EuroHealthNet CHAIN

Summary report

Social inequalities in health in the EU

Are countries closing the health gap?

About this report

This is a short version of the report 'Social inequalities in health in the EU' (September 2025), written by EuroHealthNet in collaboration with the Centre for Health Equity Analytics (CHAIN).

The report offers a comprehensive analysis of social inequalities in health across Europe, combining quantitative insights from the European Social Survey with policy expertise and in-depth case studies from EuroHealthNet's members.

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

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

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

The full EuroHealthNet-CHAIN report 'Social inequalities in health in the EU' (September 2025) is available online.

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What are social inequalities in health?

Europeans live longer than ever before, with an average lifespan of 81 years.[1] Yet, these averages hide a harsher reality. Health and wellbeing are unevenly distributed, and many people face serious obstacles to good health. Those with lower incomes or less education are less likely to live long, healthy lives.

Based on the latest comparable data from across Europe, this report confirms both the scale of health inequalities and the social and economic forces driving them. These health gaps undermine our shared European values, weaken economic competitiveness, and reduce resilience in the face of geopolitical and environmental crises.

This report sets out clear, evidence-based actions to close these gaps, strengthening Europe's cohesion and making good health a reality for all, not a privilege for the few.

Health inequalities are differences in people's health linked to social disadvantage.

They are caused by obstacles to health such as poverty, discrimination, lack of power, and unequal access to the resources that help people stay healthy. These include fair jobs, safe environments, quality education, housing, healthcare, and social support.[2] These factors are called **the social determinants of health**.

[1] Eurostat (2023). Mortality and life expectancy statistics.

[2] Braveman, P. (2025). Health inequalities, disparities, equity: what's in a name? American Journal of Public Health, 115(7), 996–1002.

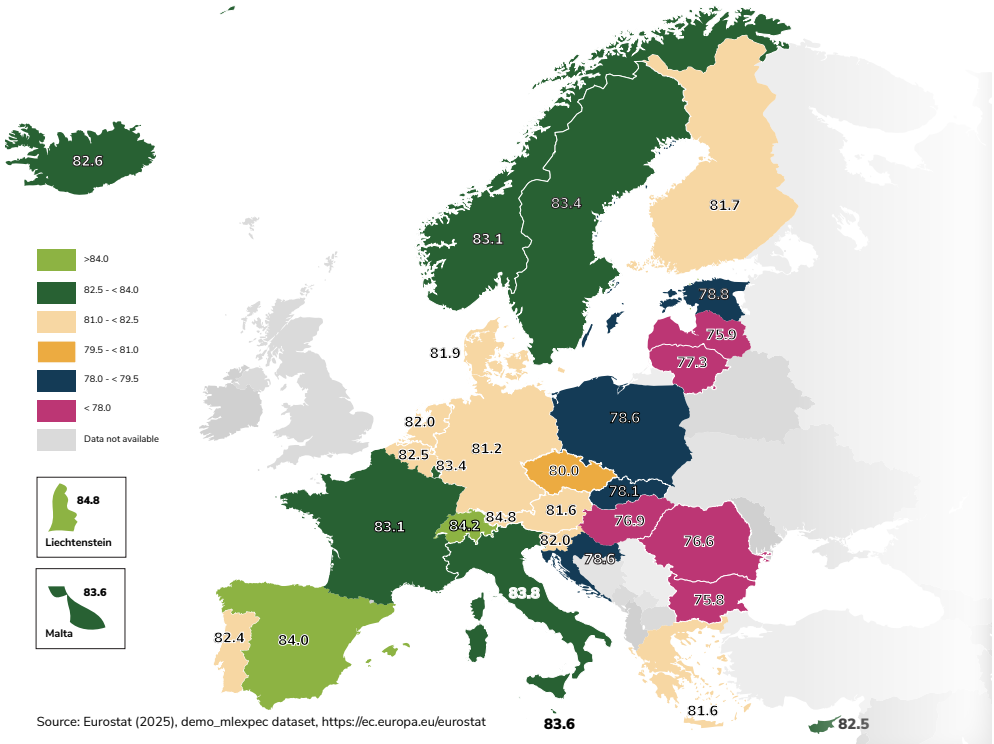
Living longer does not mean living healthier

Even as people in Europe are generally healthier than in the past, not everyone is living longer in good health.

People in the EU now live an average of 81.4 years. Yet, a child born in Spain—the country with the highest life expectancy (84 years)—can expect to live more than eight years longer than a child born in Bulgaria, where life expectancy is 75.8 years.[3]

The number of years lived in good health varies even more. In Malta, people can expect around 71 years in good health, compared with only 53 years in Latvia.[4]

Life expectancy at birth 2023 (years)



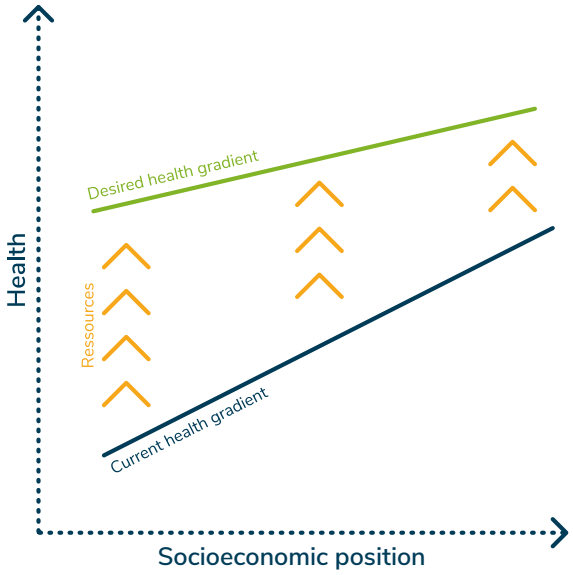
Source: Eurostat (2025), demo_mlexpec dataset, https://ec.europa.eu/eurostat

Data also reveals sharp differences within countries. The European Social Survey (ESS) shows that people in lower socioeconomic groups are twice as likely to report poor health as those in higher groups. The higher someone's position in society, the more likely they are to live a long and healthy life, a pattern known as **the social gradient in health**.

[3] Eurostat. (2023). Mortality and life expectancy statistics.

[4] Eurostat. (2023). Healthy life years statistics.

Social gradient

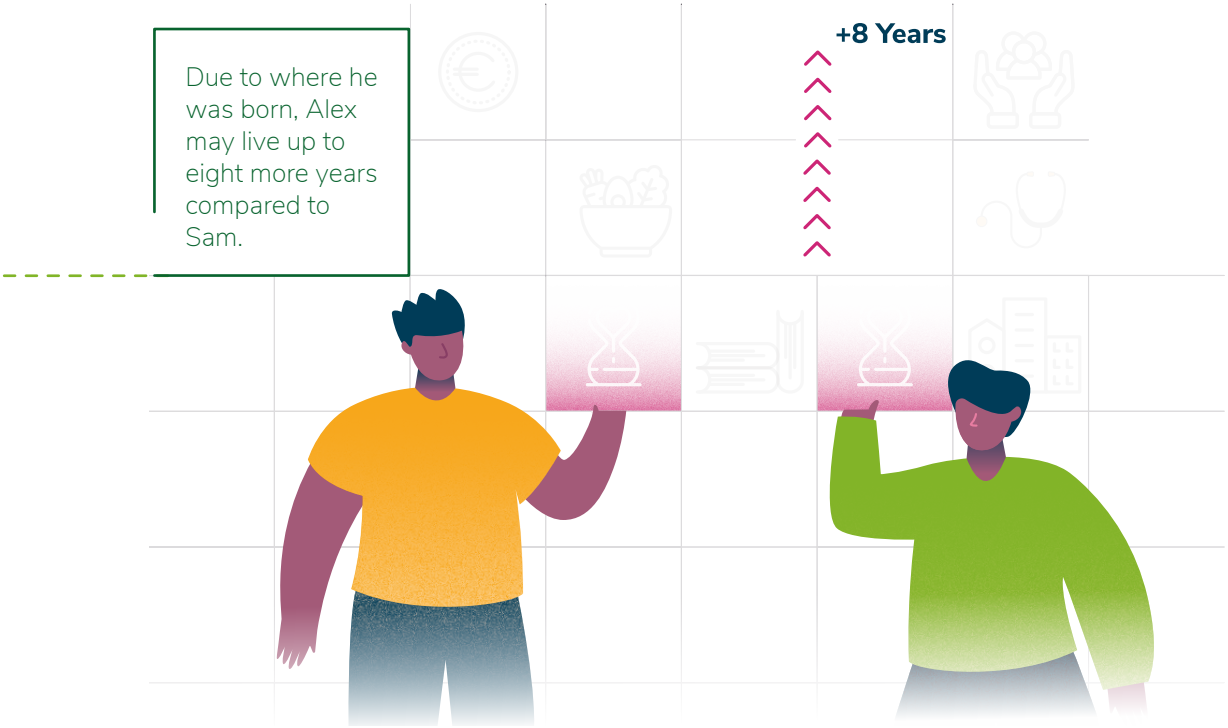


*Ressources are the support that people need to stay healthy, such as healthcare, education, safe jobs, clean environments, and social support.

The social gradient is not fixed. Health improvements over time vary across socioeconomic groups, with disparities also evident by gender, race or ethnicity, and disability. These differences highlight that health inequalities are both avoidable and unjust.

To reduce these inequalities across the EU, we must find ways to **level up** the social gradient in health, **improving health for everyone, but even more so for those facing adverse socioeconomic situations**.

Meet Alex & Sam



Why should we reduce social inequalities in health?

Health is a fundamental right. Data on social inequalities in health shows how well societies are fulfilling this right and protecting their populations.

Health inequalities affect everyone. When there is a lack of trust in public institutions and a lack of democratic engagement, it threatens social stability and undermines health. Poor health, in turn, can also lead to a lack of trust and social participation and cohesion.

By contrast, improving health for all strengthens societies. It makes them more inclusive, innovative, and productive, and able to face current and future challenges. Tackling health inequalities is, therefore, essential for Europe's competitiveness, security, and resilience.

What drives social inequalities in health?

Our health is not only the result of genetics, healthcare, or health behaviours, such as level of physical activity, alcohol use or smoking. Many of the factors that influence health lie outside the healthcare system itself. Research shows that **healthcare explains just 10% of differences in health**.[5] Structural factors drive the rest:

- financial security
- housing
- the environment
- social networks
- working and living conditions

These factors reflect deeper inequalities in power and opportunity. They shape the conditions in which people live and restrict the choices available to them.

A wider systems problem

Political and economic systems influence these structural factors and determine how resources are shared fairly. These systems set the rules for taxation, minimum wages, social welfare, and commercial activity.

[5] World Health Organization. Regional Office for Europe. (2019). Healthy, prosperous lives for all: the European Health Equity Status Report.

Commercial products and practices cause nearly one out of four deaths (24.5%) in the European region.[6]

The problem goes beyond harmful products like tobacco and alcohol. People in lower socioeconomic groups are often more exposed to industry practices, such as cheap ultra-processed foods or occupation-related carcinogens, which can worsen health inequalities.

This is why reducing health inequalities requires more than health policies alone. It demands a systemic approach, leadership, and coordinated action across sectors.

Meet Alex & Sam

Alex and Sam start from unequal positions, not because of their own choices, but due to the conditions around them.

Alex stands on stronger foundations, while Sam stands on weaker ones, that he cannot fix alone.

[6] World Health Organization. Regional Office for Europe. (2024). Commercial determinants of noncommunicable diseases in the WHO European region.

2 What does the data show about social inequalities in health?

What is the current state of social inequalities in health across the EU, and what has changed over the past 10 years? To answer these questions, this report analysed data from the European Social Survey (ESS), a high-quality, cross-national survey.

The ESS provides comparable, population-level data on attitudes, behaviours, and living conditions, including information on health and the factors that shape it. Data was analysed from ESS rounds 7 (2014) and 11 (2024), which included a health module developed by CHAIN.[7] The survey rounds involved 14 EU Member States,[8] and 3 other European countries.[9]

In this report, **self-reported health and self-reported mental health were used as indicators of health in Europe**.

Trends in self-reported health for 25-75-year-olds

Self-reported health was determined by asking people to rate their health on a five-point scale, ranging from very good to very bad.

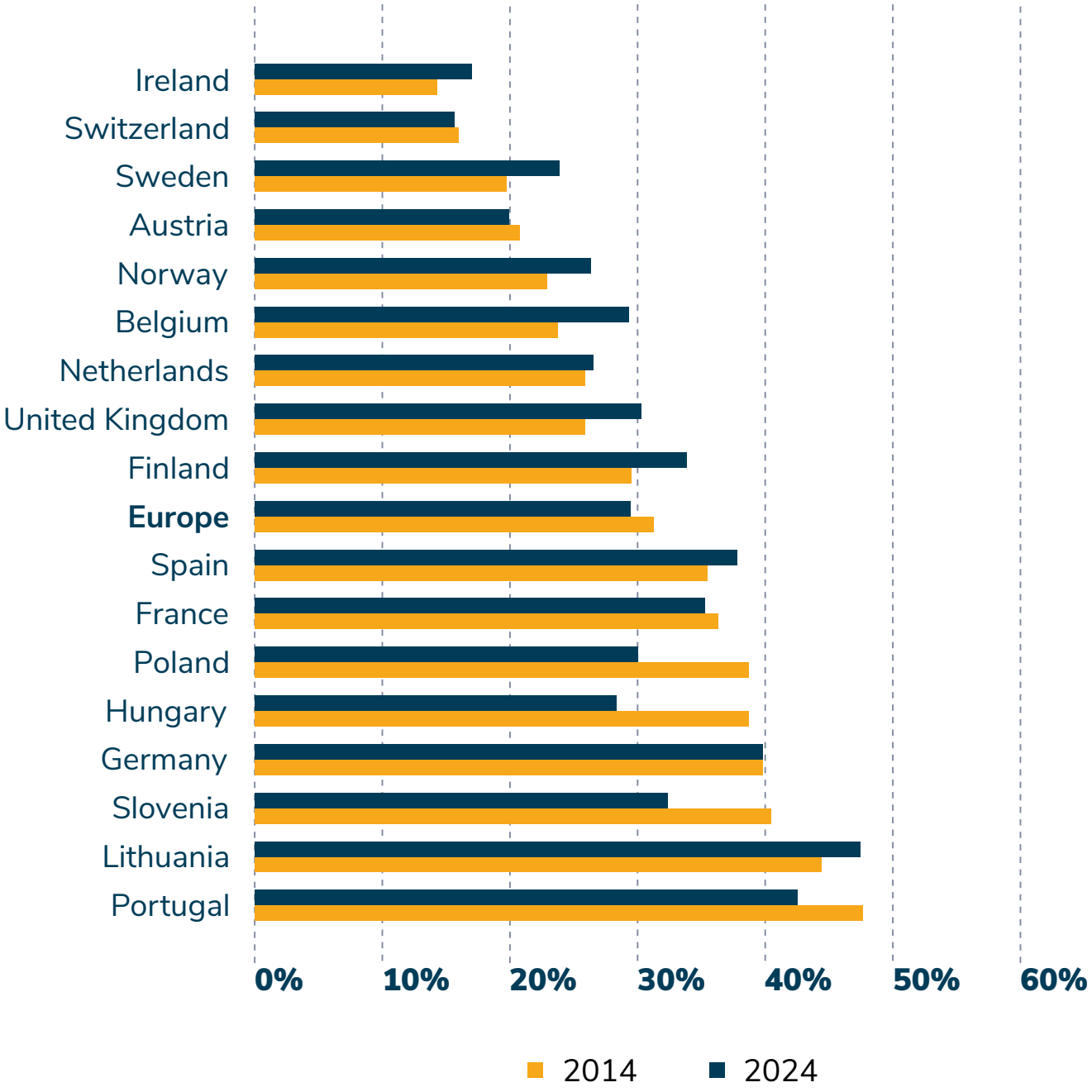
[7] Hoven, H., et al. (2025). The second Health Inequalities Module in the European Social Survey (ESS): Methodology and research opportunities. Social Science & Medicine, 380, 118228.

[8] Austria, Belgium, Finland, France, Germany, Hungary, Ireland, Lithuania, the Netherlands, Poland, Portugal, Slovenia, Spain, and Sweden

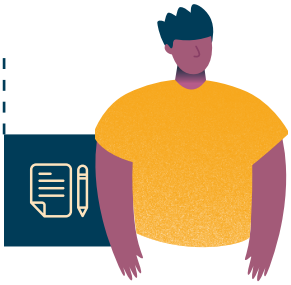
[9] Norway, Switzerland, and the United Kingdom

In 2024, almost one in three (30%) Europeans reported their health as fair to very poor. This represents a slight overall decline in poor health (1.8%), although there were large variations between countries.

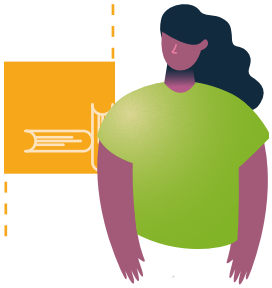
Changes in poor health between 2014 and 2024



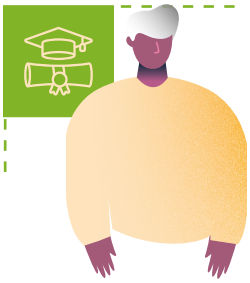
Inequality in self-reported health between educational groups



The lowest-educated group covers people who did not complete secondary school (high school level).



The middle-educated group covers people who finished high school or an equivalent vocational or technical program.



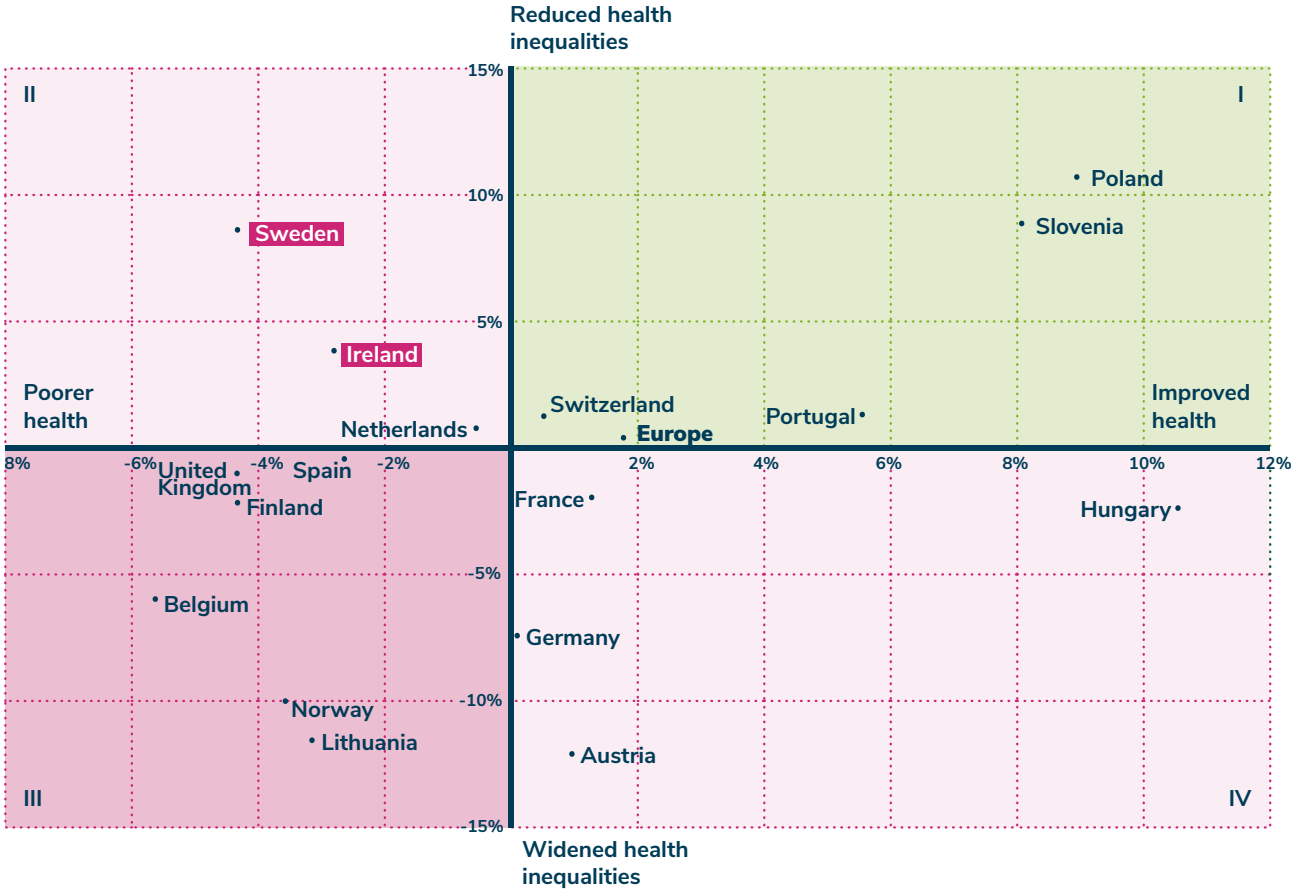
The highest-educated group covers people who completed college or university.

Across Europe, **people with the lowest education are about twice as likely to report poor health (40%) as those with the highest education (20%)**. In addition, there is a large health gap between groups with a comparable education across countries:

In 2024, 20% of people in the lowest-educated group in Switzerland reported poor health, compared to 58% in Lithuania.

8% of people in the highest-educated group in Switzerland reported poor health, compared to 29% in Spain.

Self-reported health matrix



The matrix above shows the different paths countries are on when it comes to health:

> Quadrant I: Countries are seeing an improvement in health and a reduction in health inequalities—the most favourable path.
> Quadrant II: Countries are on a path where health inequalities are decreasing, but overall health is getting poorer.
> Quadrant III: Countries are on a path where both health and health inequalities are getting worse—the most worrying path.
> Quadrant IV: Countries are on a path where health is stable or improving but inequalities are increasing.

Note: Not all absolute reductions in health inequalities in Quadrants I and II reflect genuine progress. Inequalities can also narrow if the health of higher socioeconomic groups worsens (levelling down), which is not a success story. Countries experiencing levelling down are therefore highlighted in the matrix.

Are countries closing the gaps in social inequalities in health?

Slovenia and Poland stood out as the only countries where the health gaps between education groups were shrinking, while overall health was also significantly improving for everyone.

Ireland and Sweden showed a different picture. While health inequalities decreased in these countries, this happened in part due to a decline in health amongst the more educated group.

Hungary, Austria, and Germany improved health, but inequalities grew. In Austria and Germany, better health was seen only among the higher educated, while those with less education were left behind. In Hungary, everyone's health improved, but health gains were slightly bigger for higher-educated people.

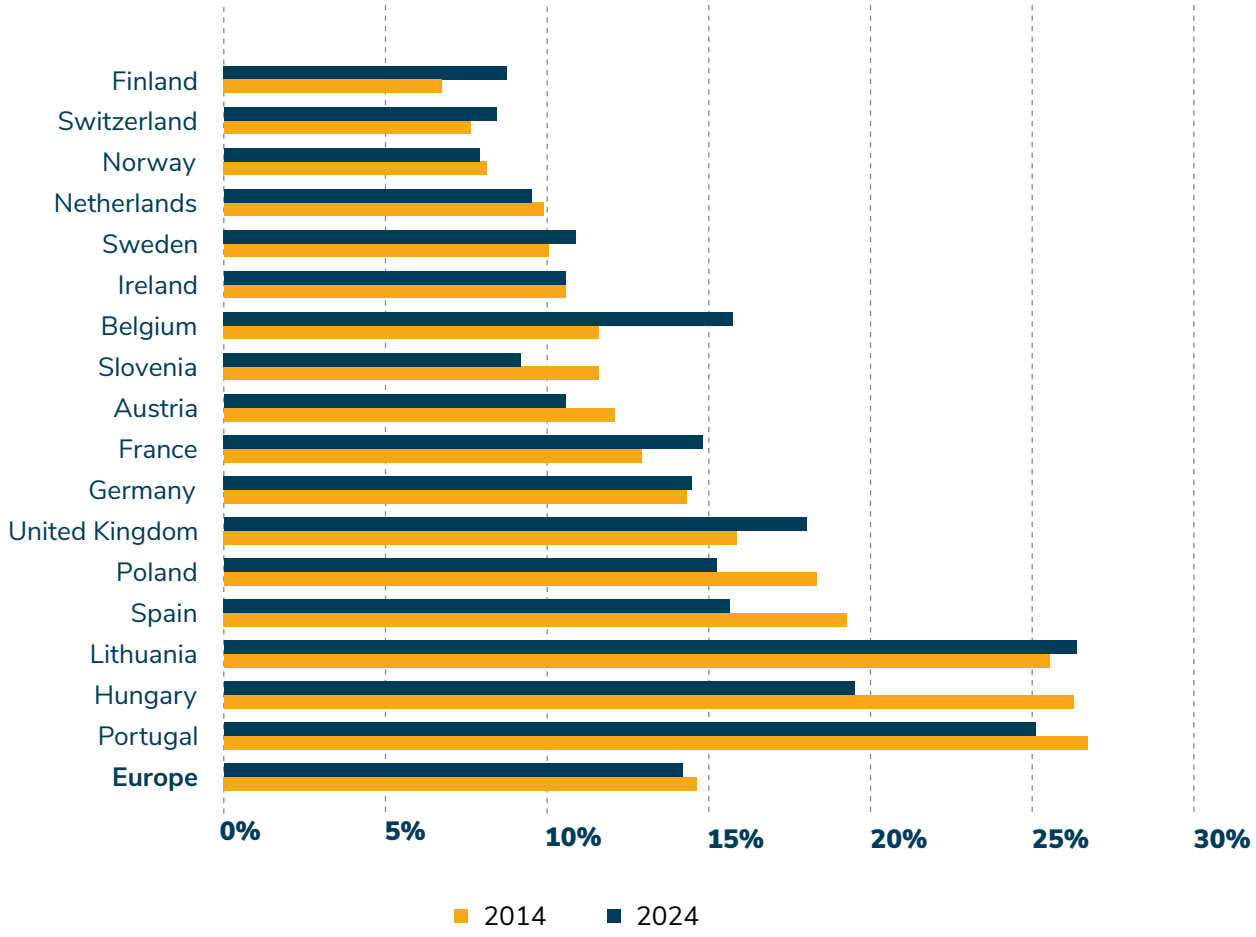
Belgium, Norway, and Lithuania faced the worst outcomes, with health worsening and inequalities increasing.

Trends in self-reported mental health for 25-75-year-olds

Self-reported mental health was measured by asking people eight questions, including whether they felt depressed, sad, lonely, whether they enjoyed life, and how often they experienced each of these feelings.

Across Europe, one in eight adults (12%) reported poor mental health in 2024. This has not changed much compared to 2014, despite changes within and between countries.

Changes in poor mental health between 2014 and 2024



Inequality in self-reported mental health between occupational groups

The lowest **occupational** group covers people in lower-level jobs, such as sales, service, manual, or routine work.

The intermediate **occupational** group covers people in mid-level jobs, such as administrative staff, technicians, small business owners, and self-employed workers.

The highest **occupational** group covers people in higher-level jobs, such as business owners, managers. professionals, and senior supervisors.

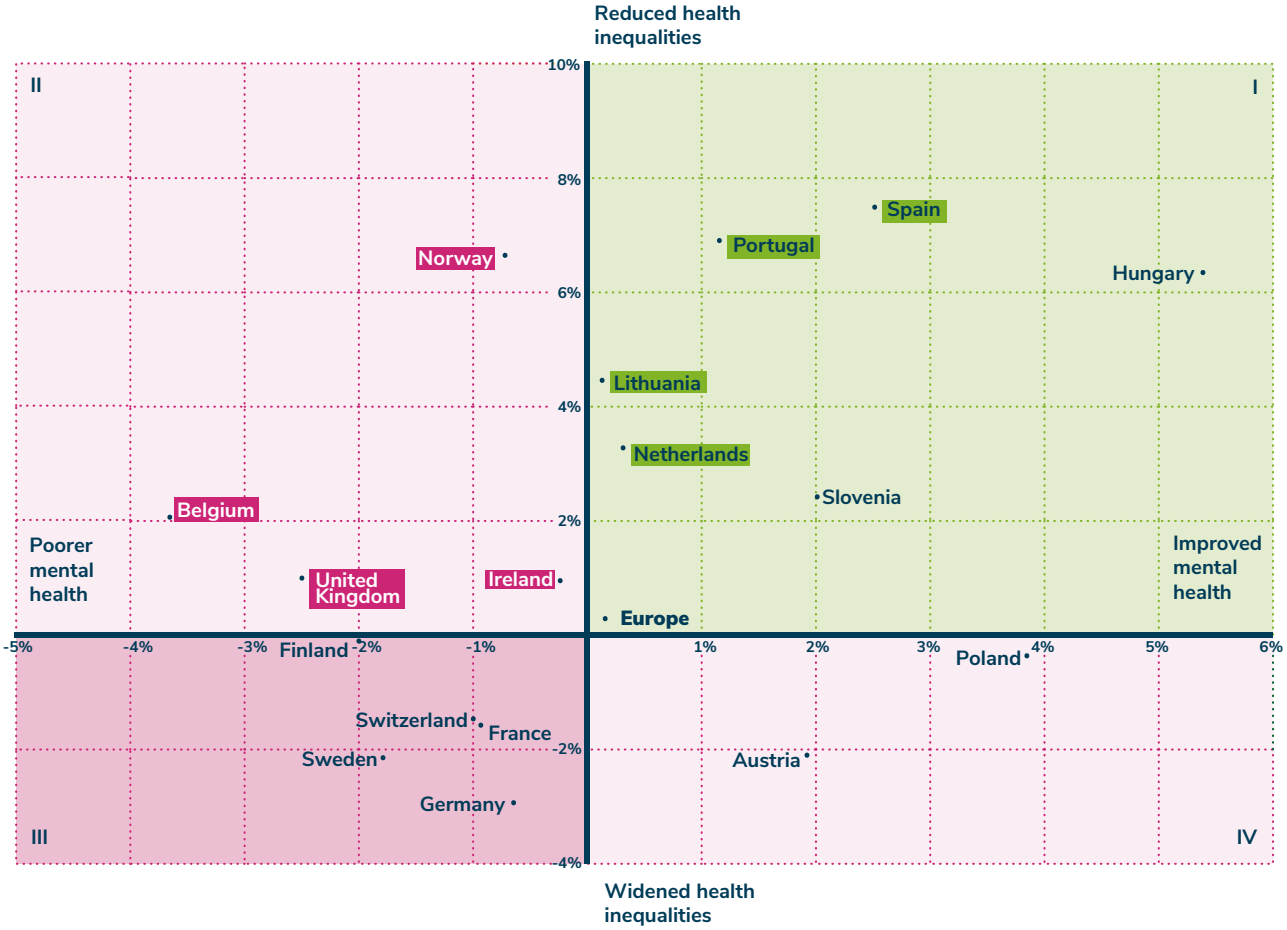
There are large differences between occupational groups. In 2024, on average, **only 8% of people in the highest occupational groups reported poor mental health, compared with 18% in the lowest occupational group.**

There are also large mental health gaps across countries for the same groups:

In 2024, 9% of people in the lowest occupational group in Norway reported poor mental health, compared to 27% in Portugal.

5% of people in the highest occupational group in Switzerland reported poor mental health, compared to 17% in Lithuania.

Self-reported mental health matrix



Are countries closing the gaps in social inequalities in mental health?

Hungary and Slovenia stood out as the only countries where mental health is improving or stable for everyone, and the gap between occupational groups is shrinking.

In Spain, Portugal, and Lithuania, mental health declined among the higher occupational group, while it improved for the lowest occupational group, leading to better mental health on average and decreasing inequalities.

In Belgium, the United Kingdom, Norway and Ireland, health inequalities narrowed, but in the context of an overall decline in mental health, across all occupational groups.

In Norway, health inequalities decreased due to poorer mental health in the higher occupational group and better mental health in the lowest occupational group.

In Poland and Austria, overall mental health improved for all occupational groups, but inequalities grew because of larger mental health gains amongst the highest occupational group.

Germany, France, Sweden, Switzerland and Finland showed the most concerning trend with declining overall mental health and widening mental health inequalities between occupational groups.

Key trends affecting health and inequalities in Europe

To understand the factors that shape people's physical and mental health, the report examined ESS data on chronic diseases, including non-communicable diseases (NCDs), healthcare experiences, health behaviours, and working and living conditions.

The results show **rising levels of chronic diseases in Northern and Western Europe**, with more people living with multiple chronic health conditions at the same time. By contrast, **chronic diseases are decreasing in Eastern Europe,** except in Lithuania, where they continue to grow.

The following positive and negative trends help explain patterns in health and inequalities across the surveyed countries:

Changes in living and working conditions:

- ⌄ More people faced housing problems, except for Central and Eastern European countries.
- ⌄ More people had unpaid caregiving responsibilities.
- ⌄ In half of the countries, more people experienced conflict during childhood.
- ⌃ Workplaces became safer, with less exposure to harmful conditions such as ergonomic and material hazards.

Changes in lifestyle:

- ⌄ Healthy eating declined, with fewer people consuming fruits and vegetables.
- ⌃ Smoking decreased in almost all countries.
- ⌃ Alcohol use decreased in most countries.
- ⌃ Slightly more people engaged in regular physical activity.

Changes in healthcare access:

- ⌄ More people faced long waiting times and difficulty getting appointments.
- ⌄ Fewer people had their healthcare needs met.
- ⌄ Fewer people saw general practitioners, while visits to specialists increased.

The underlying factors causing social inequalities in health

The report analysed what factors affect differences in health and mental health for each country in the 2024 ESS survey.

The strongest factor explaining mental health and health inequalities is people's feeling about their **financial situation**, whether they believe they have enough money to live comfortably.

For inequalities in health, body weight (BMI) was the next most important factor, followed by work conditions, behaviours like smoking, and financial difficulties during childhood.

For inequalities in mental health, job control was the next most important factor. Other factors, such as stress, lifestyle habits, and the degree of control people feel they have over their lives, also played a role, but to a lesser extent.

Meet Alex & Sam

Across Europe, 20% of the highest-educated report poor health, compared with 40% of the lowest-educated. Alex enjoys good health, while Sam struggles. EU actions and solidarity could help Sam enjoy the same level of health as Alex.

3 National policies and initiatives

Reducing social inequalities in health requires a 'whole of government approach'. This means that multiple policy sectors, including health and social services, education, housing, employment, and economic policy, must collaborate.

Wellbeing approaches

The Economy of Wellbeing approach aligns all areas of government around the goal of improving population wellbeing. It provides tools for different sectors to set priorities, balance trade-offs, and coordinate action to achieve this shared objective.

Finland – Economy of Wellbeing

Finland's National Action Plan for the Economy of Wellbeing (2023-2025) created new indicators and tools to integrate wellbeing into decision-making. The plan establishes a long-term vision for 2050, striking a balance among social, economic, and environmental goals. Despite political discussions in recent years, Finland has prioritised wellbeing as a national policy and placed it on the EU agenda, resulting in the 2019 European Council Conclusions.

Universal approaches and proportionate universalism

More generally, initiatives that benefit the entire population but have a proportionally greater impact on people facing adverse socioeconomic situations are the most effective at tackling social inequalities in health.

Proportionate universalism refers to delivering universal services at a scale and intensity proportionate to the degree of need.

Poland – Sugar tax

Through an amendment to the 2015 Public Health Act, Poland introduced a sugar tax to reduce consumption of high-sugar drinks and encourage reformulation by producers. The measure addresses diet-related health risks across the population, with the greatest impact on those with lower incomes.

Belgium – Supporting proportionate universalism

The Flemish Institute of Healthy Living supports organisations in the prevention sector in applying the principle of proportionate universalism, which combines universal actions with support for groups facing greater disadvantage. This is achieved through guides, exchange of good practices, and training.

Targeted approaches

Some actions need to be specially designed to help certain vulnerable groups. To ensure that these actions are effective, the targeted groups or communities must be involved in developing them.

Greece – Improving the health of Roma women

In Athens, the Prolepsis Institute operates a health promotion programme that empowers Roma women by building health literacy, promoting healthier behaviours, and enhancing access to services. Training covers sexual and reproductive health, cancer prevention, and vaccination, with Roma women and mediators shaping the content.

The leadership role of the health sector

While the health sector cannot influence all social and economic causes of health, it plays a leading role in helping governments make health, wellbeing, and fairness central to all policies. This includes explaining that health is not just a result of individual behaviours.

Health systems can help reduce social inequalities by:

- Collecting harmonised information to guide policymakers.
- Ensuring the equity, quality, accessibility, and sustainability of health systems.
- Monitoring the distribution of health outcomes and evaluating programmes.

Norway – The Norwegian Public Health Act

The Act makes health promotion and inequality reduction a responsibility at all levels of government. Under the Act, national authorities provide municipalities with Public Health Profiles and Childhood Profiles, which highlight local health challenges and help guide action.

Spain – Health equity checklist

The Ministry of Health in Spain published a checklist to help professionals and decision-makers integrate equity into health strategies, programmes, and activities. The tool also supports broader efforts to improve health impact assessments across the country.

4

EU-level actions

The EU's added value

The EU has a unique role in shaping the conditions that influence health. It has the power to develop regulations that Member States must enforce in areas related to the economy. In contrast, other areas, such as education, healthcare, and specific social policies, remain primarily the responsibility of national governments.

The EU can also set common standards and encourage Member States to follow them through initiatives and funding programmes. This gives EU institutions real influence in tackling social inequalities in health.

The publication of the WHO report on the Social Determinants of Health (2008) had a significant impact in terms of raising awareness about this topic. It led to the publication, in 2009, of the European Commission Communication on Solidarity in Health. This was followed by Council Conclusions and a reference in the EU 2020 strategy (2010–2020) on **"the need to combat poverty and social exclusion and reduce health inequalities to ensure that everybody can benefit from growth."**

Still, these initiatives stopped short of establishing a whole of government approach to reducing health inequalities, within and beyond the European Commission.

The EU, however, has numerous tools that directly impact social inequalities in health, particularly through employment policies addressing issues such as working hours, minimum wages, and health and safety at work, alongside other social initiatives.

The EU also has the power to regulate the commercial determinants of health, such as tobacco, alcohol, and unhealthy food, which contribute to health inequalities. However, these powers have often been underutilised, resulting in delays in proposed legislation. The upcoming **EU Cardiovascular Health Plan** presents an opportunity to act and advance wellbeing, a core objective outlined in Article 3 of the Treaty on the European Union.

The European Pillar of Social Rights

The impact of austerity measures following the 2008 financial crisis, the COVID-19 pandemic, and the green and digital transitions has increased the EU's attention to fairness, equity, and social justice, although this attention has been inconsistent.

In 2017, the European Pillar of Social Rights was established, which can be considered a crucial framework to tackle the key underlying determinants of health. A new Action Plan is now underway to strengthen this effort.

The European Pillar of Social Rights (EPSR) includes 20 principles, in the three categories of:

- (1) equal opportunities and access to the labour markets
- (2) fair working conditions
- (3) social protection and inclusion

Principle 16 of the Pillar is directly related to health: "Everyone has the right to timely access to affordable, preventive and curative health care of good quality."

The European Social Scoreboard is a tool used by the EU to monitor and compare the social performance of Member States, tracking progress on key indicators related to the 20 principles.

The EU cannot fully enforce these principles, but it tracks progress through the Social Scoreboard and holds Member States accountable via the European Semester policy coordination process.

EuroHealthNet has developed a European Pillar of Social Rights Flashcard Tool, which translates every principle into efforts to reduce health inequalities.

The European Pillar of Social Rights supports health equity through key initiatives:

- The **European Child Guarantee** ensures children in need have access to essential services, including access to healthcare, free early education, at least one healthy school meal per day, nutrition, and housing.
- The **European Anti-Poverty Strategy** (under discussion) tackles the multiple dimensions of poverty throughout a person's life.
- The **Affordable Housing Plan** (under discussion) aims to improve housing, recognising that poor conditions contribute to chronic health problems and wider health inequalities.

EU funding programmes

The goal of the EU's Cohesion Policy is to reduce disparities between regions and promote balanced development across the EU. Member States and regional authorities can, together with and under the guidance of the European Commission, allocate and use cohesion funds to achieve this goal.

At the time of writing, it is too early to analyse how the new Multiannual Financial Framework (2028-2034) will influence social and health investments. The new EU long-term budget will follow the 2024 –2029 Political Guidelines, which focus on competitiveness, preparedness, and security. To achieve these goals effectively, it will be essential to include a strong focus on health equity.

EU joint actions and tools on health inequalities

The EU has supported several projects and joint actions targeting health inequalities through its Health Programmes, such as the Joint Action Health Equity Europe (2018-2021)[10]. Recent examples include the Joint Action PreventNCD and the Joint Action on Cardiovascular Diseases and Diabetes (JACARDI), both of which aim to integrate health inequalities as a key part of their work.

The European Cancer Inequalities Registry, launched in 2021 as part of Europe's Beating Cancer Plan, tracks prevention and care across countries and regions. It highlights disparities and trends in cancer outcomes, but its impact depends on how EU Member States use and act on the data.

Meet Alex & Sam

[10] Bucciardini, R.,et al. (2023). Addressing health inequalities in Europe: key messages from the Joint Action Health Equity Europe (JAHEE). Archives of Public Health, 81(1).

5

Conclusions and recommendations

Health inequalities are deeply unfair and closely tied to social disadvantage.

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

In the past decade, **inequalities in health between EU Member States, have shown a trend of convergence**, with countries 'meeting in the middle'. Northern and Western countries, like Belgium, Sweden and Finland, saw small declines in self-reported health, while several Central, Eastern and Southern European countries saw improvements. Adult mental health overall stayed the same, despite shifts between groups within countries.

The report also highlights **worrying social inequalities in health within countries**: inequalities persisted or widened, despite improvements in Slovenia and Poland. Where inequalities declined, it is essential to consider the context, as this may reflect worsening health in higher social groups. **Financial difficulties were found to drive poor health and mental health.**

The fact that **lower socioeconomic groups continued to experience high rates of poor health**, while, in some countries, **higher socioeconomic groups also saw declines in health or mental health**, reflects a **loss of potential for Europe,** affecting quality of life, progress and its competitiveness.

Reducing these inequalities requires a whole of government approach, with leadership at the EU, national, and (sub-)national levels. The public health sector plays a key role in ensuring health equity is prioritised.

How can we close the gaps in social inequalities in health?

The recommendations from this report fall into two types:

1. Addressing the root causes of social inequalities in health

2. Strengthening the focus on and governance of social inequalities in health at the EU and (sub-) national levels

Integrate social inequalities in health across policies

- Include social inequalities in health in the EU Anti-Poverty Strategy and European Pillar of Social Right Action Plan.
- Add a health equity dimension to the EU Affordable Housing Plan and European Child Guarantee.
- Strengthen social investment in health through the European Semester.
- Ensure dedicated funding to reducing social inequalities in health in the Multiannual Financial Framework (MFF) for the EU.
- Hold joint EU Council meetings between health, social, and finance ministers.

Make social inequalities in health a priority for the health sector

- Strengthen the health sector leadership in working across sectors.
- Set up high-level cross-sectoral mechanisms on social inequalities in health.
- Involve citizens, NGOs, and businesses in policy and implementation. Improve stakeholder engagement, especially marginalised voices.

Invest in data collection and evidence

- Improve the frequency, granularity, and comparability of health inequality data across EU countries and harmonise how it is collected.
- Fill gaps in longitudinal data, especially for children, since most existing surveys focus only on adults.
- Regularly report on social inequalities in health and progress toward targets.

Strengthen tools to drive health equity

- Use the European Semester, the Social Convergence Framework, and the Social Scoreboard to guide policy.
- Apply health equity impact assessments and other tools to major policies and communicate results clearly to boost collaboration and public engagement.
- Improve EU and (sub)national funding rules and indicators to ensure resources that truly address health and social needs, reaching underserved people and communities.

Euro Health Net
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September 2025