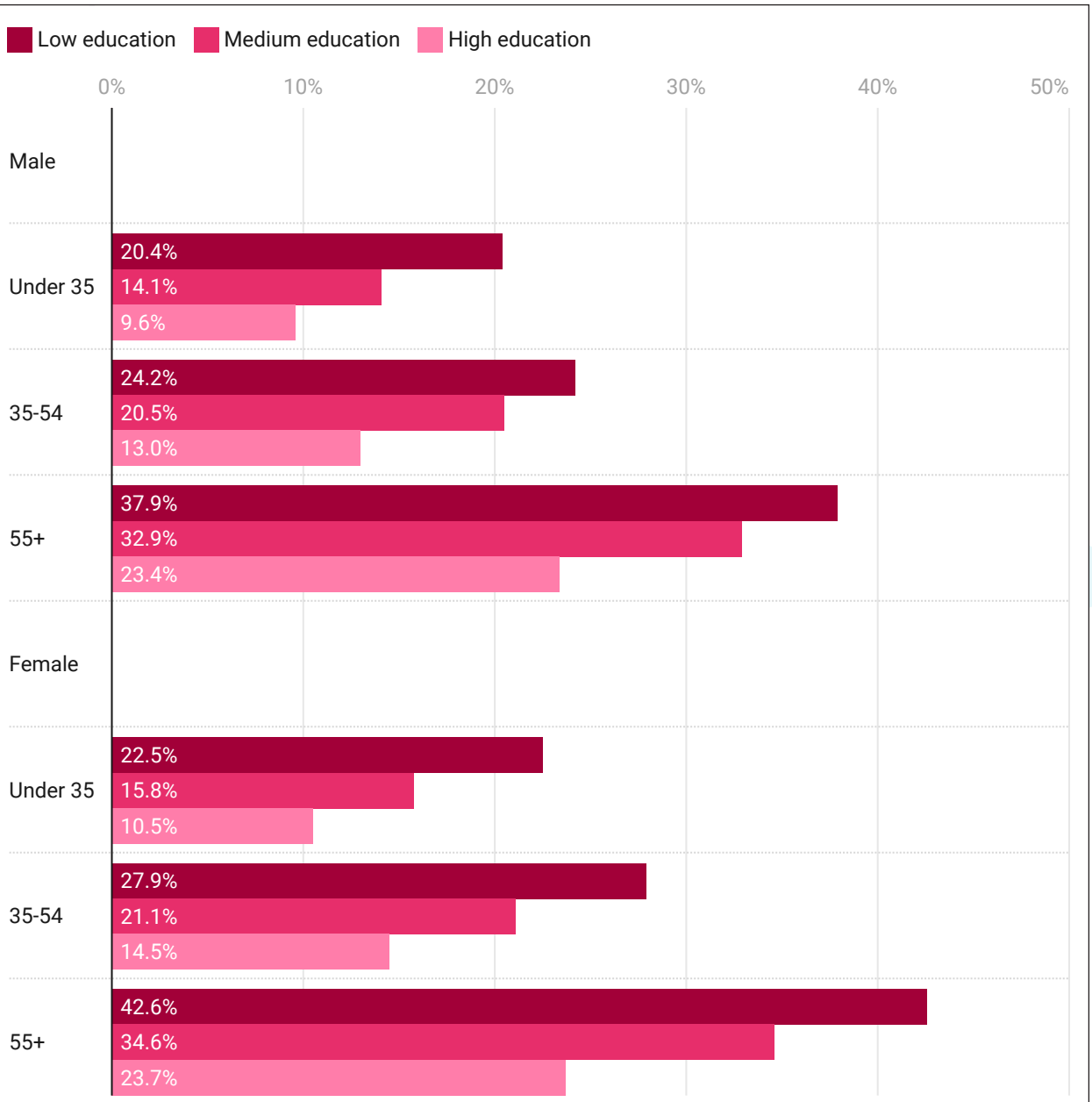
Figure 2. Self-rated health by gender and age group



Pooled, weighted data from 16 European countries (Austria, Croatia, Czechia, Denmark, Finland, France, Germany, Hungary, Iceland, Italy, Netherlands, Norway, Poland, Slovak Republic, Slovenia, and Switzerland). Values indicate the percentage of respondents reporting fair or poor health in the ISSP 2021.

In the ISSP conducted in 2021, participants from 16 European countries were asked to assess their own health status. The results revealed that, overall, Europeans aged 15 to 34 tended to report better health compared to their older peers. However, a significant proportion of young adults still indicated concerns about their health: 13.6% of young men and 14.5% of young women described their health as only "fair" or "poor," rather than selecting more positive categories like "good," "very good," or "excellent."

Figure 3. Self-rated health by gender, education and age group



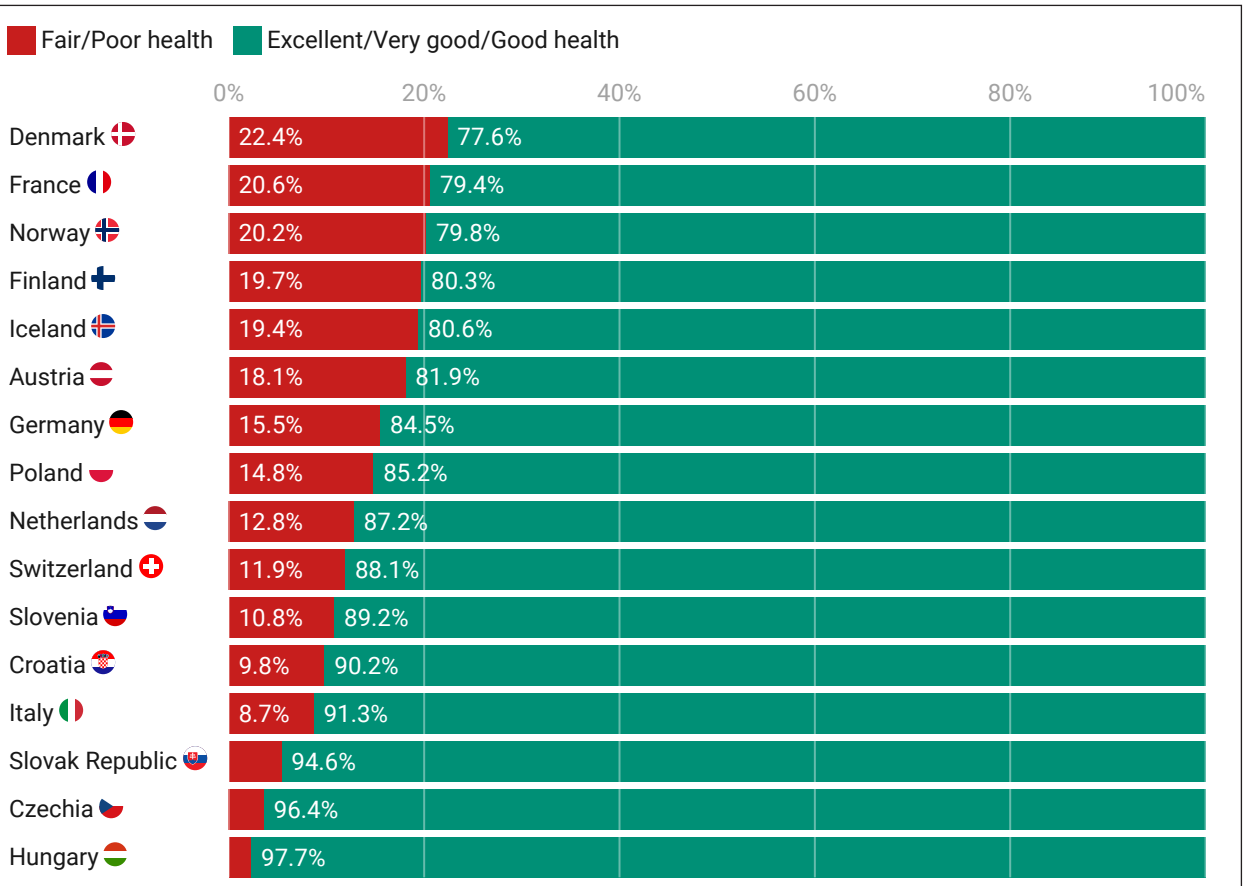
Pooled, weighted data from 16 European countries (Austria, Croatia, Czechia, Denmark, Finland, France, Germany, Hungary, Iceland, Italy, Netherlands, Norway, Poland, Slovak Republic, Slovenia, and Switzerland). Values indicate the percentage of respondents reporting fair or poor health in the ISSP survey 2021.

Self-rated health also varied substantially by educational attainment, with more disadvantaged groups consistently reporting worse health across all age brackets and genders (Figure 3). Among young adults aged 15 to 34, the proportion of individuals who rated their health as only “fair” or “poor” decreased steadily with higher levels of education. For example, among young men, 20.4% of those with lower secondary education or below reported poor health, compared to 14.1% with upper secondary and just 9.6% with tertiary education. The same pattern was evident among young women, with 22.5%, 15.8%, and 10.5% reporting fair or poor health across the three educational levels, respectively.

This educational gradient became even more pronounced with age. Among men aged 55 and over, 37.9% of those with the lowest education rated their health poorly, compared to 32.9% with upper secondary and 23.4% with tertiary education. Women in this age group reported similarly stark differences: 42.6% with the lowest education level reported fair or poor health, dropping to 34.6% among those with upper secondary and 23.7% with tertiary education.

These results highlight a persistent and widening inequality in self-rated health by education over the life course, especially among older populations. They underscore the role of education not only in shaping access to healthcare and health information but also in influencing lifelong health trajectories. Educational attainment may reflect broader structural and material advantages – including healthier working conditions, better access to resources, and healthier lifestyles – that accumulate over time to shape how individuals perceive and experience their health.

Figure 4. Self-rated health among younger Europeans



Weighted data from the ISSP 2021. Values indicate the percentage of respondents aged 15-34 years reporting fair/poor or good/very good/excellent health.

The findings also showed notable differences between countries in how young people perceived their health. The lowest shares of fair or poor health were found in Hungary (2.3%), Czechia (3.6%), and Slovak Republic (5.4%), where more than 94% of young adults rated their health positively. These high levels of perceived wellbeing may reflect cultural factors, or differing health expectations.

Countries such as Italy (8.7%), Croatia (9.8%), Slovenia (10.8%), and Switzerland (11.9%) also reported relatively low rates of fair or poor health among young people, suggesting a generally positive view of personal health in both Southern and Central Europe.

At the other end of the spectrum, Denmark (22.4%), France (20.6%), Norway (20.2%), and Finland (19.7%) had the highest proportions of young people reporting fair or poor health – despite being high-income countries with advanced healthcare systems. In these settings, higher reporting may reflect greater awareness of mental health issues or more critical health self-assessments.

The pattern suggests that perceptions of health among young people do not align neatly with national wealth or healthcare system performance. Instead, they point to the influence of broader social and psychological factors, lifestyle conditions, and cultural norms in shaping how health is experienced and reported. These differences underscore the value of the Social Determinants of Health approach in understanding the full picture of youth health across Europe.

4.2 Behavioural and psychosocial determinants

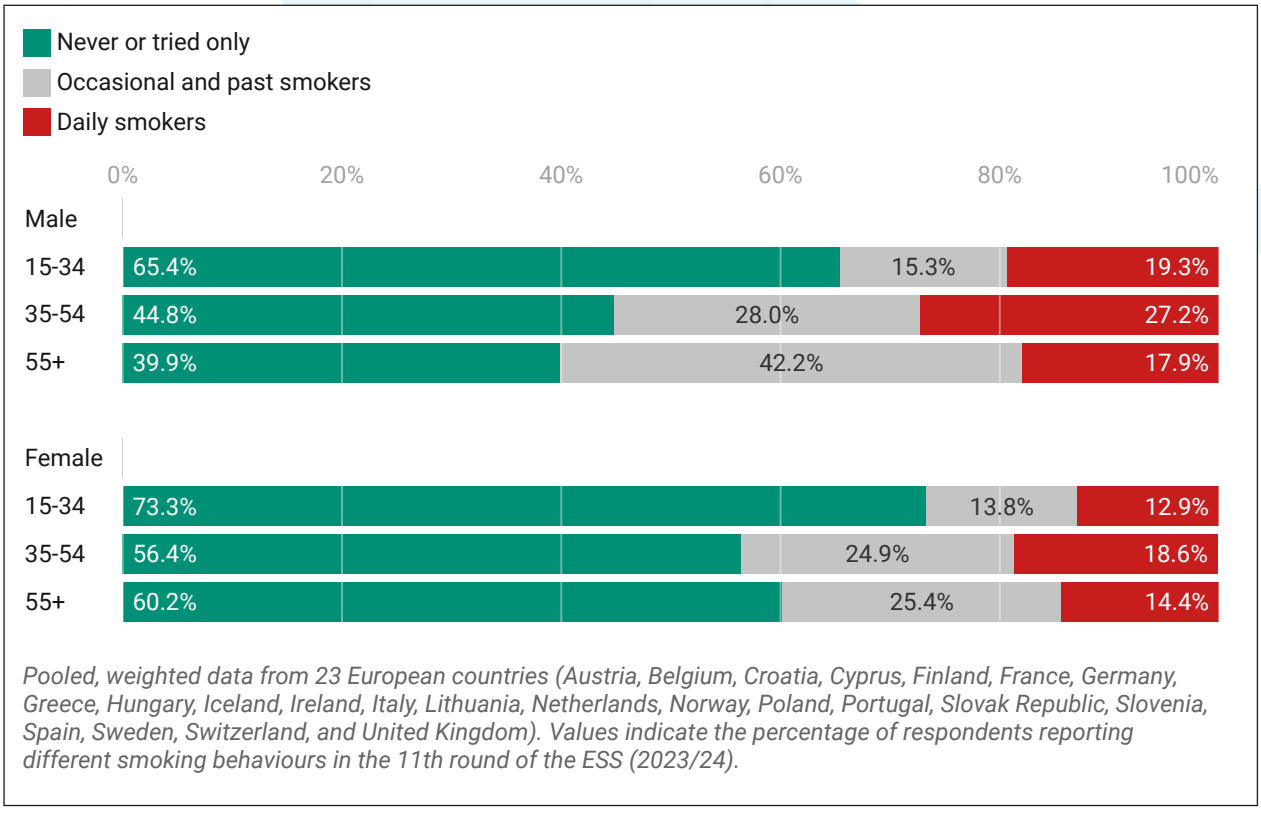
4.2.1 Behavioural determinants

Behavioural factors refer to actions and habits that can either promote good health or increase the risk of health problems. These include lifestyle choices, such as diet, physical activity, smoking, and alcohol use.

According to results from the 11th round of the ESS, conducted between 2023 and 2024, the smoking habits of young European men closely resembled those of men aged 55 years and older. Among young men aged 15 to 34 years, 19.3% reported smoking daily, compared to 17.9% in the 55+ age group. Smoking rates were considerably higher among men aged 35 to 54 years, with 27.3% identifying as daily smokers, indicating a notable improvement in smoking behaviour among the younger generation compared to this age group.

For women, the trends were even more encouraging. Only 12.9% of young women reported smoking daily, a lower rate than both women aged 35 to 54 years (18.6%) and women aged 55 and above (14.4%). This suggests that younger European women are less likely to engage in daily smoking compared to older female age groups.

Figure 5. Smoking habits among Europeans



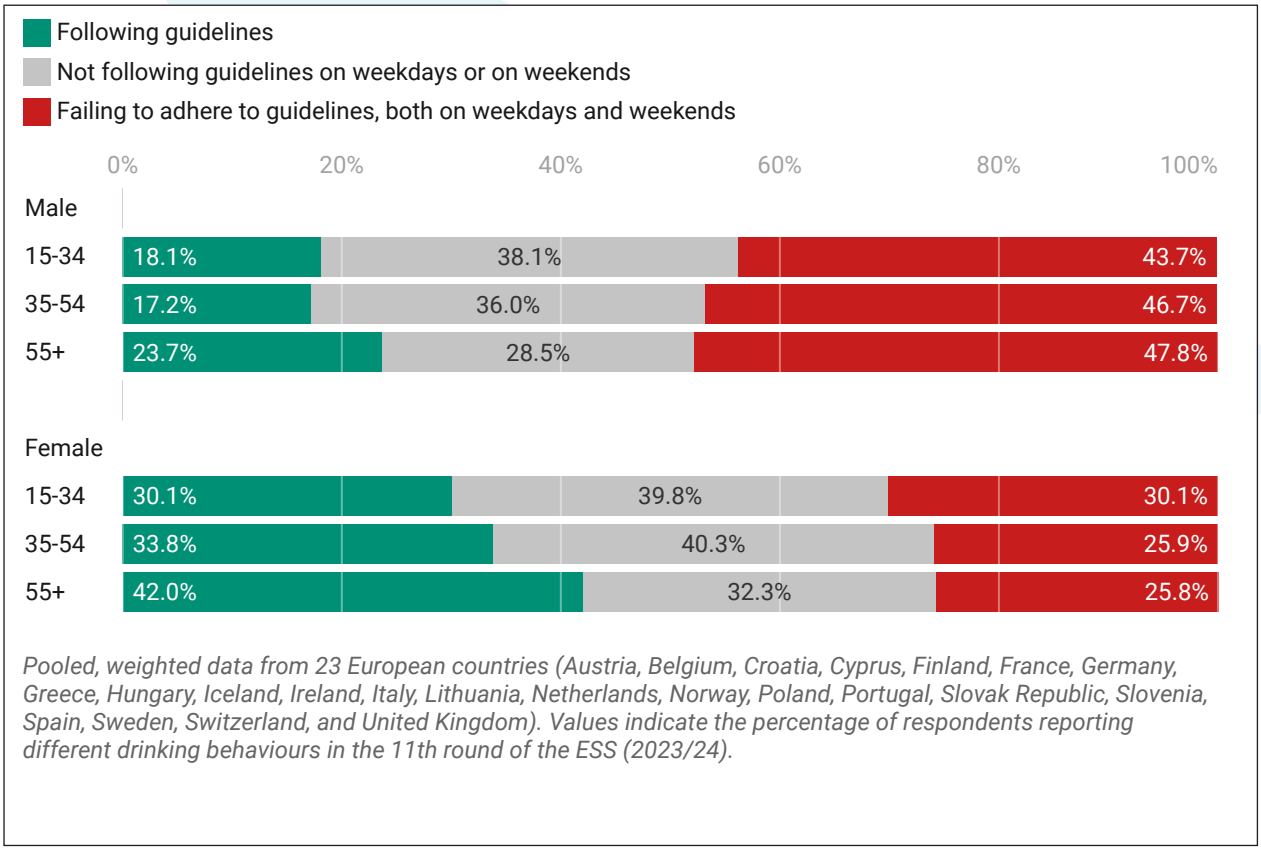
Pooled, weighted data from 23 European countries (Austria, Belgium, Croatia, Cyprus, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Lithuania, Netherlands, Norway, Poland, Portugal, Slovak Republic, Slovenia, Spain, Sweden, Switzerland, and United Kingdom). Values indicate the percentage of respondents reporting different smoking behaviours in the 11th round of the ESS (2023/24).

In contrast, alcohol consumption behaviour followed a different trend. Men in both the 15-34 year (18.1%) and 35-54 year (17.2%) age groups were less likely to adhere to European alcohol consumption guidelines compared to men aged 55 years or older (23.7%). This is defined as drinking no more than two units per day, with one unit equal to 8 grams of alcohol, both on weekdays and weekends.

Although women were overall more likely than men to follow the recommended drinking limits, younger women showed lower adherence compared to older women. Only 30.1% of young women (15-34 years) reported drinking within the recommended limits, compared to 33.8% among women aged 35 to 54 years, and 42% among those aged 55 and over.

These findings highlight that, while younger generations show positive trends in smoking habits, improvements in alcohol consumption behaviour are less evident, particularly among young women.

Figure 6. Following guidelines for recommended alcohol consumption (grams/day)

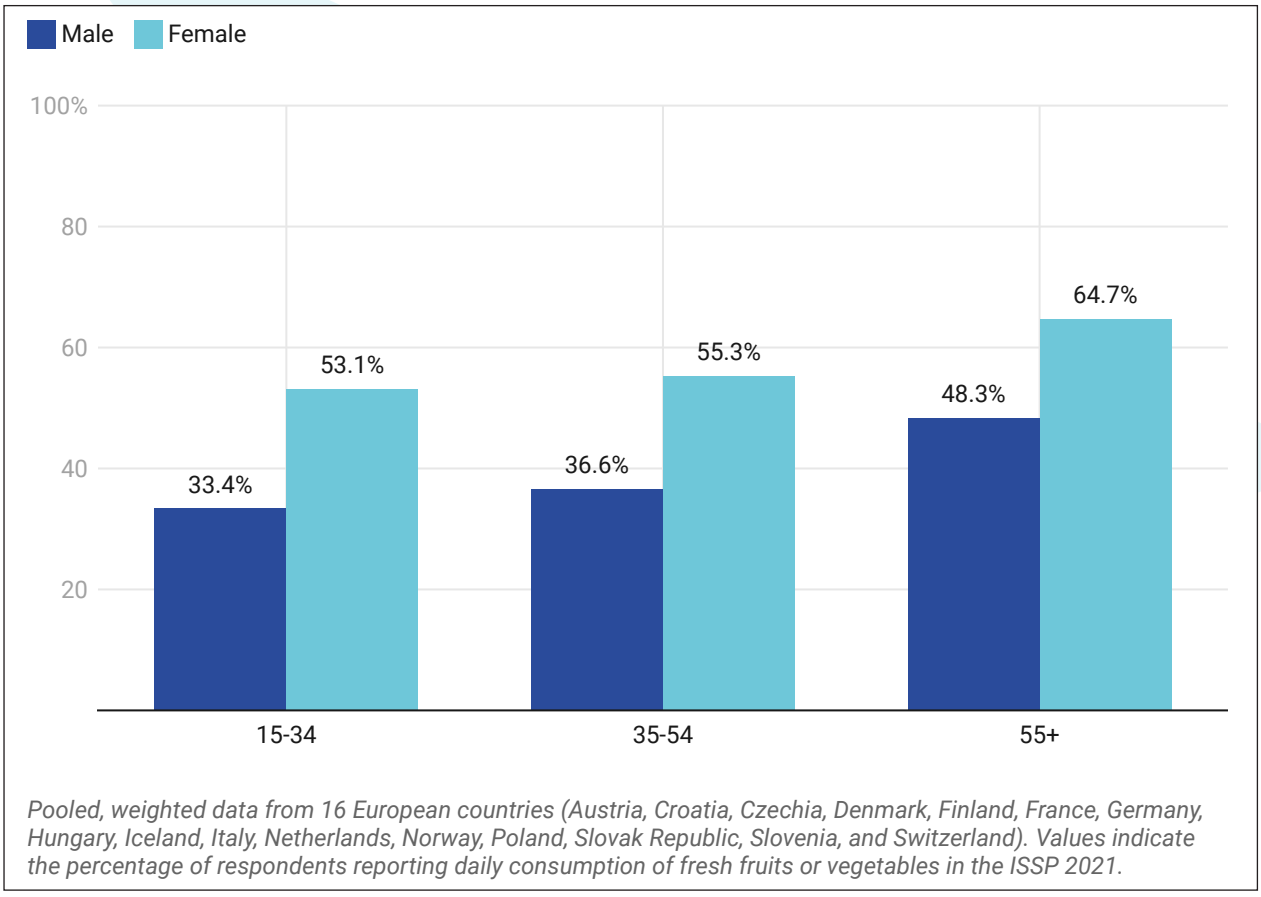


Pooled, weighted data from 23 European countries (Austria, Belgium, Croatia, Cyprus, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Lithuania, Netherlands, Norway, Poland, Portugal, Slovak Republic, Slovenia, Spain, Sweden, Switzerland, and United Kingdom). Values indicate the percentage of respondents reporting different drinking behaviours in the 11th round of the ESS (2023/24).

Data from the ISSP shows that the daily consumption of fresh fruits and vegetables increased with age among both men and women in 2021. Among young men aged 15-34, only 33.4% reported eating fresh fruits or vegetables daily, compared to 36.6% in the 35-54 age group and 48.3% among those aged 55 and over. Women reported substantially higher daily intake across all age groups. Over half of young women (15-34 years) – 53.1% – consumed fresh produce daily, rising to 55.3% among women aged 35 to 54, and reaching 64.7% in the oldest age group (55+).

These findings highlight both a clear gender gap and an age-related increase in healthy eating habits, suggesting that younger men in particular may benefit from greater encouragement to incorporate fruits and vegetables into their daily diets.

Figure 7. Daily consumption of fresh fruits and vegetables



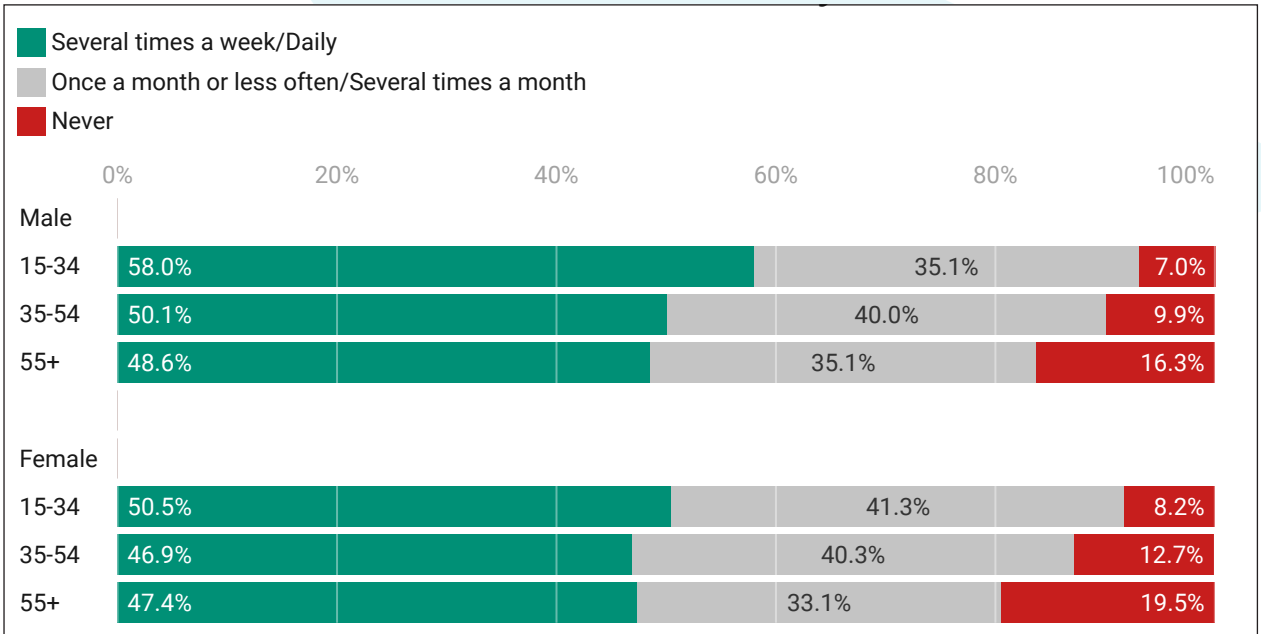
Pooled, weighted data from 16 European countries (Austria, Croatia, Czechia, Denmark, Finland, France, Germany, Hungary, Iceland, Italy, Netherlands, Norway, Poland, Slovak Republic, Slovenia, and Switzerland). Values indicate the percentage of respondents reporting daily consumption of fresh fruits or vegetables in the ISSP 2021.

Clear differences in physical activity habits across age and gender groups in Europe were also observed in the ISSP (2021). Among young men aged 15-34, 58% reported engaging in physical activity that makes one sweat or breathe more heavily than usual for at least 20 minutes several times a week or daily. This proportion declined slightly with age, with 50.1% of men aged 35 to 54 years and 48.6% of those aged 55 and older maintaining similar levels of activity.

For women, the trend was comparable but with overall lower rates of frequent activity. About 50.5% of young women reported being physically active several times a week or daily, compared to 46.9% among women aged 35-54 and 47.4% in the 55+ group.

The share of individuals who never engaged in physical activity increased with age among both men and women. Among young men aged 15-34, only 7% reported never exercising, while among those 55 years and older, this figure rose to 16.3%. Similarly, 8.2% of young women reported never being physically active, compared to 19.5% among women in the oldest age group. These patterns suggest that while younger adults tend to be more physically active, there is a gradual decline with age, especially among women, highlighting the importance of promoting active lifestyles throughout the life course.

Figure 8. Doing physical activity for at least 20 minutes that makes one sweat or breathe more heavily than usual

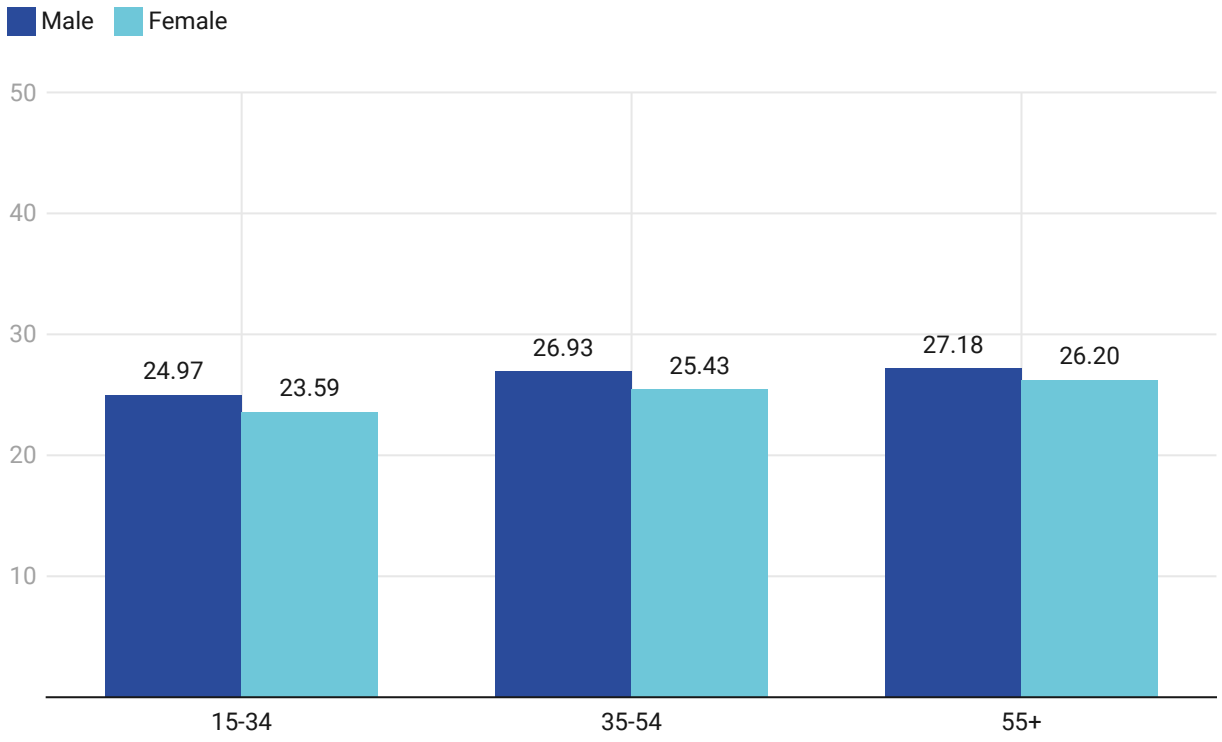


Pooled, weighted data from 16 European countries (Austria, Croatia, Czechia, Denmark, Finland, France, Germany, Hungary, Iceland, Italy, Netherlands, Norway, Poland, Slovak Republic, Slovenia, and Switzerland). Values indicate the percentage of respondents reporting different physical activity behaviours in the ISSP 2021.

Although younger adults in Europe appear more likely to engage in physical activity compared to older age groups, their average body mass index (BMI) values suggest that challenges around maintaining a healthy weight still persist. According to the 2021 ISSP data, the mean BMI among young men (15-34) was 24.97, placing them just below the threshold for being classified as overweight (BMI of 25 or above). Among men aged 35-54, the mean BMI increased to 26.93, and slightly further to 27.18 in those aged 55 and older, indicating that being overweight becomes more common with age. A similar trend was seen among women: young women had a mean BMI of 23.59, which gradually rose to 25.43 in the 35-54 age group and 26.2 among women aged 55 and over.

These patterns partly reflect normal physiological changes associated with ageing, such as a slowing metabolism, decreased muscle mass, and increased fat accumulation. However, they also underscore the continued importance of supporting healthy behaviours throughout the life course, as lifestyle practices and social conditions strongly influence how these physiological changes manifest. Promoting healthy nutrition, physical activity, and accessible preventive care from early adulthood onward remains essential for mitigating excess weight gain and improving long-term health outcomes.

Figure 9. Average Body Mass Index Among Europeans by age group

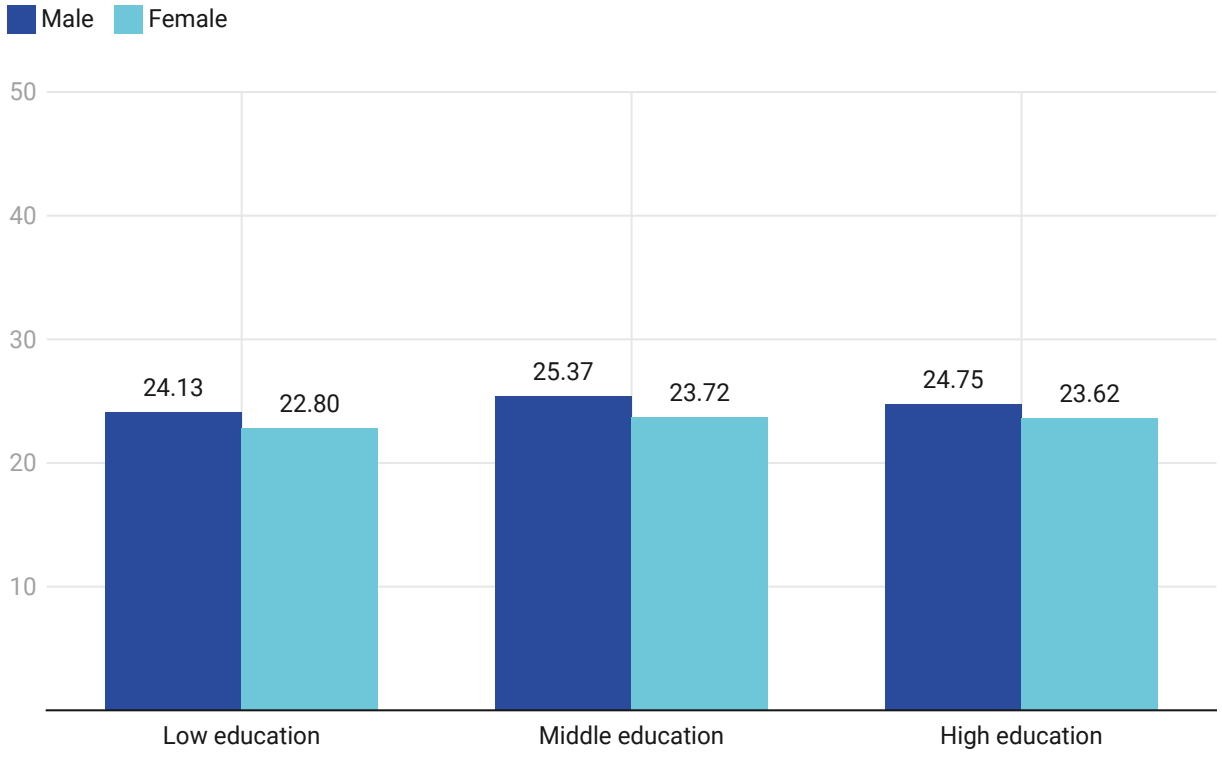


Pooled, weighted data from 16 European countries (Austria, Croatia, Czechia, Denmark, Finland, France, Germany, Hungary, Iceland, Italy, Netherlands, Norway, Poland, Slovak Republic, Slovenia, and Switzerland). Values indicate calculated mean Body Mass Index (BMI; kg/m2) based on self-reported weight and height in the ISSP 2021.

Educational attainment also appears to be associated with differences in average BMI among younger Europeans. According to the 2021 ISSP data, young men (aged 15-34) with upper secondary or post-secondary education had the highest mean BMI at 25.37, crossing the threshold into the overweight category. This compares to 24.13 among those with lower secondary education or below, and 24.75 among those with tertiary or post-tertiary education. A similar but slightly less pronounced pattern was observed among young women: those with the lowest level of education had a mean BMI of 22.80, while those with upper secondary or post-secondary education averaged 23.72, and those with tertiary education had a mean BMI of 23.62.

These findings suggest that the relationship between education and BMI is not linear, particularly among men, and may be shaped by multiple intersecting factors such as health literacy, dietary habits, occupational activity levels, and socioeconomic conditions. Nonetheless, they highlight that educational background can play a role in shaping health-related outcomes and reinforce the importance of tailoring health promotion strategies to different social groups, particularly during young adulthood when long-term behaviours are established.

Figure 10. Average Body Mass Index among younger Europeans by education

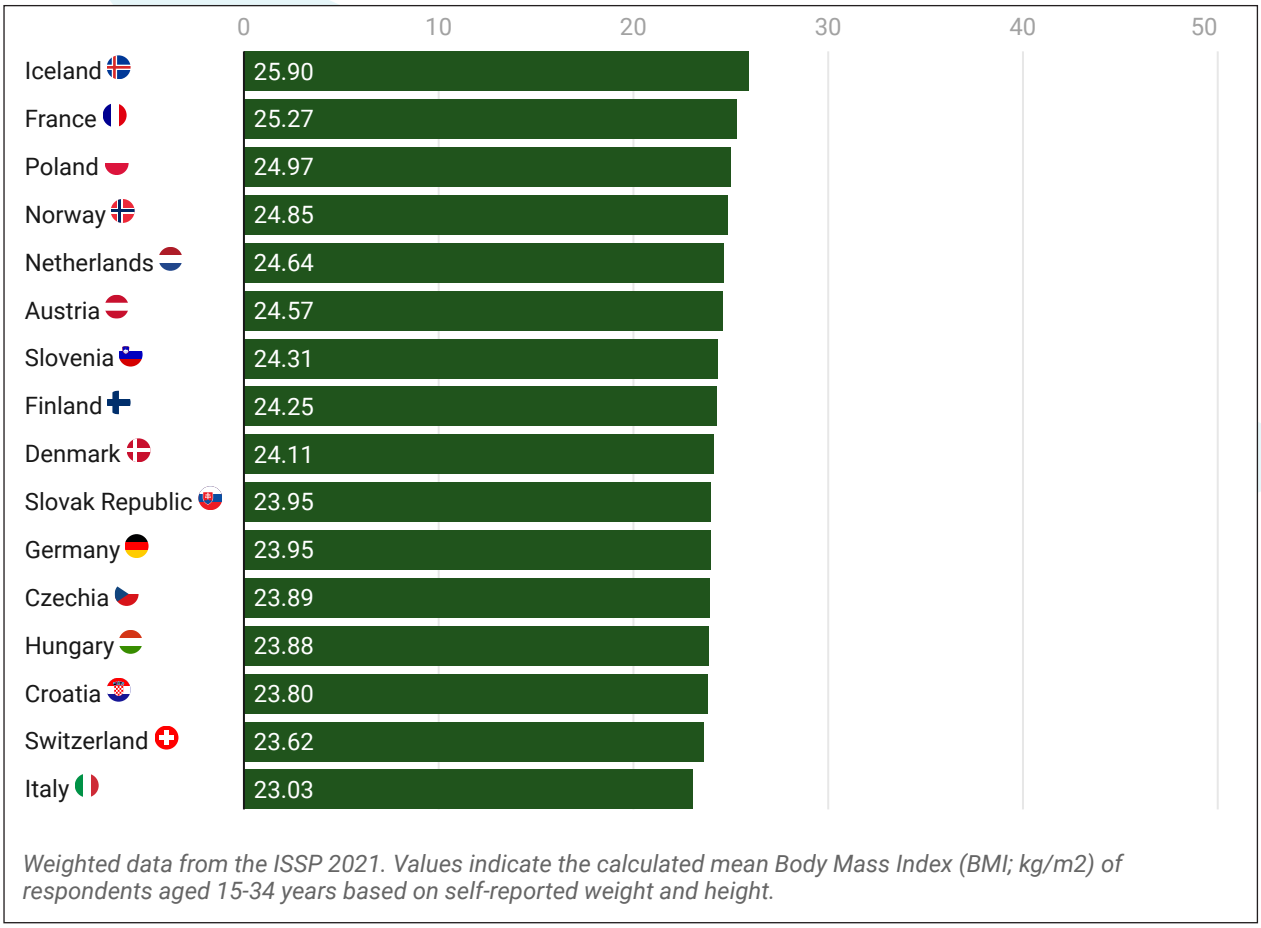


Pooled, weighted data from 16 European countries (Austria, Croatia, Czechia, Denmark, Finland, France, Germany, Hungary, Iceland, Italy, Netherlands, Norway, Poland, Slovak Republic, Slovenia, and Switzerland). Values indicate the calculated mean Body Mass Index (BMI; kg/m2) of respondents aged 15-34 years based on self-reported weight and height in the ISSP 2021.

Looking at differences across countries, the ISSP reveals notable variations in average BMI levels among younger Europeans aged 15-34. Those in Italy reported the lowest mean BMI at 23.03, followed closely by Switzerland (23.62) and Croatia (23.8). Several Central European countries, including Hungary (23.88), the Czech Republic (23.89), and Slovakia (23.95), also had mean BMI values below 24. In contrast, higher average BMI values were observed in countries like France (25.27) and Iceland (25.9), where the mean BMI exceeds the overweight threshold. Northern and Western European countries such as Norway (24.85), the Netherlands (24.64), and Austria (24.57) had intermediate levels.

These country-level differences highlight how lifestyle, diet, and broader social determinants may influence weight trends across Europe, underscoring the need for tailored public health strategies to address rising BMI levels.

Figure 11. Average Body Mass Index among younger Europeans



Weighted data from the ISSP 2021. Values indicate the calculated mean Body Mass Index (BMI; kg/m2) of respondents aged 15-34 years based on self-reported weight and height.

4.2.2 Psychosocial determinants

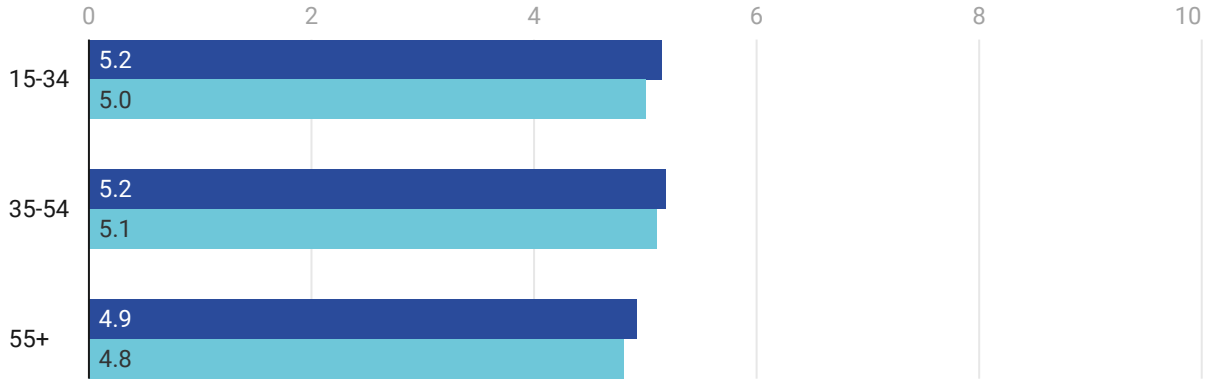
Psychosocial determinants of health refer to the social and psychological aspects of a person's life that influence their overall wellbeing. These include factors like the strength of personal relationships, sense of belonging, levels of social trust, and the support individuals receive from their communities. Mental wellbeing also plays a central role in this category, as feelings of happiness, emotional resilience, and connection to others can all have a strong impact on both physical and mental health outcomes.

Generalised trust – a key psychosocial determinant of health – refers to the belief that most people can be trusted. It reflects a person's sense of social connection, security, and confidence in others, and is often shaped by life experiences and social environments. In ESS Round 11 (2023/24), trust was measured on a scale from 0 (you can't be too careful) to 10 (most people can be trusted).

Overall, reported levels of trust were modest, with average scores hovering around the mid-point of the scale across all age and gender groups. Among men, mean trust scores were highest in the younger and middle-aged groups, with men aged 15-34 scoring 5.15 and those aged 35-54 scoring 5.18. In contrast, men aged 55 and over had a slightly lower average of 4.92.

A similar pattern was seen among women, though at slightly lower levels overall: young women (15-34) reported an average trust score of 5, which rose modestly to 5.1 in the 35-54 age group, before falling to 4.8 among women aged 55 and older. These findings suggest a slight decline in trust with age for both genders, potentially reflecting broader social changes or personal experiences over the life course, and consistently lower average trust levels among women compared to men.

Figure 12. Trust in others by gender and age group



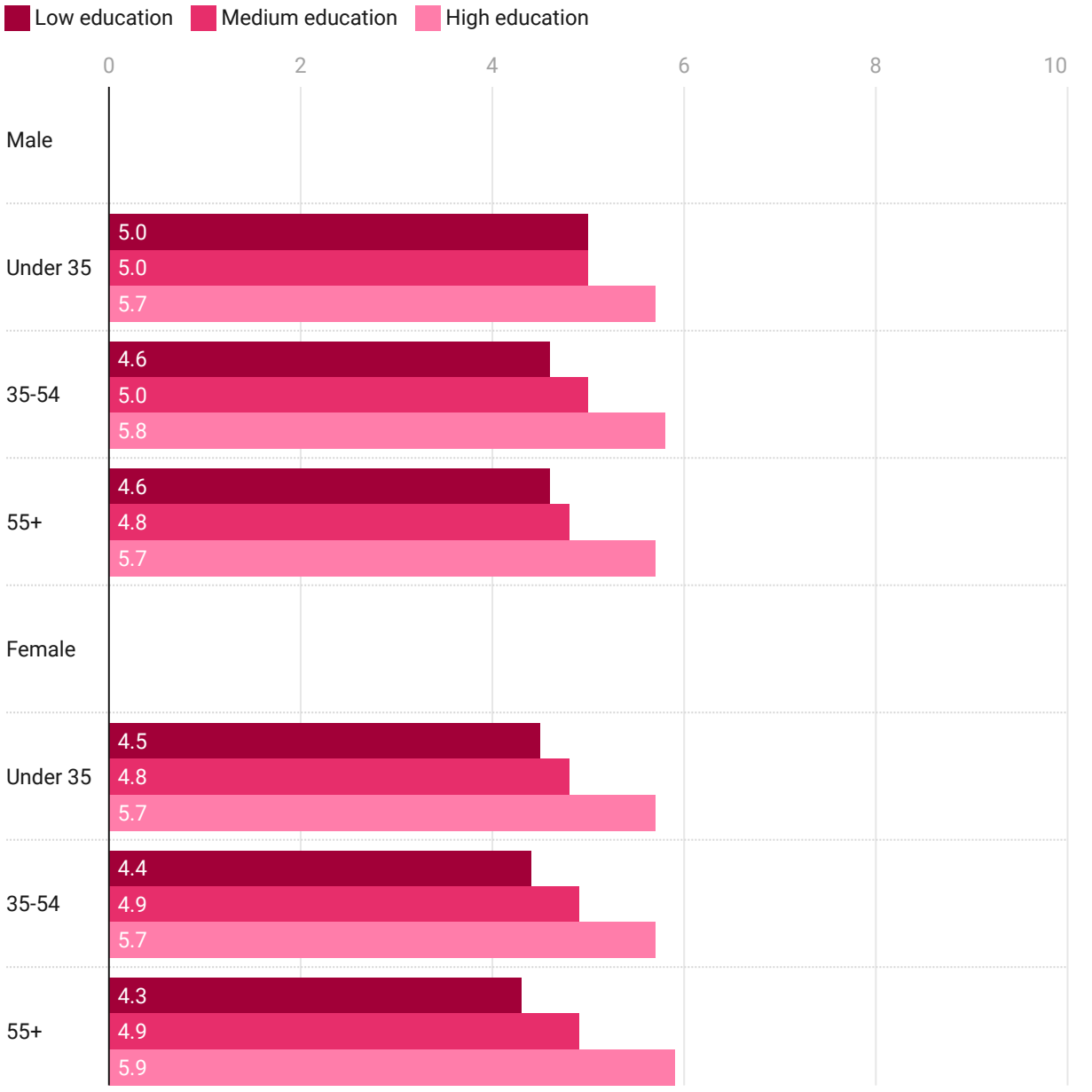
Pooled, weighted data from 23 European countries (Austria, Belgium, Croatia, Cyprus, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Lithuania, Netherlands, Norway, Poland, Portugal, Slovak Republic, Slovenia, Spain, Sweden, Switzerland, and United Kingdom). Values indicate the mean reported score of respondents for the statement "Most people can be trusted or you can't be too careful" in the 11th round of the ESS (2023/24). Responses were given on a scale from 0 (You can't be too careful) to 10 (Most people can be trusted).

In addition to age and gender, educational attainment was also closely associated with generalised trust. Among both men and women across all age groups, trust levels were consistently higher among those with tertiary or post-tertiary education, compared to individuals with lower educational backgrounds.

Among young men (15-34), those with tertiary education reported a mean trust score of 5.7, notably higher than their peers with lower secondary or upper secondary education (both 5.0). This pattern became more pronounced in the older age groups: men aged 35-54 with tertiary education reported an average trust score of 5.8, compared to 5.0 among those with upper secondary and 4.6 with lower secondary education. Similar differences were observed among men aged 55+, where those with the highest education still reported a markedly higher score (5.7) than their peers with lower education (4.6-4.8).

For women, the same trend held true. Among young women (15-34), those with tertiary education reported an average trust score of 5.7, compared to 4.5 and 4.8 for those with lower and upper secondary education, respectively. Women aged 35-54 and those 55+ showed nearly identical patterns, with trust scores reaching 5.7-5.9 among those with tertiary education, compared to around 4.3-4.9 among those with less education.

Figure 13. Trust in others by education, gender and age group



Pooled, weighted data from 23 European countries (Austria, Belgium, Croatia, Cyprus, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Lithuania, Netherlands, Norway, Poland, Portugal, Slovak Republic, Slovenia, Spain, Sweden, Switzerland, and United Kingdom). Values indicate the mean reported score of respondents for the statement "Most people can be trusted or you can't be too careful" in the 11th round of the ESS (2023/24). Responses were given on a scale from 0 (You can't be too careful) to 10 (Most people can be trusted).

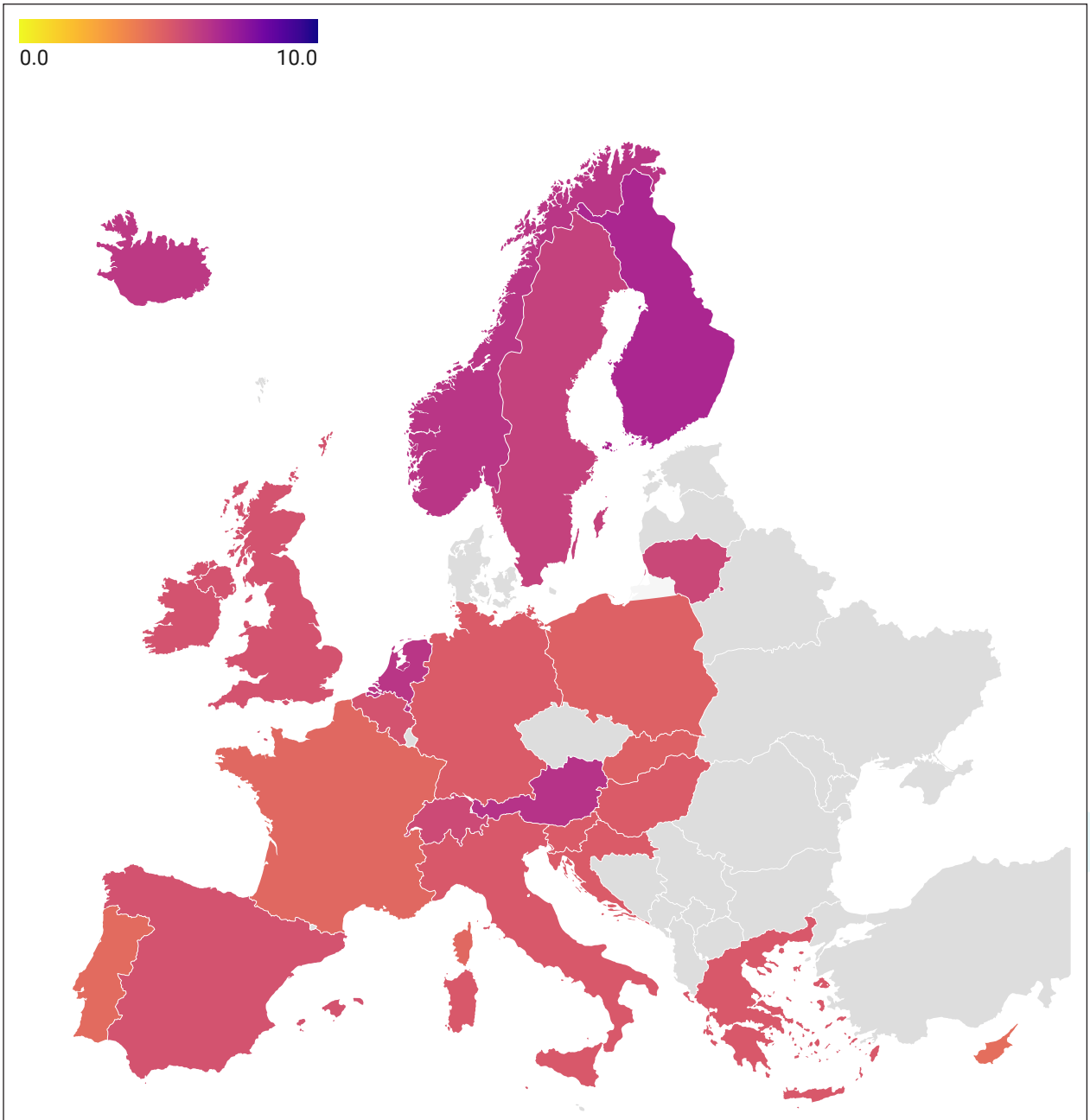
These findings underscore the importance of educational background as a key psychosocial determinant of health. Higher levels of education may foster greater access to diverse social networks, higher levels of civic engagement, and more positive interpersonal experiences – factors that are likely to enhance trust in others and strengthen social cohesion. Conversely, lower education levels may be associated with greater social and economic vulnerability, potentially undermining trust and contributing to broader health inequalities.

Looking specifically at the youngest age group, cross-country comparisons reveal considerable variation in levels of generalised trust across Europe. Among young adults, trust scores ranged from as low as 4.3 in Cyprus to as high as 6.7 in Finland, reflecting differing social and cultural environments that may shape how young people perceive others around them.

Trust levels were lowest in several Southern and Central European countries, including Portugal (4.4), France (4.5), Poland (4.7), and Slovak Republic (4.7). In contrast, Nordic countries consistently reported higher levels of trust among young people, with Norway (6.2), the Netherlands (6.2), Iceland (6.1), and Finland (6.7) at the upper end of the scale. Countries like Switzerland (5.5), the United Kingdom (5.2), and Spain (5.2) reported mid-range trust levels.

These differences suggest that young people's sense of social trust is not only influenced by age or gender, but also by the broader national and cultural context in which they live. Understanding these patterns is important, as social trust is closely tied to mental wellbeing and plays a significant role in shaping community life, social cohesion, and even long-term health outcomes.

Figure 14. Trust in others among younger Europeans



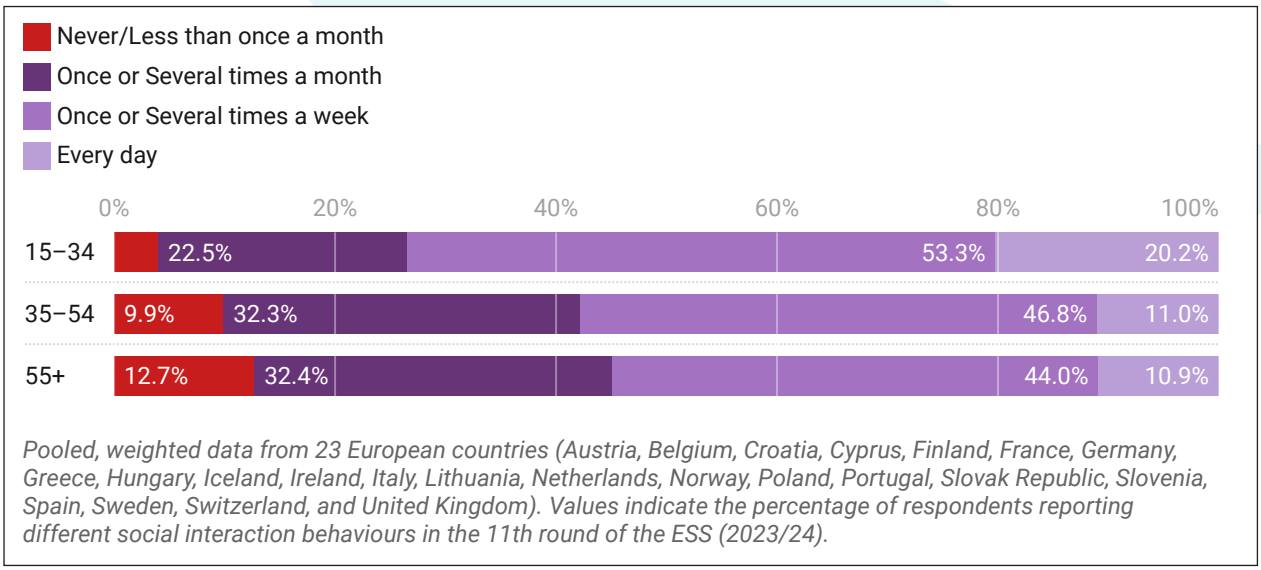
Weighted data from 23 European countries from the 11th round of the ESS survey (2023/24). Values indicate the mean reported score of respondents aged 15–34 years for the statement "Most people can be trusted or you can't be too careful." Responses were given on a scale from 0 (You can't be too careful) to 10 (Most people can be trusted).

The observed differences in trust among young people across Europe may also reflect patterns in social connectedness, such as how often individuals interact with friends, relatives, or colleagues. Data from the ESS (Round 11, 2023/24) show that younger adults (15-34 years) were the most likely to engage in frequent social contact, with 53.3% reporting that they meet socially once or several times a week, and an additional 20.2% doing so every day. This contrasts with older age groups, where only 44% of those aged 55 and over reported weekly social interaction, and just 10.9% met with others daily.

At the other end of the spectrum, infrequent social contact was far more common among older adults. Among those aged 55+, 12.7% reported meeting socially less than once a month or never, compared to just 4% in the youngest group. The 35-54 age group fell consistently in the middle across all frequency categories.

These findings reflect a broader pattern in which younger people tend to be more socially active, which may help explain their higher levels of generalised trust compared to older respondents aged 55+. Regular face-to-face interactions likely reinforce feelings of connection and belonging – key elements of psychosocial wellbeing – and may serve as a protective factor for mental health across the life course.

Figure 15. Socially meeting with friends, relatives or colleagues



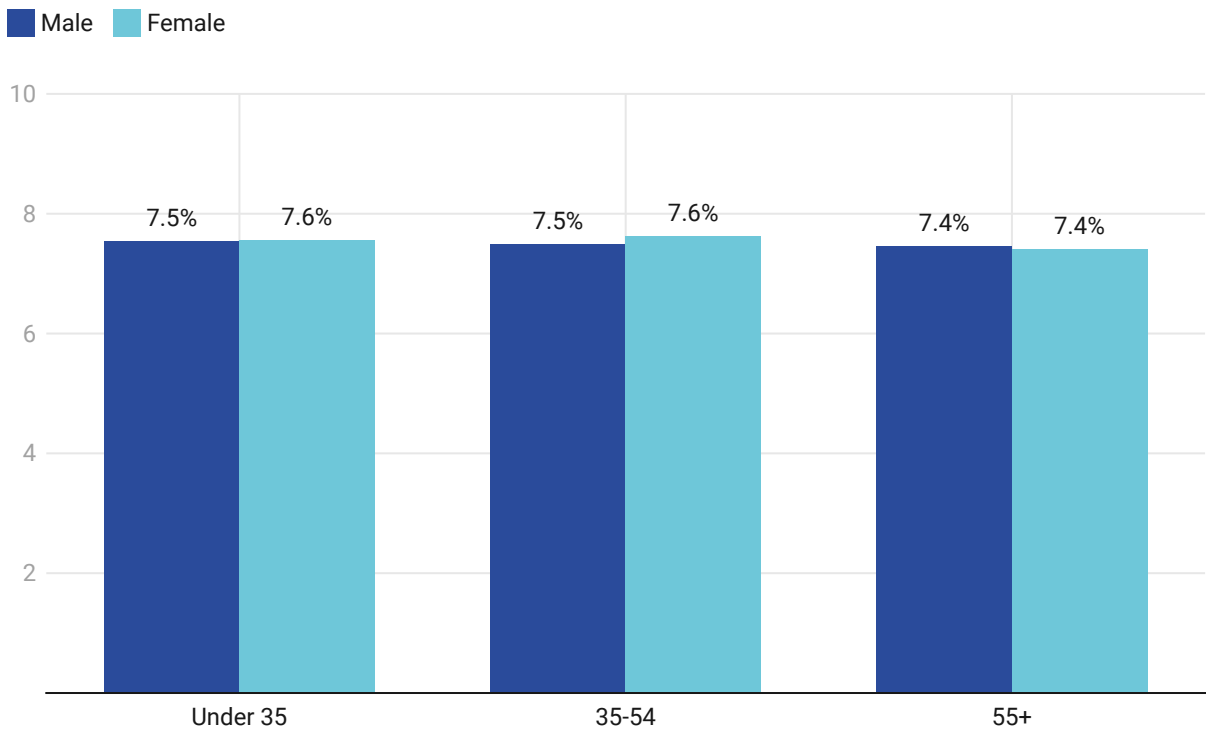
Pooled, weighted data from 23 European countries (Austria, Belgium, Croatia, Cyprus, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Lithuania, Netherlands, Norway, Poland, Portugal, Slovak Republic, Slovenia, Spain, Sweden, Switzerland, and United Kingdom). Values indicate the percentage of respondents reporting different social interaction behaviours in the 11th round of the ESS (2023/24).

Patterns of social interaction and trust appear to align closely with reported levels of happiness across age and gender. In the latest ESS (2023/24), respondents rated their happiness on a scale from 0 (extremely unhappy) to 10 (extremely happy). Overall, happiness levels were consistently high, though subtle differences were observed across demographic groups.

Among men, mean happiness scores showed a slight decline with age: 7.5 in the 15-34 age group, compared to 7.5 of those aged 35-54 and aged 55 and over. For women, the pattern was somewhat different – happiness was highest in midlife at 7.6 for those aged 35-54, while both younger (15-34: 7.6) and older (55+: 7.4) women reported slightly lower scores.

These results suggest that happiness levels are relatively stable across the adult life course, but they may be influenced by age-specific social factors – such as how often individuals engage with others and how much they trust those around them. The slightly lower happiness among older adults, particularly women, may reflect a combination of reduced social interaction and lower generalised trust, both of which are important components of psychosocial wellbeing.

Figure 16. Happiness levels by gender and age group



Pooled, weighted data from 23 European countries (Austria, Belgium, Croatia, Cyprus, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Lithuania, Netherlands, Norway, Poland, Portugal, Slovak Republic, Slovenia, Spain, Sweden, Switzerland, and United Kingdom). Values indicate the mean reported score of respondents for the question "How happy are you?" in the 11th round of the ESS (2023/24). Responses were given on a scale of 0 (Extremely unhappy) to 10 (Extremely happy).

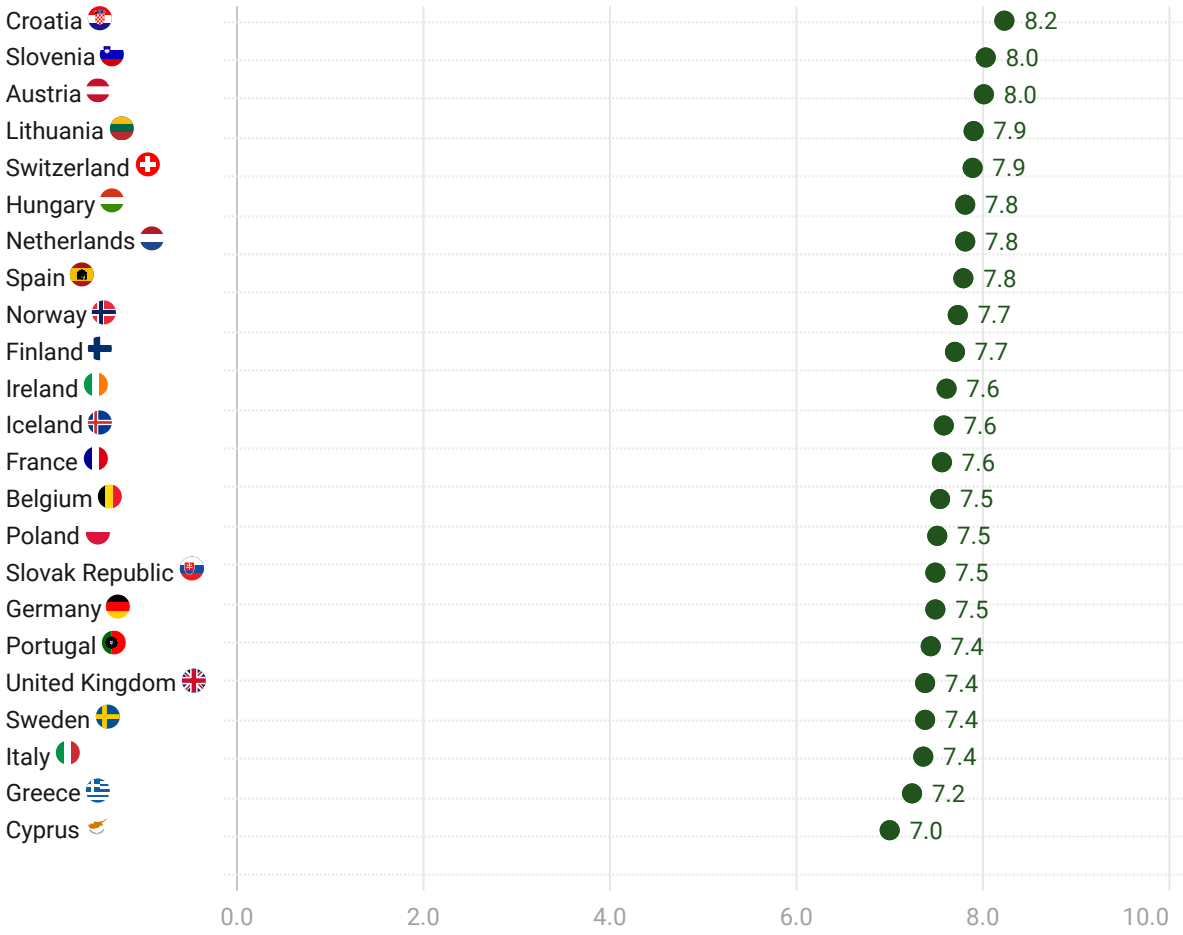
Looking more closely at cross-country differences, the happiness levels of younger adults varied considerably across Europe. While the average scores were relatively high overall, ranging from 7.0-8.2 on a scale from 0 (extremely unhappy) to 10 (extremely happy), the data suggests that national and cultural contexts play an important role in shaping young people's emotional wellbeing.

At the lower end of the scale, countries such as Cyprus (7), Greece (7.2), and Italy (7.4) reported the lowest average happiness scores among young adults, potentially reflecting broader social or economic pressures faced by youth in these societies. Sweden, the United Kingdom (both 7.4), and Portugal (7.4) also reported below-average scores.

In the middle range, countries like Germany, the Slovak Republic, and Poland (all around 7.5) indicated moderate levels of happiness. Slightly higher scores were observed in countries such as France and Ireland (7.6), and several Nordic countries – including Finland and Norway (7.7) – where young people reported above-average levels of happiness.

At the more positive end of the scale, some Central and Northern European countries stood out with notably high happiness scores. These included Austria (8.0), Slovenia (8.0), and Croatia (8.2) – the highest among all countries surveyed. Similarly, young people in the Netherlands and Hungary (both 7.8), and Switzerland (7.9) also reported above-average happiness levels.

Figure 17. Happiness levels of younger Europeans

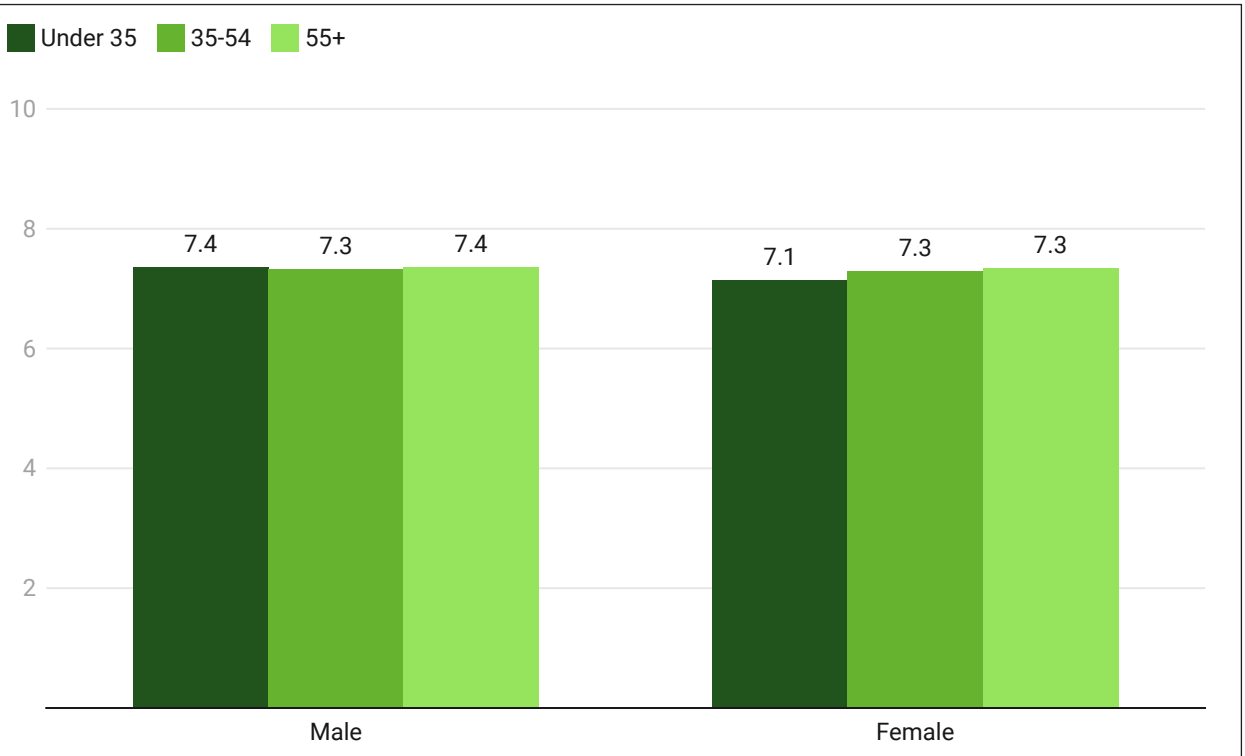


Weighted data from 23 European countries from the 11th round of the ESS (2023/24). Values indicate the mean reported score of younger adults aged 15-34 years for the question "How happy are you?" Responses were given on a scale of 0 (Extremely unhappy) to 10 (Extremely happy).

Taken together, these findings highlight the context-dependent nature of happiness – influenced not only by individual circumstances or age, but also by the broader social, political, and cultural environment. Considered alongside levels of social trust and frequency of social contact, happiness provides a valuable additional lens for understanding the psychosocial wellbeing of Europe's younger generations.

In addition to happiness and social trust, a person's perceived control over their life plays a crucial role in psychosocial wellbeing. A strong sense of control is linked to better coping skills, lower stress levels, and improved physical and mental health outcomes. Feeling that one can influence their circumstances is especially important during times of transition or uncertainty – common experiences for younger adults.

Figure 18. Sense of control by age group and gender



Pooled, weighted data from 23 European countries (Austria, Belgium, Croatia, Cyprus, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Lithuania, Netherlands, Norway, Poland, Portugal, Slovak Republic, Slovenia, Spain, Sweden, Switzerland, and United Kingdom). Values indicate the mean reported score of respondents for the question "How much control do you feel you have over your life in general nowadays?" in the 11th round of the ESS (2023/24). Responses were given on a scale from 0 (No control at all) to 10 (Complete control).

According to ESS Round 11 (2023/24), Europeans across all age groups reported relatively high levels of perceived control in their lives, with average scores between 7.1 and 7.4 on a scale from 0 (no control at all) to 10 (complete control). Among men, mean scores were consistent across age groups: 7.4 for those aged 15-34, and 7.3 for both the 35-54 and 55+ age groups. Among women, younger respondents (15-34) reported slightly lower average control (7.1) compared to older women, whose scores aligned with those of men (7.3 across both older age groups).

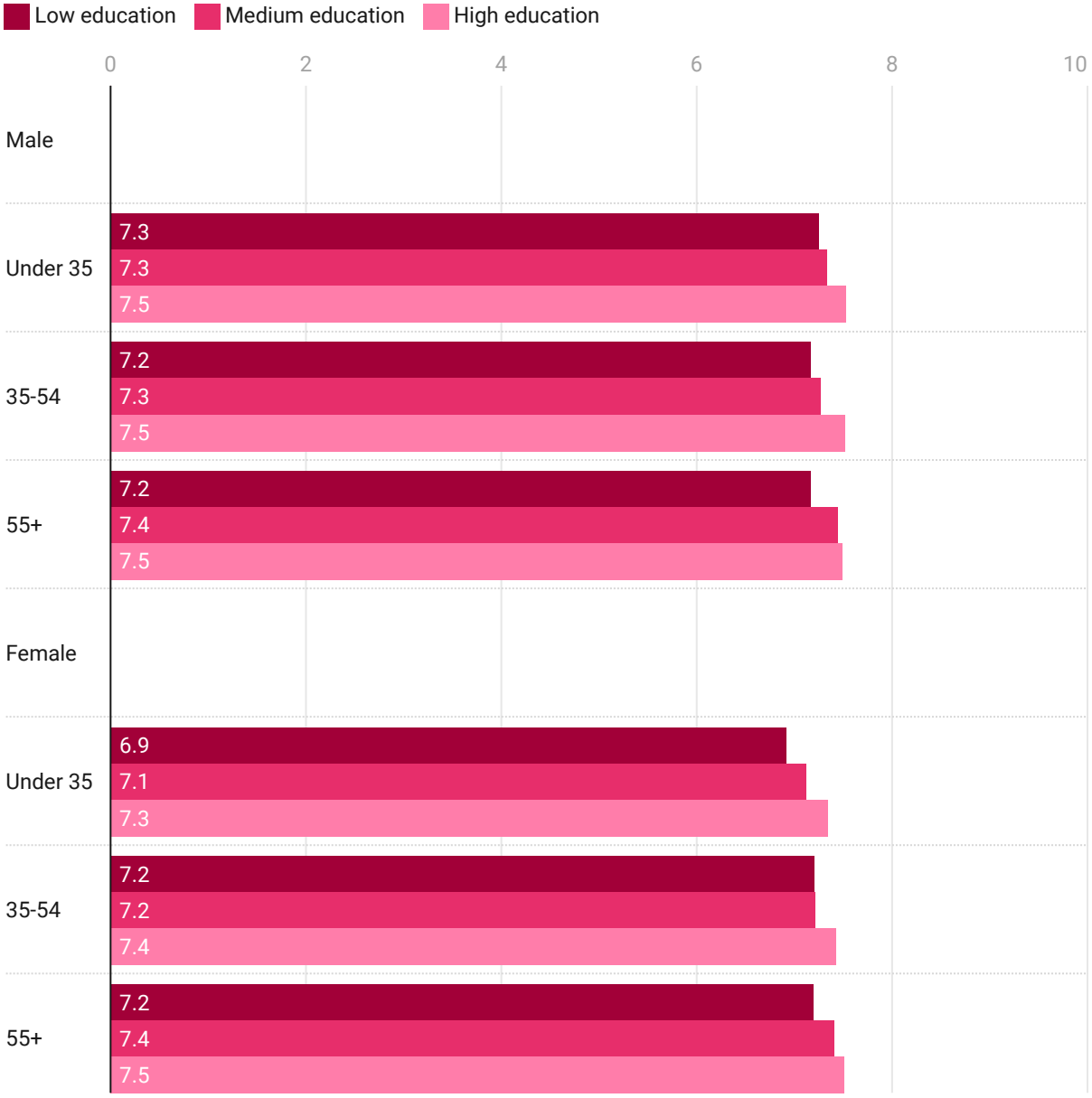
As with other psychosocial indicators, education appears to be closely linked to an individual's sense of control over their life. Across all age groups and genders, higher educational attainment was associated with slightly higher average scores, suggesting that education may foster not only knowledge and skills but also a greater sense of agency and autonomy.

Among young men (15-34), those with relatively high levels of education reported an average score of 7.5, compared to 7.3 for those with medium education and 7.2 for those with lower levels of education. This pattern remained consistent across older age groups. Men aged 35-54 and 55+ with higher education also reported higher levels of perceived control (7.5), while those with lower levels of education maintained scores around 7.2-7.4.

Similar trends were observed among women, though at slightly lower levels overall. Young women with tertiary education reported a sense of control score of 7.3, compared to 7.1 for those with upper secondary and 6.9 for those with lower secondary education.

For older women, the educational gradient remained evident, with scores ranging from 7.2 among the least educated to 7.5 among those with the highest educational qualifications.

Figure 19. Sense of control by education, gender and age group



Pooled, weighted data from 23 European countries (Austria, Belgium, Croatia, Cyprus, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Lithuania, Netherlands, Norway, Poland, Portugal, Slovak Republic, Slovenia, Spain, Sweden, Switzerland, and United Kingdom). Values indicate the mean reported score of respondents for the question "How much control do you feel you have over your life in general nowadays?" in the 11th round of the ESS (2023/24). Responses were given on a scale from 0 (No control at all) to 10 (Complete control).

These results suggest that, while a general sense of agency is present across the population, younger women may feel slightly less empowered in their daily lives. This could reflect broader patterns in gendered expectations, employment conditions, or life stage pressures—all of which can shape perceptions of autonomy and control.

Educational attainment also appears to play a consistent role: across all age and gender groups, those with tertiary education report a stronger sense of control over their lives. Higher education may provide individuals with not only more resources and opportunities but also the confidence and capacity to shape their own life course – contributing to stronger mental resilience and a greater sense of control over daily circumstances. This highlights how both gender and socioeconomic factors contribute to psychosocial wellbeing. Taken together with earlier findings on trust, happiness, and social connection, these patterns offer valuable insights into the social foundations of mental and emotional health across Europe.

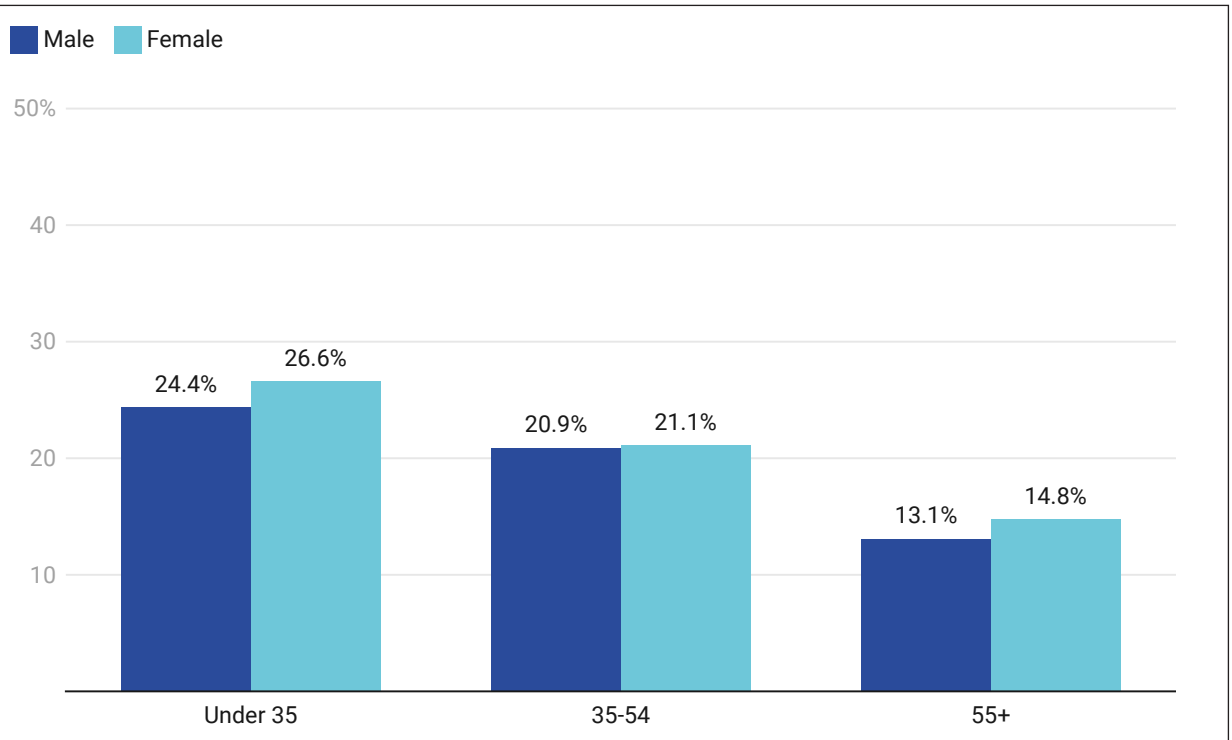
4.3 Material determinants

Material determinants of health refer to the physical and financial conditions in which people live and work. Factors like housing quality, financial stability, and the ability to afford basic needs – such as food or bills – can strongly influence health and help explain inequalities across different groups.

Adequate and safe housing is a key material determinant of health. Poor housing conditions – such as mould, dampness, overcrowding, or lack of basic facilities – can contribute to a wide range of health problems, including respiratory issues, stress, and exposure to extreme temperatures. Data from the 2023/24 ESS reveals that housing problems are widespread among younger adults, with the prevalence decreasing steadily with age.

Among men, 24.4% of those aged 15-34 reported having at least one serious issue with their accommodation, compared to 20.9% of those aged 35-54 and only 13.1% among those aged 55 and older. A similar age-related pattern was observed among women: 26.6% of young women lived in problematic housing conditions, dropping to 21.1% in the middle age group and 14.8% amongst the oldest.

Figure 20. Housing problems in Europe by gender and age group

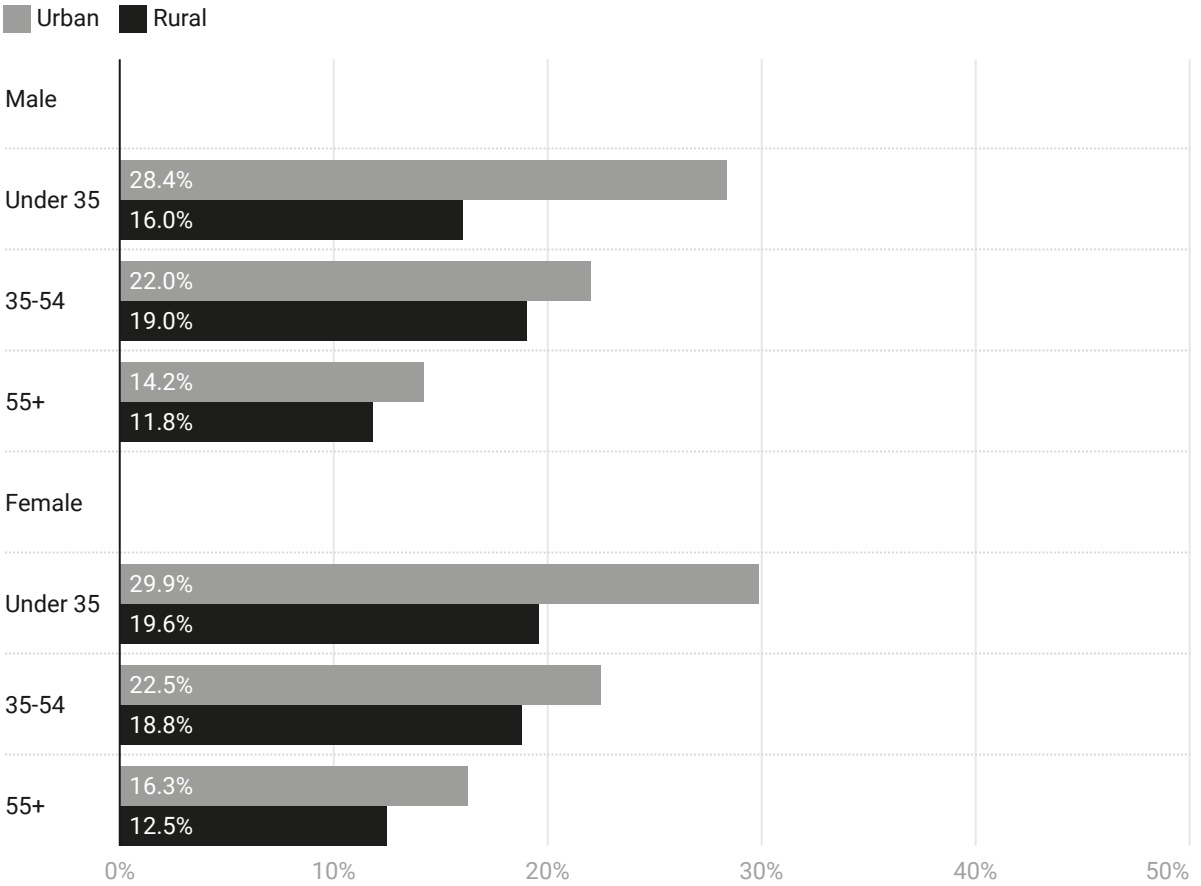


Pooled, weighted data from 23 European countries (Austria, Belgium, Croatia, Cyprus, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Lithuania, Netherlands, Norway, Poland, Portugal, Slovak Republic, Slovenia, Spain, Sweden, Switzerland, and United Kingdom). Values indicate the percentage of respondents having one or more problems with their accommodation (mould or rot in windows, doors or floors; damp walls or leaking roof; lack of indoor flushing toilet; lack of bath and shower; overcrowding; extremely hot or extremely cold) in the 11th round of the ESS (2023/24).

Notably, urban-rural differences were also evident. Across all age groups, urban residents were more likely to report poor housing conditions than those living in rural areas. Among young men aged 15-34, 28.3% of those in urban areas experienced housing problems compared to 16.0% in rural areas. Similarly, 29.8% of young women in urban areas reported issues with their housing, compared to 19.6% in rural areas. These gaps persisted across older age groups, albeit to a lesser extent.

These findings suggest that younger generations, particularly those living in urban settings, are more likely to face housing-related disadvantages. Contributing factors may include unaffordable rental markets, less stable living arrangements, and limited access to quality housing early in life – all of which can have lasting effects on health and wellbeing. Addressing housing inequalities is therefore critical to improving population health and ensuring more equitable living conditions across age groups and regions.

Figure 21. Housing problems by area of residence, gender and age group



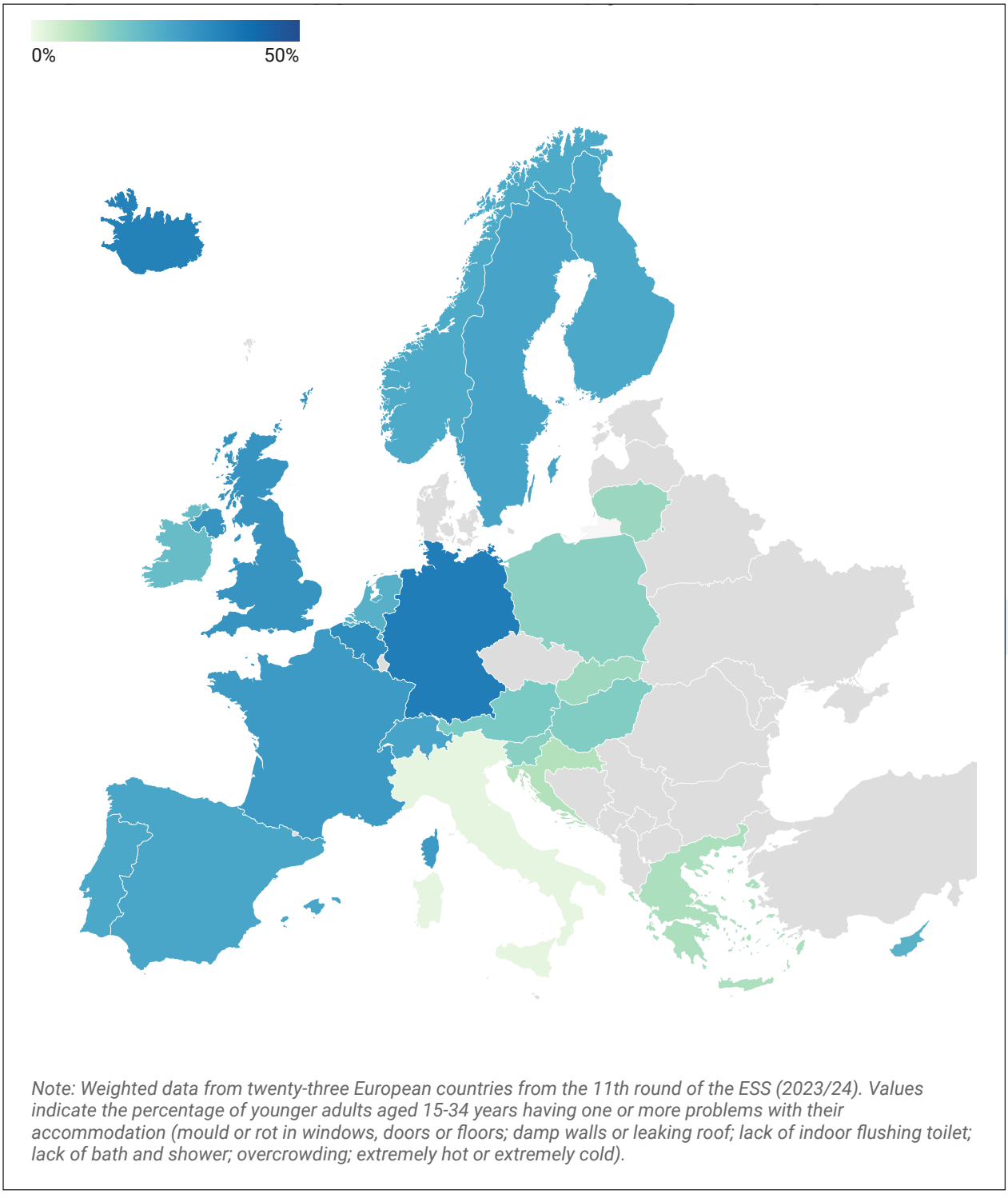
Pooled, weighted data from twenty-three European countries (Austria, Belgium, Croatia, Cyprus, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Lithuania, Netherlands, Norway, Poland, Portugal, Slovak Republic, Slovenia, Spain, Sweden, Switzerland, and United Kingdom). Values indicate the percentage of respondents having one or more problems with their accommodation (mould or rot in windows, doors or floors; damp walls or leaking roof; lack of indoor flushing toilet; lack of bath and shower; overcrowding; extremely hot or extremely cold) in the 11th round of the ESS (2023/24).

The share of young adults facing housing problems varies widely across Europe, reflecting national differences in housing markets, infrastructure, and social support systems. According to 2023/24 data, the prevalence of housing issues among 15-34-year olds ranged from below 10% in some countries to over one-third in others.

At the lowest end, Croatia (8.9%), Greece (9.7%), and Italy (10.5%) reported the fewest young adults experiencing poor housing conditions. Several Central and Eastern European countries, such as the Slovak Republic (11.8%), Lithuania (12.1%), Poland (14.1%), Slovenia (14.2%), and Hungary (15.3%), also had relatively low rates.

In contrast, Western and Northern European countries showed much higher levels. For example, over one in three young adults in Germany (36.4%), Iceland (35.2%), and Belgium (32.2%) reported at least one housing problem. Similarly high rates were observed in the United Kingdom (30.4%), France (28.7%), and Sweden (26.2%).

Figure 22. Housing problems among younger Europeans

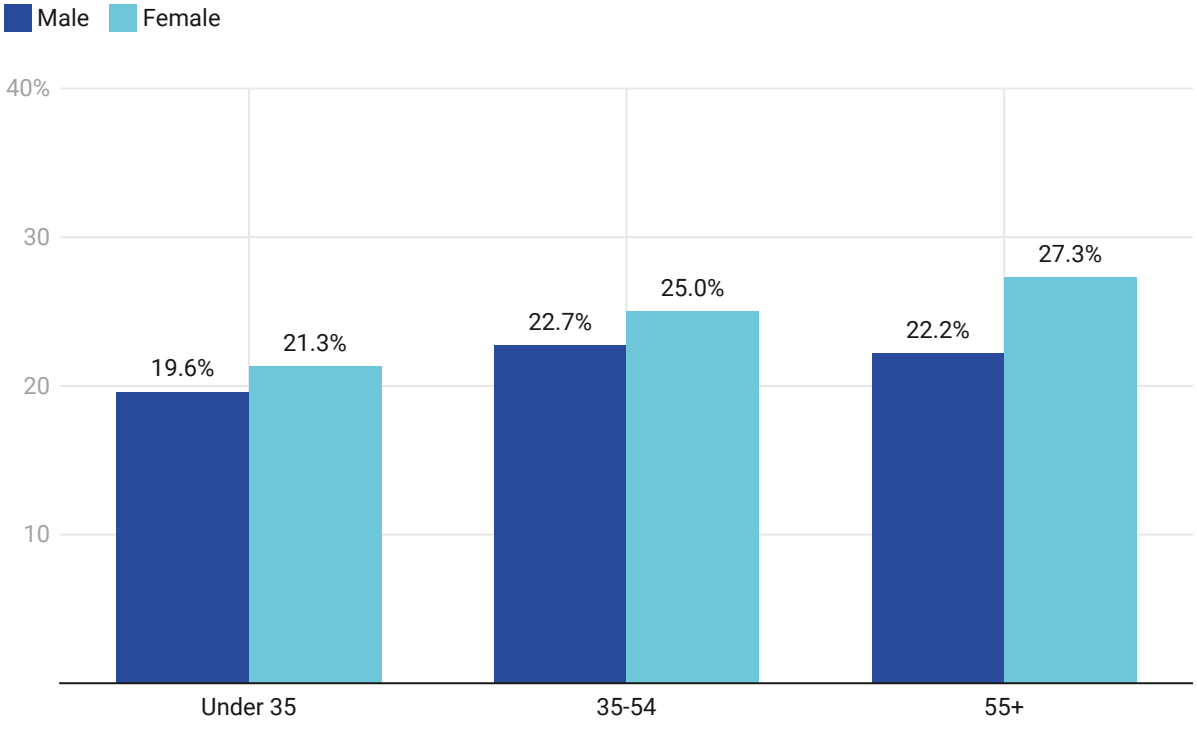


Note: Weighted data from twenty-three European countries from the 11th round of the ESS (2023/24). Values indicate the percentage of younger adults aged 15-34 years having one or more problems with their accommodation (mould or rot in windows, doors or floors; damp walls or leaking roof; lack of indoor flushing toilet; lack of bath and shower; overcrowding; extremely hot or extremely cold).

These findings reveal a striking pattern: younger adults in some of the wealthiest countries in Europe are among the most likely to experience housing issues. This suggests that affordability, urban density, and access to secure housing may present significant challenges for youth even in high-income settings – underscoring the importance of including housing policy in efforts to improve population health and reduce health inequalities.

The ability to meet basic financial needs is a core material determinant of health. Struggling to cover everyday expenses – such as housing, food, transportation, or bills – can contribute to chronic stress, limit access to health-supporting resources, and deepen social inequalities. According to data from the 2019 ISSP, a notable share of Europeans report finding it very or fairly difficult to make ends meet from their household's total income.

Figure 23. Difficulties in making ends meet from total household income by gender and age group

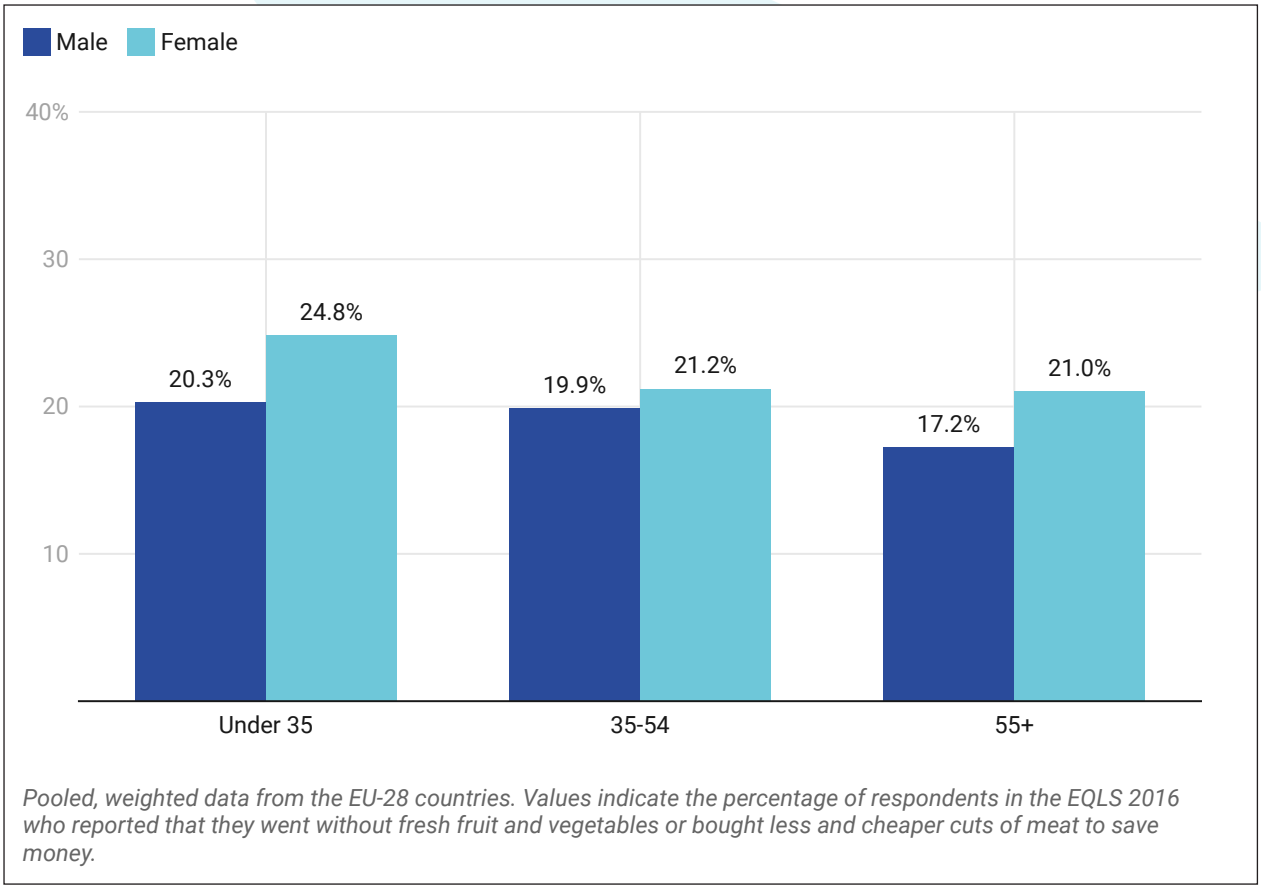


Pooled, weighted data from sixteen European countries (Austria, Bulgaria, Croatia, Czechia, Denmark, Finland, France, Germany, Great Britain, Iceland, Italy, Lithuania, Norway, Sweden, Slovenia, and Switzerland). Values indicate the percentage of respondents in the ISSP 2019 who reported that it is fairly or very difficult to make ends meet with their total household income.

Among men, financial strain was slightly more common in the middle and older age groups. While 19.6% of men aged 15-34 reported financial difficulty, the proportion rose to 22.7% among those aged 35-54 and 22.2% for those 55 and older. Among women, the pattern was more pronounced: 21.3% of young women reported difficulty making ends meet, rising to 25% in the middle age group and 27.3% in the oldest group. These figures suggest that financial vulnerability is widespread across all age groups, but may disproportionately affect older women, likely reflecting long-term gender disparities in income and savings.

Additional data from the 2016 EQLS offers a closer look at specific ways financial pressure impacts everyday life. When asked whether they had gone without fresh fruits and vegetables, or had to buy cheaper or less meat than they wanted, in order to save money, a significant share of both young men and women said yes. Among women aged 18-34, 24.8% reported cutting back on food quality or quantity due to financial constraints, compared to 20.3% of young men. While this behaviour was slightly less common in older age groups, it remained noteworthy, especially among women aged 35-54 (21.2%).

Figure 24. Going without fresh fruit and vegetables or buying less/cheaper cuts of meat to save money by gender and age group

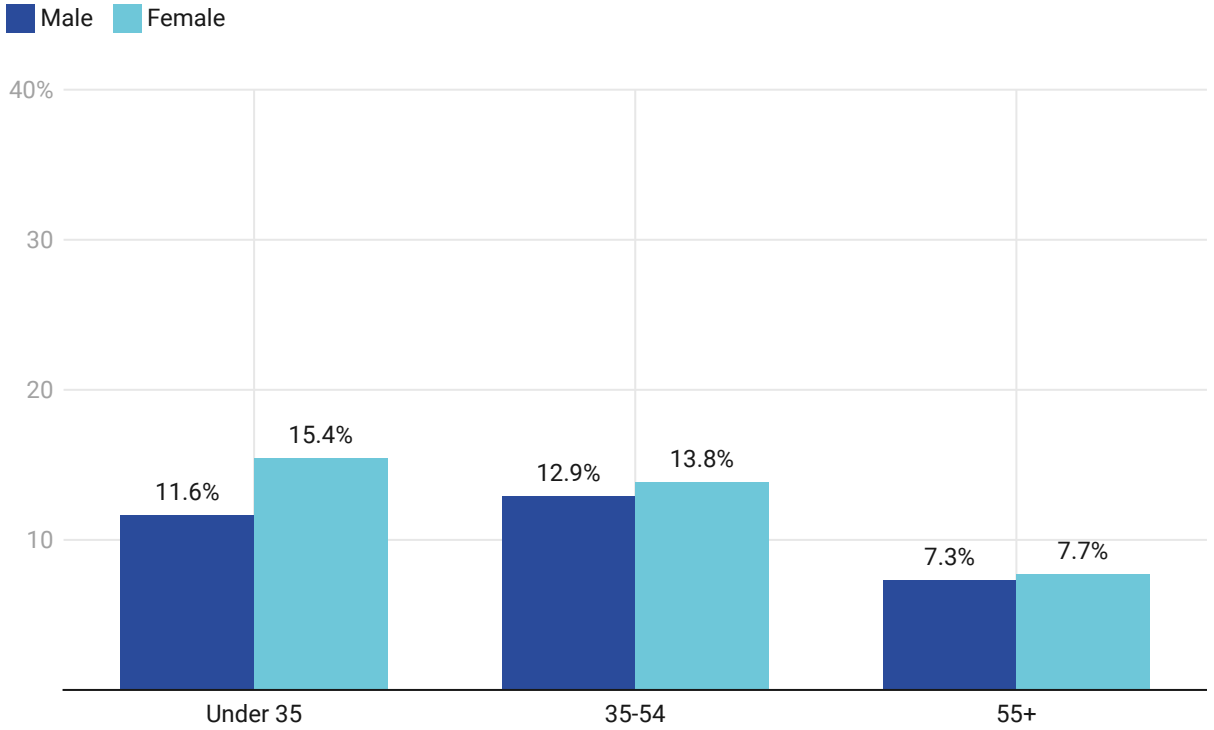


Pooled, weighted data from the EU-28 countries. Values indicate the percentage of respondents in the EQLS 2016 who reported that they went without fresh fruit and vegetables or bought less and cheaper cuts of meat to save money.

Another telling indicator of financial strain is the inability to pay regular bills on time, such as rent, mortgage payments, or utilities. Again, younger adults were among the most affected. According to the 2016 EQLS, 11.6% of men and 15.4% of women aged 18-34 reported having arrears in such essential payments. In comparison, arrears were reported by 12.9% of men and 13.8% of women aged 35-54, and dropped to 7.3% and 7.7%, respectively, in the oldest group (55+).

Taken together, these findings highlight that while financial hardship is not exclusive to any one age group, younger adults – particularly young women – are more likely to face trade-offs that affect health, such as skipping nutritious food or falling behind on essential bills. These forms of material deprivation reflect deeper vulnerabilities and underline the importance of addressing financial security as a key component of health equity.

Figure 25. Having arrears in rent/mortgage payments or utility bills by gender and age group



Pooled, weighted data from the EU-28 countries. Values indicate the percentage of respondents in the EQLS 2016 who reported that they had arrears in rent or mortgage payments, or utility bills, such as electricity, water, gas.

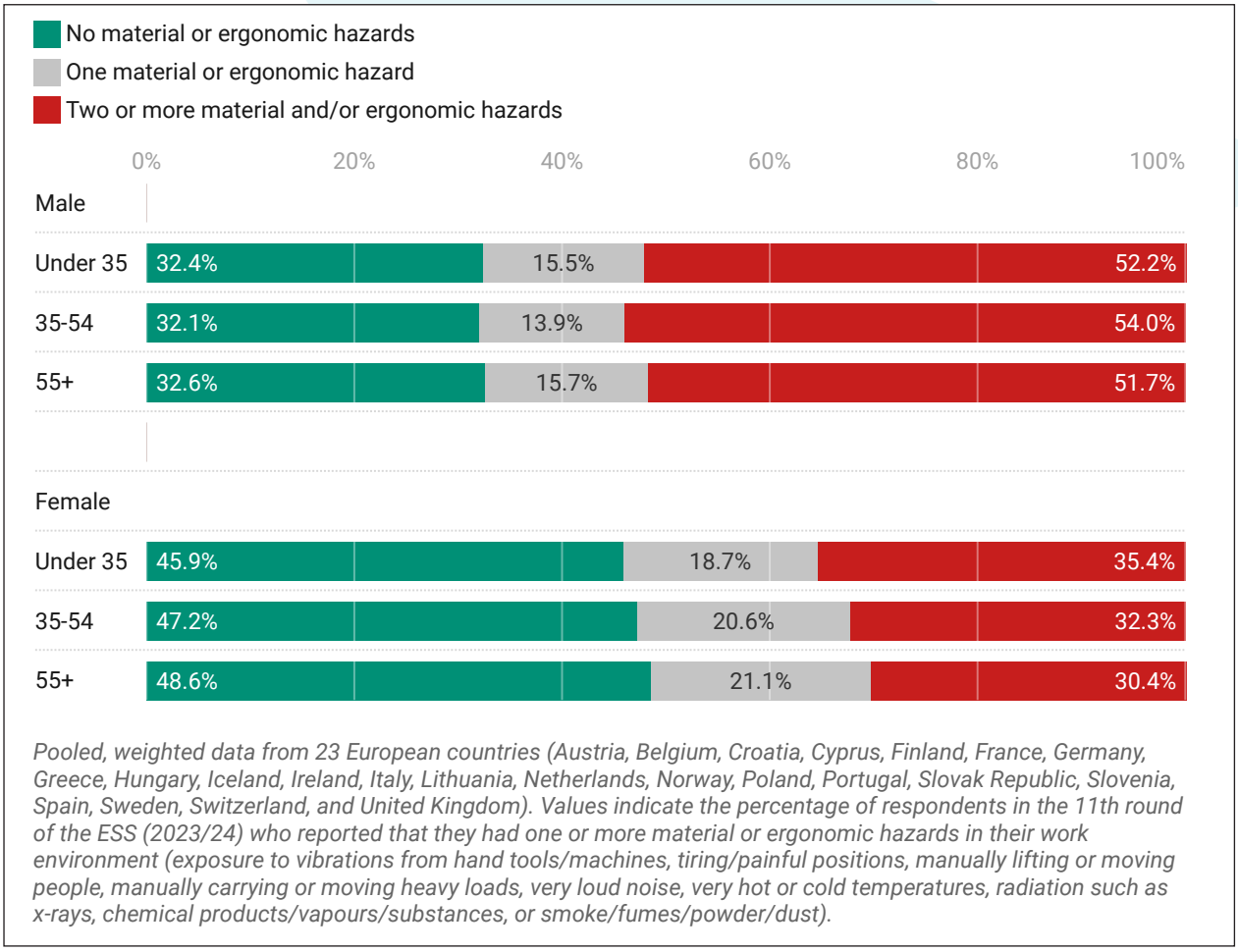
4.4 Occupational determinants

Occupational determinants of health refer to the ways in which people's jobs and working conditions influence their physical and mental wellbeing. This includes both the physical environment – such as exposure to noise, poor ergonomics, or unsafe conditions – and the psychosocial aspects of work, like job stress, limited control over tasks, long working hours, or job insecurity. The ability to maintain a healthy work-life balance is also an important element. Together, these factors influence how work impacts health, both in the short term and over the course of one's working life.

The physical environment of the workplace – including factors like noise, poor posture, repetitive movements, and exposure to uncomfortable temperatures or heavy lifting – plays a significant role in occupational health. Such material and ergonomic hazards can lead to musculoskeletal problems, fatigue, and long-term physical strain.

According to ESS Round 11 (2023/24), a large share of workers across all age groups report being exposed to two or more hazards at work, particularly among men. More than half of male workers – 51.7% of those aged 55+, 54% aged 35-54, and 52.2% aged 15-34 – reported multiple material or ergonomic risks. Only around one-third of men across all age groups reported having no exposure to such hazards.

Figure 26. Material and ergonomic hazards in the work environment by gender and age group



Pooled, weighted data from 23 European countries (Austria, Belgium, Croatia, Cyprus, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Lithuania, Netherlands, Norway, Poland, Portugal, Slovak Republic, Slovenia, Spain, Sweden, Switzerland, and United Kingdom). Values indicate the percentage of respondents in the 11th round of the ESS (2023/24) who reported that they had one or more material or ergonomic hazards in their work environment (exposure to vibrations from hand tools/machines, tiring/painful positions, manually lifting or moving people, manually carrying or moving heavy loads, very loud noise, very hot or cold temperatures, radiation such as x-rays, chemical products/vapours/substances, or smoke/fumes/powder/dust).

Among women, the overall exposure was lower, but still significant. The share of those reporting two or more hazards was highest among the youngest group (35.4%), followed by those aged 35-54 (32.3%) and 55+ (30.4%). Conversely, no exposure to such hazards was reported by 45.9% of young women and rose to 48.6% among women aged 55 and older.

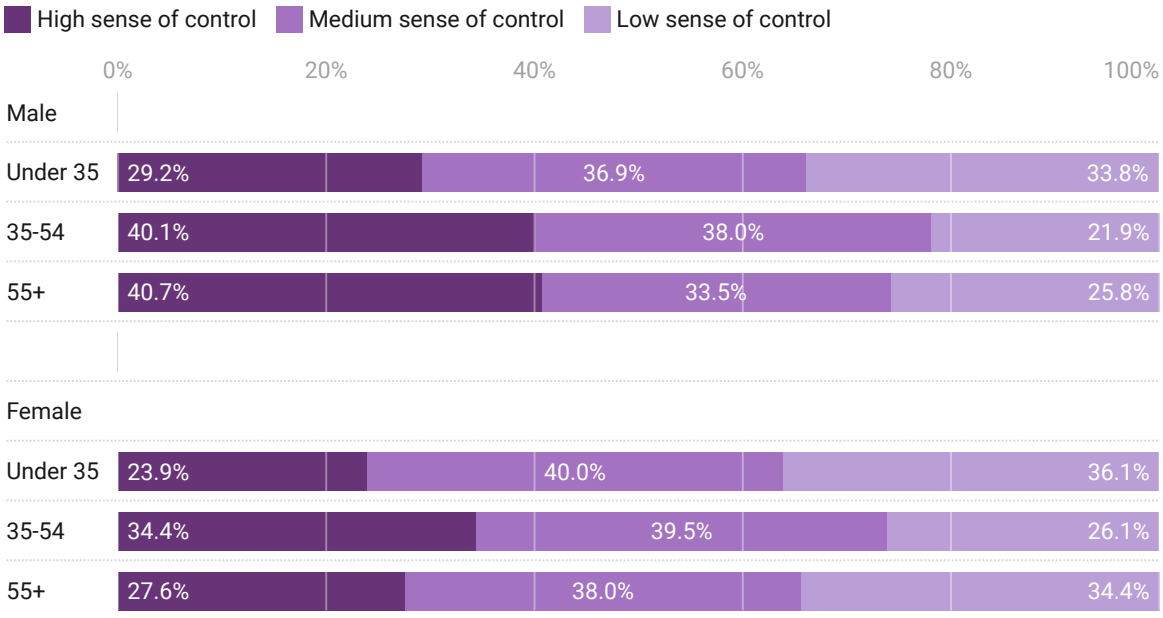
These findings show that, while gender differences in physical job exposure persist, younger women appear more likely than older women to face such work hazards. Among men, high exposure remains consistently widespread across the life course. This underscores the need for stronger occupational safety standards and ergonomic interventions to protect workers' health across sectors and age groups.

Having control over one's work – such as the ability to make decisions, manage one's time, or influence how tasks are performed – is a key psychosocial aspect of occupational health. Low job control has been linked to higher stress, burnout, and negative long-term health outcomes. Data from the ESS (2023/24) show that younger workers are the most likely to experience low levels of control in their jobs, with notable differences between men and women.

Among men aged 15-34, only 29.2% reported high job control, compared to 40.1% in the 35-54 group and 40.7% among men aged 55 and older. In contrast, 33.8% of young men reported low control – the highest among male age groups.

For women, the pattern was similar but even more pronounced. Just 23.9% of women aged 15-34 reported high control over their work, and 36.1% experienced low control – more than any other female age group. Older women, particularly those aged 55 and over, also reported low levels of high job control (27.6%), pointing to a potential accumulation of occupational disadvantage over the life course.

Figure 27. Job control by gender and age group



Pooled, weighted data from 23 European countries (Austria, Belgium, Croatia, Cyprus, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Lithuania, Netherlands, Norway, Poland, Portugal, Slovak Republic, Slovenia, Spain, Sweden, Switzerland, and United Kingdom). Values indicate the percentage of respondents in the 11th round of the ESS (2023/24) who reported that they had high (a score of 8-10), medium, or low (a score of 0-3) control over their job (allowed to decide how daily work is organised and/or influence policy decisions about activities of the organisation – 0 "I have no influence" to 10 "I have complete control").

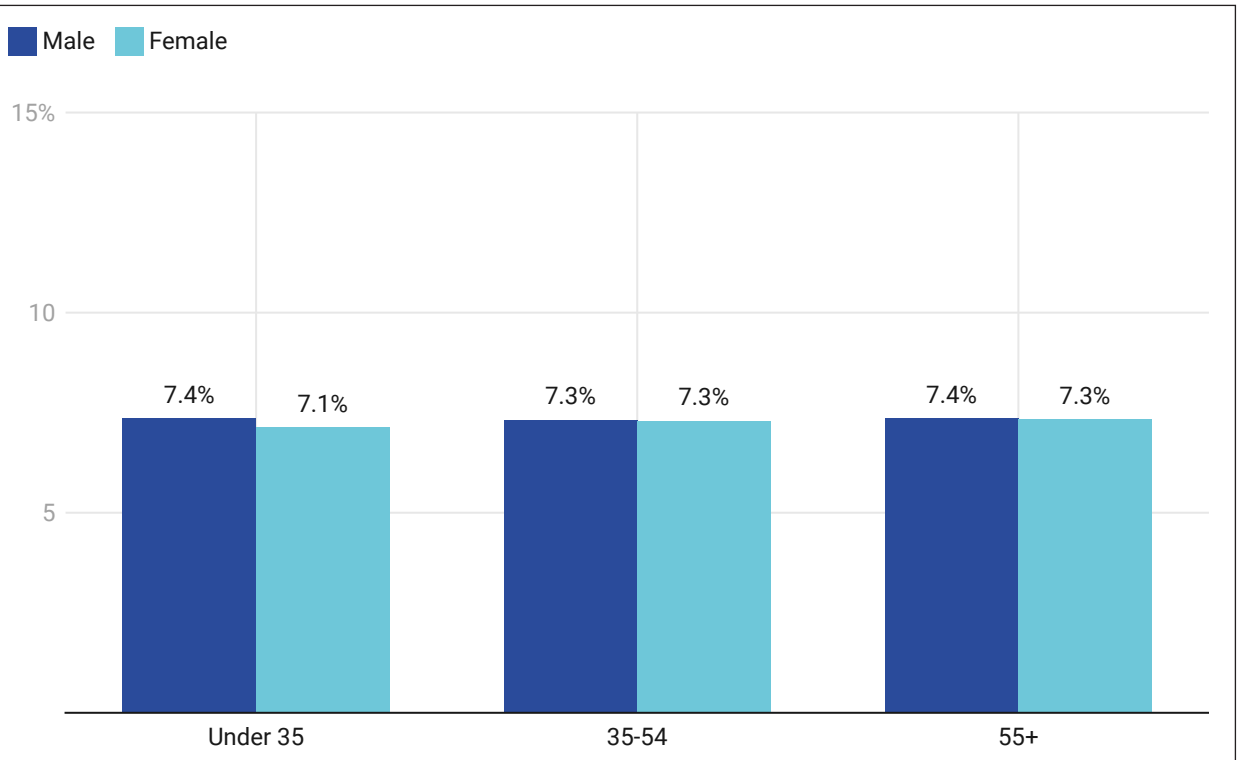
These findings suggest that low job autonomy is most commonly reported by younger and female workers, which may be partly due to their concentration in more junior positions that offer less decision-making power. At the same time, reduced autonomy among older workers could reflect experiences of age discrimination or shifting work-related priorities later in life. Together, these patterns point to structural inequalities in the workplace that influence health across different stages of the life course.

Job insecurity – or the fear of losing one's job – is another important psychosocial factor influencing workers' mental health and overall wellbeing. Persistent uncertainty about employment can increase stress, reduce motivation, and negatively impact long-term health outcomes. According to the 2016 EQLS, younger workers were the most likely to perceive their job as unstable.

Among men aged 15-34, 9.9% reported that it was either very or rather likely they would lose their job in the next six months. This figure dropped to 7.1% among men aged 35-54 and rose slightly again to 8.6% among men aged 55 and older.

Among women, the pattern was slightly different. The youngest age group again reported the highest rate of perceived job insecurity (11.3%), followed by 8.2% in the 35-54 age group and only 5.4% among those aged 55 and over. These findings suggest that younger women are particularly vulnerable to feelings of employment insecurity, possibly reflecting their overrepresentation in temporary, lower-paid, or less stable forms of work. At the same time, the increase in perceived insecurity among older men may indicate concerns about ageism or reduced re-employment opportunities later in life.

Figure 28. Job insecurity by gender and age group



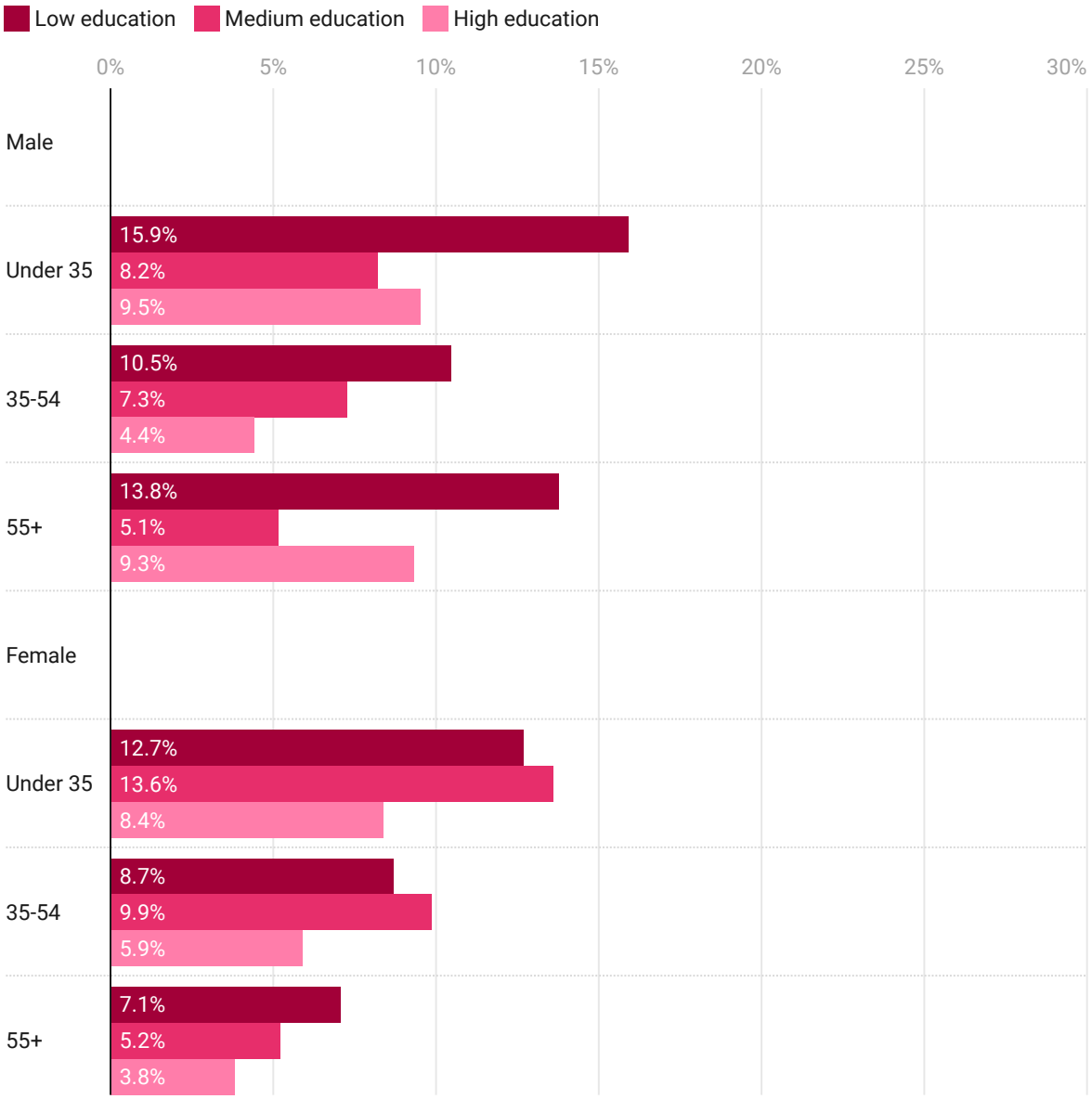
Pooled, weighted data from the EU-28 countries. Values indicate the percentage of respondents in the EQLS 2016 who reported that they were very or rather likely to lose their job in the next six months.

Overall, job insecurity appears to affect a significant share of young adults, adding to the broader picture of occupational challenges they face — including high exposure to physical hazards and limited control over work. Addressing employment precarity, particularly among early-career workers and women, is essential for supporting occupational health and reducing stress-related risks over the long term.

Perceived job insecurity also varied notably by educational attainment, suggesting that socioeconomic position plays a key role in how secure individuals feel in their employment. In the 2016 EQLS, job insecurity was more prevalent among those with lower levels of education, particularly among younger adults.

Among young men (15-34), 15.9% of those with lower secondary education or below felt that losing their job was likely – almost double the rate observed among their peers with upper secondary (8.2%) or tertiary (9.5%) education. This gradient persisted in older age groups, with 10.5% of men aged 35-54 and 13.7% of men aged 55+ with lower education anticipating job loss, compared to only 4.4% and 9.3%, respectively, among tertiary-educated men.

Figure 29. Job insecurity by education, gender and age group



Pooled, weighted data from the EU-28 countries. Values indicate the percentage of respondents in the EQLS 2016 who reported that they were very or rather likely to lose their job in the next six months.

The pattern was similar for women, though with some notable differences. Young women (15-34) with upper secondary education reported the highest perceived insecurity (13.6%), followed by those with lower (12.7%) and tertiary (8.4%) education. For women aged 35-54, perceived job insecurity dropped across all education levels but remained highest among those with upper secondary (9.9%) and lowest among tertiary-educated women (5.9%). Among the oldest women (55+), the risk perception further declined, with just 3.8% of those with tertiary education anticipating job loss, compared to 5.2% and 7.1% for those with upper and lower education, respectively.

These findings suggest that individuals with lower education levels tend to feel more vulnerable in the labour market, likely reflecting differences in job quality, contract stability, and access to social protections. Moreover, even among the younger population, where job insecurity is generally higher, education appears to offer some buffering effect against perceived precarity.

Together with earlier results, this highlights how educational inequalities intersect with age and gender in shaping perceived occupational disadvantage, and underscores the importance of promoting not only access to education but also secure and fair employment opportunities across the life course.

4.5 Healthcare access

Access to healthcare is a critical determinant of health, shaping whether people can receive timely, appropriate, and affordable care when they need it. While many discussions focus on the availability of services, access goes far beyond just having a nearby clinic. It also includes whether people feel they can afford care, whether they can navigate the system easily, and whether they trust the system to provide the best possible treatment, especially in serious situations.

In many cases, barriers to access appear not only as logistical or financial challenges, but as unmet medical needs, where individuals are unable to get the care they require due to cost, waiting times, or system inefficiencies. The perceived quality of healthcare services also plays a major role — if people believe that care is rushed, disorganised, or substandard, they may delay or avoid seeking treatment altogether.

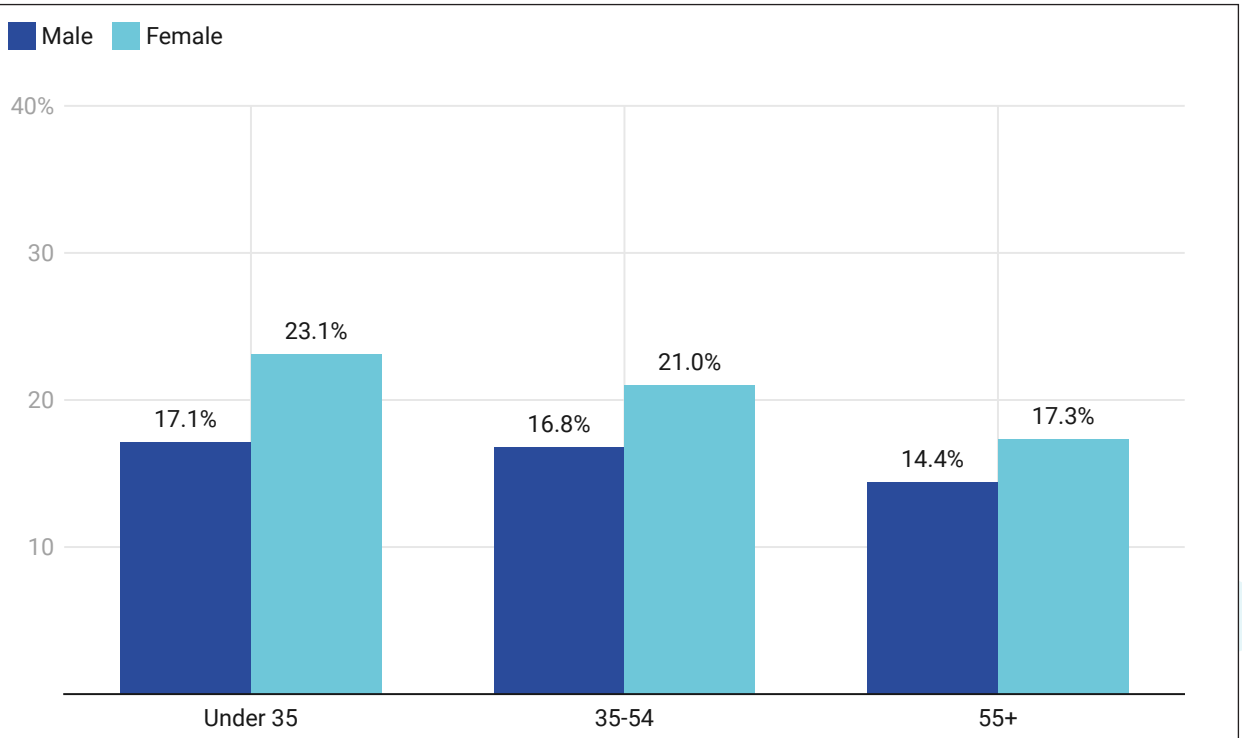
One of the clearest indicators of limited access to healthcare is whether people can get medical help when they need it. Unmet medical needs – being unable to access a consultation or treatment in the past 12 months despite needing it – highlights serious gaps in healthcare systems. These gaps can be due to cost, long waiting times, lack of nearby providers, or other barriers that prevent individuals from receiving timely care.

According to ESS 2023/24 data, younger adults were the most likely to report unmet medical needs, especially young women. Among women aged 15-34, 23.1% said they were unable to receive necessary medical care in the past year – the highest among all age and gender groups. The share was also high among women aged 35-54 (21%) and dropped to 17.3% among those aged 55 and older.

Among men, the pattern was similar but less pronounced. 17.1% of men aged 15-34 reported unmet needs, slightly higher than 16.8% (35-54) and 14.4% among those aged 55+.

These findings suggest that younger adults – especially young women – face the greatest difficulties in accessing healthcare, potentially due to financial limitations, long waiting times, or insufficient pathways to care. This includes possible limited availability of services and/or obstacles related to taking time off work. Addressing these barriers is essential for ensuring equity in accessing and preventing the worsening of health conditions, which is avoidable.

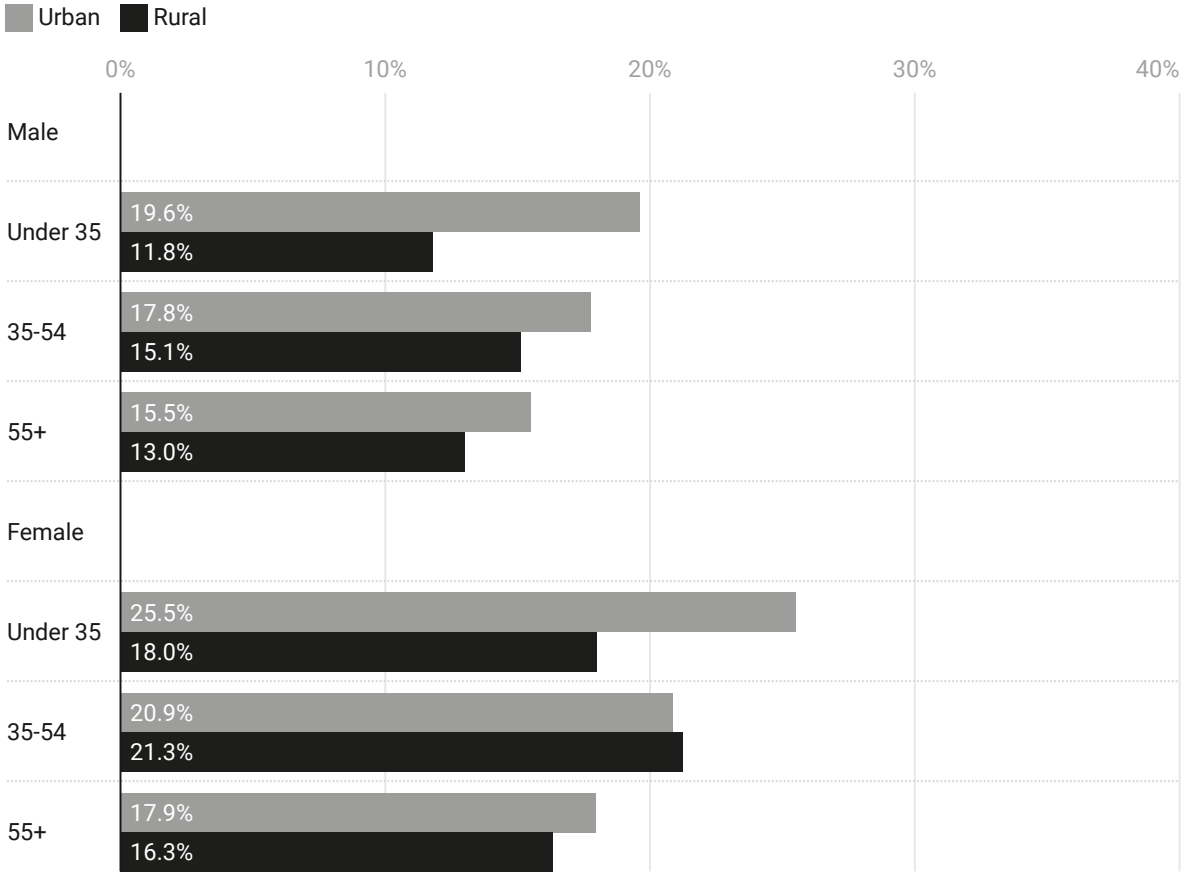
Figure 30. Unmet medical needs (last 12 months) by gender and age group



Pooled, weighted data from 23 European countries (Austria, Belgium, Croatia, Cyprus, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Lithuania, Netherlands, Norway, Poland, Portugal, Slovak Republic, Slovenia, Spain, Sweden, Switzerland, and United Kingdom). Values indicate the percentage of respondents in the 11th round of the ESS (2023/24) who reported being unable to get or medical consultation or treatment they needed in the previous twelve months.

In addition to age and gender differences, place of residence also plays a role in shaping access to care. Across most age groups, individuals living in urban areas were more likely to report unmet medical needs compared to those in rural settings. This pattern was especially clear among young adults: 25.5% of urban women aged 15-34 reported being unable to access needed care in the past year, compared to 18.0% of their rural counterparts. Similarly, 19.6% of young urban men reported unmet needs versus 11.8% in rural areas. This trend was somewhat less pronounced in older age groups, but still present. These findings may reflect longer waiting times or greater demand in urban healthcare systems, or potentially differing expectations and thresholds for seeking care. It also underscores the importance of considering geographic context when addressing barriers to healthcare access.

Figure 31. Unmet medical needs (last 12 months) by area of residence, gender and age group



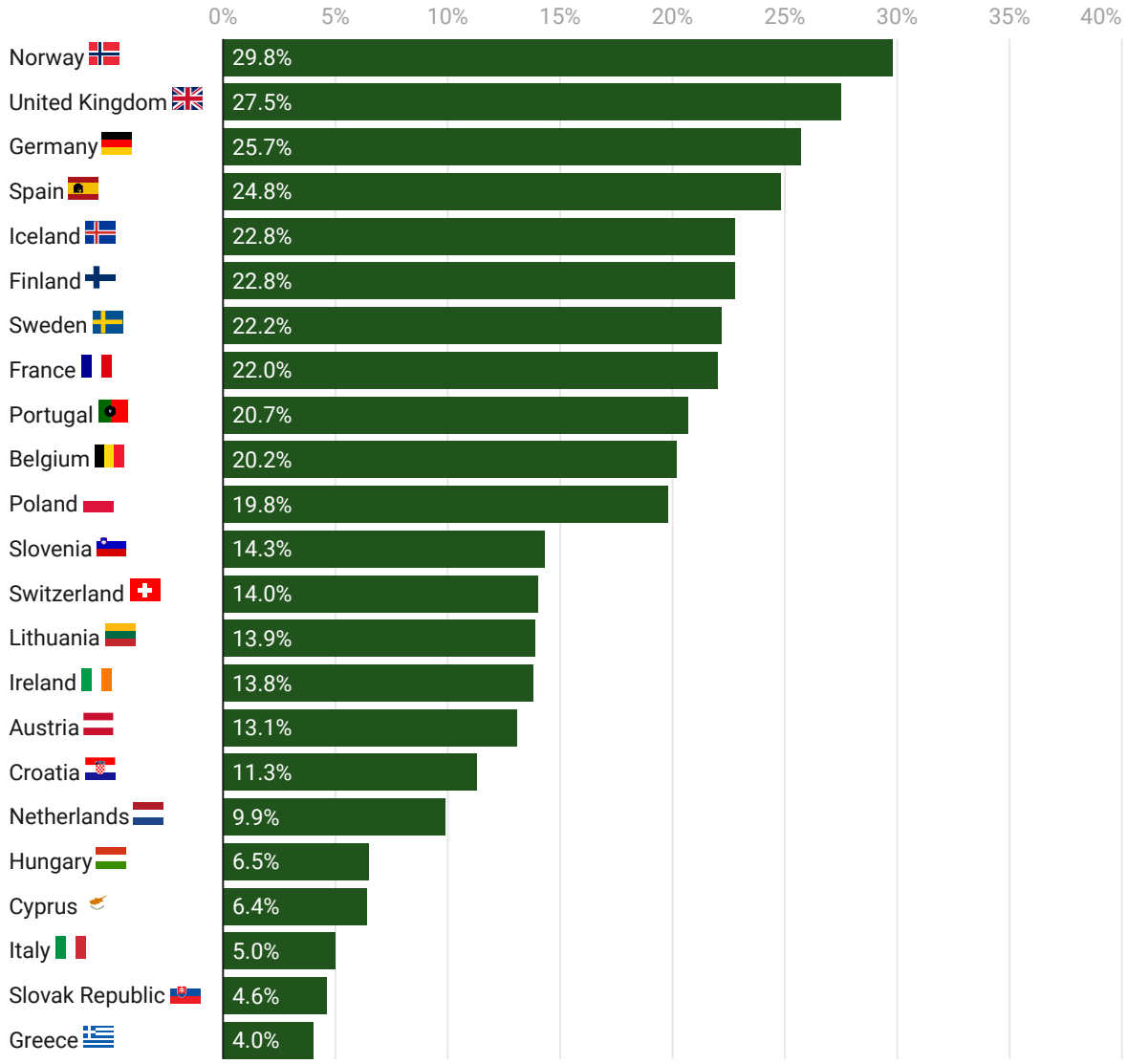
Pooled, weighted data from 23 European countries (Austria, Belgium, Croatia, Cyprus, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Lithuania, Netherlands, Norway, Poland, Portugal, Slovak Republic, Slovenia, Spain, Sweden, Switzerland, and United Kingdom). Values indicate the percentage of respondents in the 11th round of the ESS (2023/24) who reported being unable to get or medical consultation or treatment they needed in the previous twelve months.

While younger adults – particularly those living in urban areas – were generally more likely to report unmet healthcare needs, the extent of this issue varied significantly between countries. Among those aged 15-34, the share of individuals who were unable to access a required medical consultation or treatment in the past year ranged from just a few percent to nearly one-third, reflecting stark contrasts in national healthcare systems.

At the lowest end, Greece (4%), the Slovak Republic (4.6%), and Italy (5%) reported the fewest young adults experiencing unmet medical needs, suggesting that care may be more accessible or that demand is lower in these settings. Similarly low rates were observed in Cyprus (6.4%), Hungary (6.5%), and the Netherlands (9.9%).

In contrast, Nordic and Western European countries reported notably higher levels. More than one in five young adults reported unmet needs in France (22%), Sweden (22.2%), Finland (22.8%), and Iceland (22.8%), with the figure rising to 24.8% in Spain, 25.7% in Germany, 27.5% in the United Kingdom, and peaking at 29.8% in Norway.

Figure 32. Unmet medical need among younger Europeans



Note: Weighted data from the 11th round of the ESS (2023/24). Values indicate the percentage of respondents aged 15-34 years who reported being unable to get or medical consultation or treatment they needed in the previous twelve months.

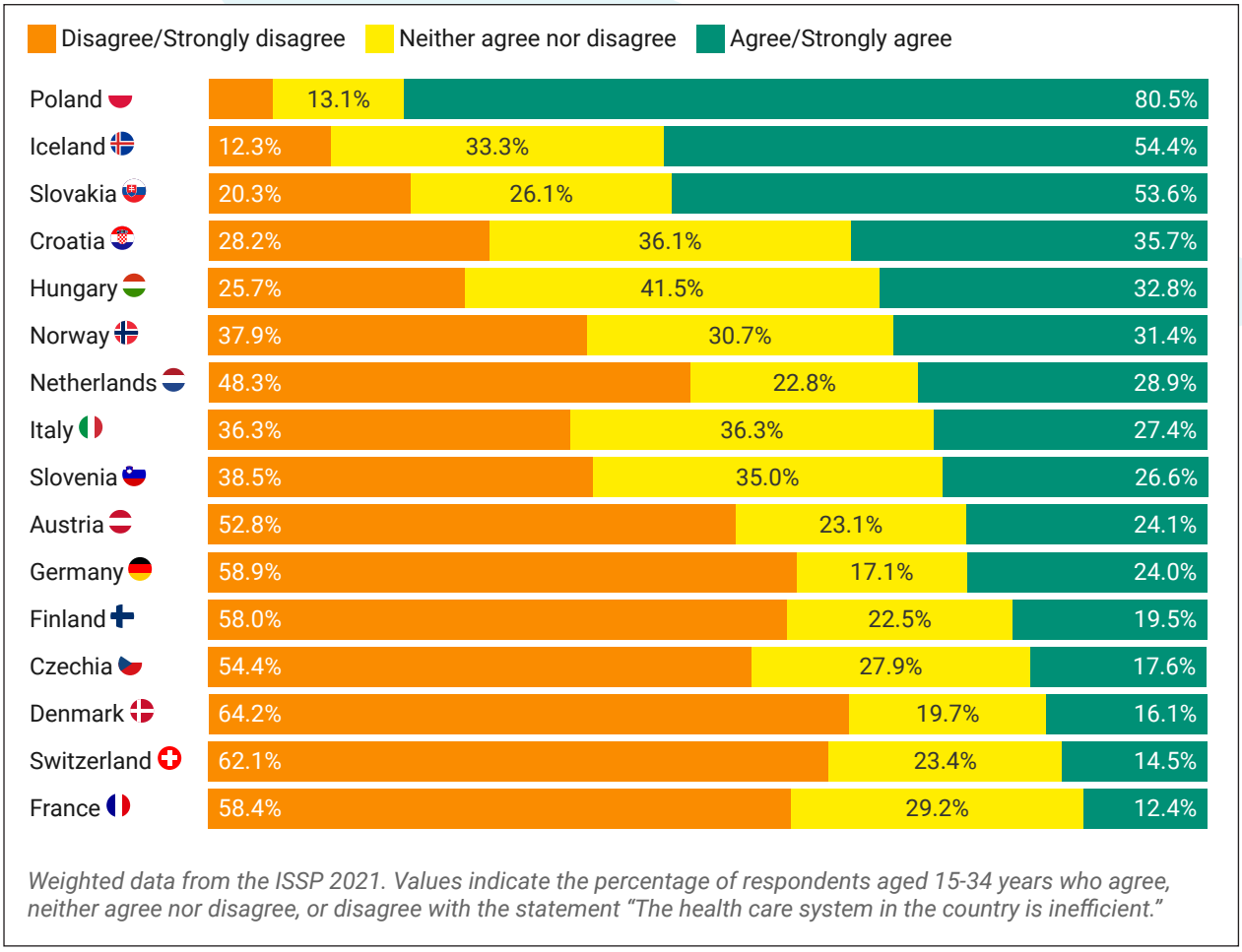
These findings challenge the common assumption that higher-income countries always ensure better healthcare access. In fact, some of the most developed systems in Europe still face access challenges for young people, possibly due to overburdened services, long waiting lists, or structural barriers such as regional disparities or bureaucratic hurdles. Ensuring that healthcare systems are truly accessible – especially for younger populations who may have fewer financial resources or less experience navigating care – remains a critical goal for improving equity.

How people perceive the efficiency of their healthcare system offers insight into overall trust and satisfaction with how care is delivered. When individuals believe the system is disorganised, wasteful, or poorly managed, it can reduce their willingness to seek care and increase frustration with healthcare institutions – even if access is technically available.

Across European countries, there is wide variation in how young adults evaluate the efficiency of their national healthcare systems. In countries such as France (58.4%), Switzerland (62.1%), Denmark (64.2%), and Finland (58.0%), a clear majority of respondents aged 15-34 disagreed or strongly disagreed with the idea that their system is inefficient. This suggests relatively high confidence in the structure and functioning of their healthcare services.

Other countries showed a more mixed picture. In Germany (58.9%) and Austria (52.8%), just over half of young respondents rejected the notion of inefficiency, while substantial shares still agreed – 24% and 24.1%, respectively. In Slovenia (26.6%), Italy (27.4%), and the Netherlands (28.9%), nearly one-third of young adults felt their systems were inefficient, indicating deeper public concerns.

Figure 33. Inefficiency of health care system amongst younger Europeans



Weighted data from the ISSP 2021. Values indicate the percentage of respondents aged 15-34 years who agree, neither agree nor disagree, or disagree with the statement "The health care system in the country is inefficient."

At the other end of the spectrum, perceived inefficiency was widespread in several Central and Eastern European countries. In Norway (31.4%), Hungary (32.8%), and Croatia (35.7%), about one-third of the younger adult population agreed with the inefficiency statement. In the Slovak Republic, over half of young respondents (53.6%) viewed their healthcare system as inefficient. The highest dissatisfaction was reported in Iceland (54.4%) and, especially Poland, where a striking 80.5% of young adults agreed or strongly agreed that their healthcare system is inefficient – the highest level of discontent across all countries surveyed.

These findings reflect not only system performance but also public expectations, past experiences, and cultural standards of service. High levels of perceived inefficiency may signal underlying issues, such as bureaucracy, underfunding, poor coordination, or long waiting times – all of which can undermine the accessibility and effectiveness of healthcare.

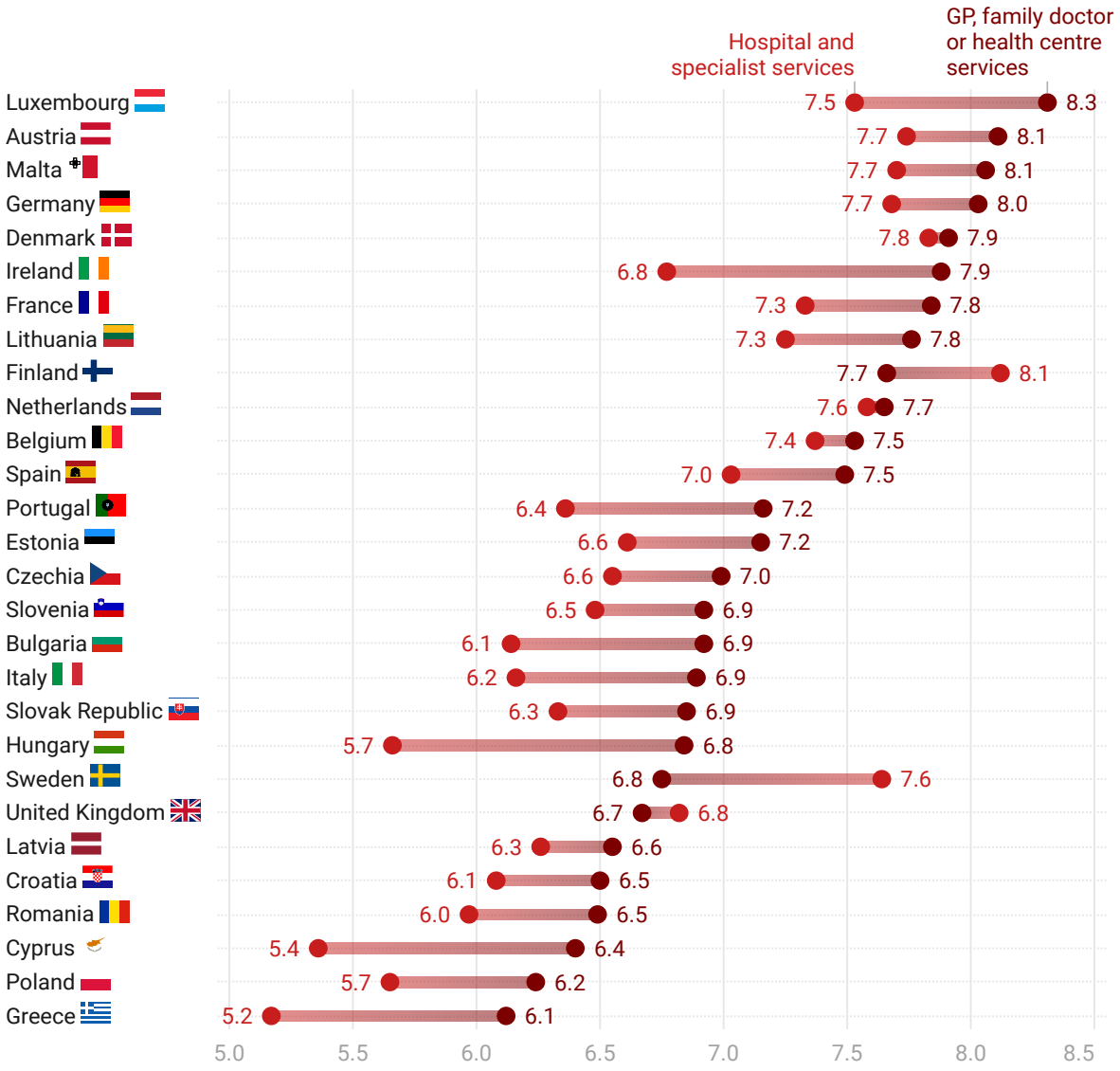
Perceptions of the quality of care are also a key component of healthcare access. Even when services are available, young people may delay or avoid seeking help if they feel the quality of care is low – whether due to rushed appointments, lack of empathy, outdated facilities, or concerns about treatment accuracy. Assessing how young Europeans rate the quality of different parts of the healthcare system provides important insight into trust and satisfaction.

Data from the 2016 EQLS shows that young people across Europe rate hospital and specialist services more critically than primary care. In many countries, ratings for general practitioners (GPs) and local health centres were significantly higher than for hospitals.

At the lower end of perceived quality, Cyprus (6.4 for primary care / 5.36 for hospital care), Poland (6.2 / 5.7), and Greece (6.1 / 5.2) had the lowest ratings overall, especially for hospital and specialist services. These results may reflect ongoing challenges related to healthcare infrastructure, accessibility, or user experience in more intensive care settings.

The largest differences in perceived quality between primary care and hospital services were found in Cyprus (a gap of 1.04 points), Hungary (6.8 / 5.6, gap of 1.2), and Ireland (7.9 / 6.8, gap of 1.1). In these countries, young people appear significantly more satisfied with local or GP-level care than with hospital-based services, suggesting disparities in perceived responsiveness, efficiency, or care quality between levels of the system.

Figure 34. Perceived quality of health care services among younger Europeans



Weighted data from EQLS 2016. Values indicate the mean reported score of younger adults aged 18-34 years regarding the quality of GP, family doctor or health centre services and the quality of hospital and specialist services (from 1 "very poor quality" to 10 "very high quality").

At the top of the scale, young people rated both types of care highly in countries like Austria (8.1 for primary care / 7.7 for hospital care), Germany (8 / 7.7), Malta (8.1 / 7.7), and Luxembourg (8.3 / 7.5) – all showing strong satisfaction across the healthcare system.

Overall, these results suggest that young Europeans are more satisfied with primary care than with hospital and specialist care, and that perceived healthcare quality remains uneven across Europe. Improving the experience of patients – especially in hospital settings – may help strengthen trust in healthcare systems and encourage earlier and more frequent use of care when needed.

Trust in the healthcare system – particularly in its ability to provide high-quality care in serious situations – is a critical component of perceived healthcare access. It reflects not just personal experiences, but also broader beliefs about system efficiency, equity, and quality. When individuals are

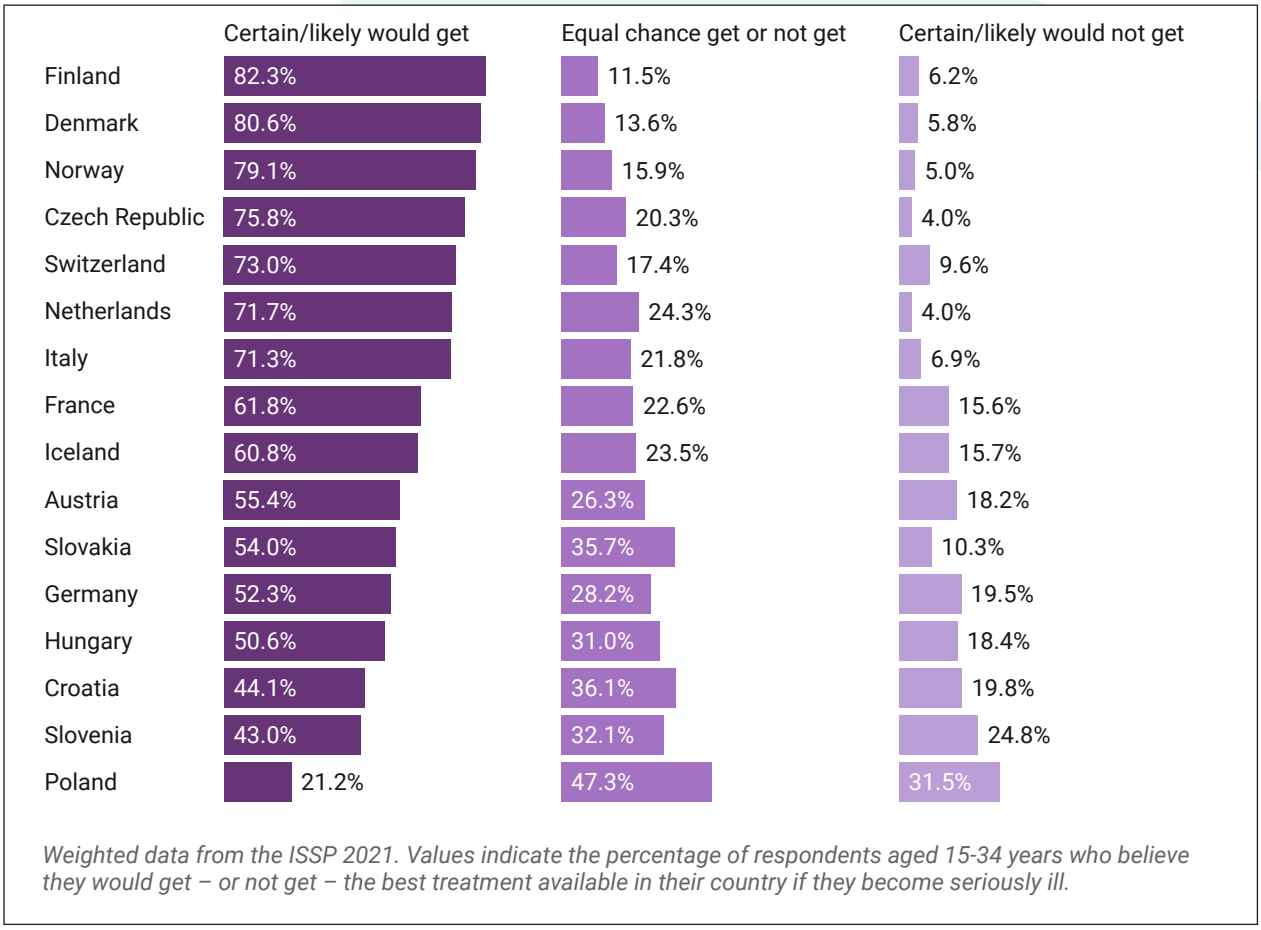
confident they would receive the best available treatment if they became seriously ill, it signals a high level of institutional trust and perceived fairness in healthcare delivery.

Among young Europeans, there are significant differences in this level of trust across countries. In Finland (82.3%), Denmark (80.6%), Norway (79.1%), and the Netherlands (71.7%), the vast majority of young respondents said it was likely or certain they would receive the best treatment if seriously ill. The Czech Republic (75.8%), Switzerland (73%), and Italy (71.3%) also ranked high in treatment confidence.

In contrast, Eastern and Central European countries showed much lower levels of confidence. Only 54% of Slovakian and 50.6% of Hungarian young adults believed they would likely receive the best care. Confidence dropped further in Croatia (44.1%), Slovenia (43%), and Poland, where just 21.2% of young people expressed trust in receiving the best possible treatment – with over 30% saying it was unlikely or certain they would not.

These perceptions highlight a trust gap in parts of Europe, often overlapping with countries reporting higher unmet medical needs, greater financial strain, or weaker perceived efficiency in the healthcare system. Building trust through better quality, accessibility, and equity in healthcare is essential to ensure young people engage confidently with medical services, especially in moments of serious need.

Figure 35. Would get the best treatment available in the country if becoming seriously ill – the opinion of younger Europeans



Weighted data from the ISSP 2021. Values indicate the percentage of respondents aged 15-34 years who believe they would get – or not get – the best treatment available in their country if they become seriously ill.

5 Conclusion

Across Europe, the health and wellbeing of young people are shaped by a complex interplay of social, economic, and systemic factors. While self-rated health levels are generally high among younger adults, deeper analysis reveals growing inequalities and vulnerabilities across key domains. In particular, educational attainment plays an important role: young adults with lower levels of education are significantly more likely to report fair or poor self-rated health compared to their peers with higher levels of education.

In terms of behavioural determinants, young people engage in healthier habits, such as lower smoking rates and greater physical activity than older generations. However, their diets often remain suboptimal, and average BMI values in some countries approach or exceed the threshold of being overweight. Educational differences in BMI among young adults were relatively modest, but slight variations still suggest that social background may play a role in shaping health-related behaviours and outcomes.

Psychosocial factors – including trust in others, frequency of social contact, and happiness – show that while many young adults maintain strong social networks and report relatively high wellbeing, these measures vary considerably across countries and are closely linked to broader social cohesion. Educational background was also found to influence key psychosocial indicators, with higher education associated with greater trust and a stronger sense of control over life. Moreover, while average levels of perceived life control were generally stable across age groups, young women consistently reported lower scores, pointing to subtle but persistent gendered disparities in perceived autonomy.

When it comes to material conditions, many young people face unstable housing, financial insecurity, and a need to compromise on essentials like food. These struggles often reflect unaffordable living costs and limited social protections early in life. Area of residence also played a role, with young adults living in urban settings more frequently reporting poor housing conditions than those in rural areas.

Occupational determinants reveal that younger workers are more exposed to physical job hazards and report lower control over their work – especially women. In addition, younger workers – particularly those with lower educational attainment – more frequently reported job insecurity, with many anticipating potential job loss within the next six months. Such conditions may not only undermine immediate health and work-life balance, but also have long-term consequences for career progression and chronic stress.

Finally, in terms of healthcare access, younger Europeans are more likely to report unmet medical needs, especially young women. Trust in receiving quality care – or in receiving the best treatment when seriously ill – varies widely across Europe, with some of the highest doubts found in countries with lower perceived efficiency and poorer material conditions. Unmet needs were also shaped by geography: young people living in urban areas reported higher levels of unmet medical care than those in rural settings, suggesting that barriers to access are not only systemic, but also spatial.

Altogether, the findings highlight that while many young Europeans report favourable health outcomes overall, their health and wellbeing are shaped by interrelated social, economic, and structural conditions. These inequalities – influenced by their broader social environments – may hinder the collective potential of Europe's youth and signal that many countries still have progress to make in achieving health equity. Addressing these underlying determinants is essential for promoting wellbeing, resilience, and opportunity in the next generation – and ensuring no young person is left behind in Europe's pursuit of health for all.

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