

Early years

Young adults

Working age

Later life

Policy action for health equity from early years to later life

The second WHO European Health Equity Status Report

World Health Organization
European Region

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Abstract

Health equity is fundamental to a prosperous, resilient WHO European Region. Yet, millions of people across the Region continue to face avoidable differences in health, well-being and life opportunities. This second WHO European Health Equity Status Report examines how these inequities emerge and accumulate across the life-course and identifies practical pathways for reducing them. Drawing on regional data, comparative evidence, macroeconomic modelling and country experience, the report finds that an estimated 187 million people are being held back from reaching their full potential by avoidable health and social inequities. Across all stages of life, these inequities are driven largely by a limited set of interconnected factors, including income insecurity, poor housing and living conditions, barriers to learning and employment, weak social connections and inequitable access to essential services. Together, these disadvantages undermine health, economic participation, social cohesion and public-system resilience. Beyond documenting the challenge, the report provides an agenda for action. Using more than 60 examples from across the Region, it highlights effective policies and programmes that can be adapted and scaled, alongside innovative financing and investment approaches that align resources with equity goals. The report demonstrates that investing in health equity delivers substantial social and economic returns and is essential to building healthier populations, stronger economies and more cohesive societies.

Keywords. HEALTH EQUITY; HEALTH INEQUITIES; LIFE COURSE PERSPECTIVE; SOCIAL COHESION; SOCIAL DETERMINANTS OF HEALTH; SOCIOECONOMIC FACTORS; SUSTAINABLE DEVELOPMENT

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Foreword

Across the WHO European Region, too many people continue to face avoidable barriers to good health. These barriers are shaped by the conditions in which people are born, grow, learn, work and age, and they result in health inequities that affect individuals, communities and societies alike.

The good news is that health inequities are neither inevitable nor beyond our capacity to change. As this report demonstrates, they can be reduced through deliberate policy choices and sustained action. Importantly, the evidence shows that progress is possible within the timeframe of a political cycle, delivering benefits for people and societies today while creating stronger foundations for the future.

At a time of demographic change, economic uncertainty and growing environmental challenges, health equity must be understood not only as a public health objective but as a cornerstone of resilient and prosperous societies. When everyone has a fair opportunity to achieve good health, and when those experiencing the poorest health are able to attain the levels of health enjoyed by the most advantaged groups, communities are stronger, avoidable pressures on health and care systems are reduced, public systems are more sustainable, and countries are better equipped to withstand and respond to future challenges.

This report moves beyond describing inequities to identifying concrete actions that governments and partners can take to reduce them. Drawing on evidence and practical examples from across the Region, it highlights policies that improve the conditions for health throughout the life course and demonstrates how coordinated action across sectors can deliver meaningful results.

The findings reinforce a simple but powerful message: investing in health equity is an investment in societal capabilities, social cohesion and shared prosperity. By addressing the factors that limit people's opportunities to live healthy lives, countries can strengthen resilience, unlock human potential and build a more sustainable future for all.

I encourage policy-makers, practitioners and partners to use this report as a guide for action and a resource for accelerating progress towards fairer, healthier and more resilient societies.

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Officer-in-Charge, WHO Regional Office for Europe

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Abbreviations

3+H	the three main living conditions per life stage plus equity-focused health services
ALMPs	active labour-market programmes
CVD	cardiovascular disease
ECEC	early childhood education and care
ESG	environmental, social and governance
ESS	European Social Survey
EU	European Union
EU-SILC	European Union Statistics on Income and Living Conditions
GDP	gross domestic product
HBSC	Health Behaviour in School-aged Children
HDI	Human Development Index
HESRi2	second iteration of the Health Equity Status Report Initiative
NCDs	noncommunicable diseases
NEET	not in employment, education or training
NHS	National Health Service (United Kingdom)
OOP	out-of-pocket
Q	quintile
UHC	universal health coverage
UNICEF	United Nations Children's Fund
WVS	World Values Survey

Executive summary

Europe's health gap is widening but it can be closed

An estimated 187 million people or roughly one in five people across the WHO European Region are living in poorer health than they need to, held back by multiple barriers built into the places where they grow up, learn, work and grow old. Since 2010, poor health among low-income adults has risen sharply, while it has barely changed among the most affluent.

This isn't simply a question of money. Benefits protect people when they need it most, but on their own they don't open doors to thrive. This *second WHO European Health Equity Status Report* calls for pairing benefits with interventions that build skills, create opportunities and open routes into good work, housing and training.

People on lower incomes are more likely to face several barriers at once: a cold or insecure home, fewer chances to learn, insecure work, isolation and harder access to care; each compounds health inequities, and together they limit what people can achieve, It is not only the poorest who are affected; health gets worse at every step down the socioeconomic ladder. Health equity means giving everyone a fair chance to reach their potential. Governments already fund most of the policies that can do this. They need to direct that spending to the barriers that are holding people and societies back.

Key numbers

The gap:

- One in five, 187 million, people across the WHO European Region, roughly one in five, are living in poorer health than they need to – 35 million children and adolescents, 19 million young people, 99 million working-age adults and 34 million older people;
- Children in the least-affluent households are twice as likely to die before age 5 years as those in the most affluent;
- 36% of the least-affluent 16–24-year-olds spend over 40% of household income on housing compared to under 1% of the most-affluent;
- 23% and 20% of the least-affluent young women and men, respectively, report poor life satisfaction compared to 10% and 11% of the most-affluent – among moderately affluent young women the rate is 21%, so it isn't only the poorest who feel held back; and
- The rise in poor health among low-income women and men rose from 36% to 43% and 32% to 42% respectively between 2010 and 2023, while it stayed broadly stable among the most affluent.

What works:

- Pensions cut poverty among older women from 86% to 23%, and among older men from 83% to 19%;
- Well-designed social transfers have cut child poverty by up to 50% in many countries;
- Investing 0.1% of gross domestic product in health, jobs, housing and social protection would keep about 300 000 working-age adults out of long-term illness in a country of 80 million people; and

- Positive country examples:
  - in Croatia the share of young people not in employment, education or training fell from around 20% in 2013 to around 12% in 2024, under the reinforced European Union Youth Guarantee;
  - in the county of Frome, United Kingdom, emergency hospital admissions fell by 14% over 3 years under a community-based model linking primary care and social prescribing, while rising 29% in the surrounding area;
  - in Georgia, a universal older-age pension cut poverty in older people by around 15 percentage points, with the strongest effect in rural areas; and
  - in Kazakhstan, a school-based mental health programme cut suicidal ideation among adolescents by 36% and depressive symptoms by 56% in its pilot;
  - in Poland, child poverty and social exclusion fell by almost 10 percentage points between 2015 and 2023, since the universal Family 800+ child benefit was introduced.

Why it matters beyond health

Health inequity isn't only a health problem. When people are too ill to work, countries lose their competitiveness and capabilities to prosper. And when illness goes untreated, it returns as higher costs for hospitals and welfare systems

Closing the gap would make countries in the WHO European Region stronger in the following five ways:

- Demographic prospects: more healthy years to learn, work, care for others and live independently, turning population ageing from a pressure into an opportunity.
- Health services: less pressure on health systems, as problems are caught early before they become acute.
- Social cohesion and mobility: fairer chances to get on in life whatever people's starting point, and more people who feel they have a stake in their society.
- Economic competitiveness: more people healthy enough to work, learn new skills and move into better jobs.
- Security and resilience: societies where people are healthy, financially secure and connected to their communities are better prepared for crises; whether a pandemic, conflict or economic shock.

By life stage

Children and adolescents (35 million falling behind)

Children's chances are shaped early. Growing up in a household that can't make ends meet, in a cold or damp home, or without good early learning, narrows the options open to them in later life.

The gap:

- Children in the least affluent households are twice as likely to die before age 5 years than the most affluent, and six times more likely to live in severely deprived housing (12% versus 2%). What works:
- In France, Paris's School Streets have permanently pedestrianized over 270 streets around schools – a quarter of which are in disadvantaged neighbourhoods – cutting nitrogen dioxide around schools by 10–30%; and in the United Kingdom (Scotland) the Scottish Child Payment has reduced material deprivation and food insecurity by 8–9 percentage points, and is projected to lift around 50 000 children out of poverty in 2026–2027.
- Priorities: integrated health and family support in community hubs, affordable public goods for healthy childhood, nurturing schools, and safe physical and digital environments.

Young people (19 million falling behind)

Many young people find the usual routes to an independent adult life blocked, by housing they can't afford, services they can't reach and fragmented routes into training and decent work. This goes beyond money: poor life satisfaction is twice as common among the least-affluent young women than among the most affluent, and almost as common among those in the middle.

The gap

- Around 36% of the least-affluent 16–24-year-olds spend over 40% of disposable household income on housing, compared with under 1% of their most-affluent peers. About one in eight young people are not in employment, education or training.

What works:

- Finland's Ohjaamo one-stop guidance centres bring employment, education, health and social services together for under-30s; 22% of users moved into work, 32% into education or training and 7% secured housing; and the Netherlands (Kingdom of The) @Ease offers free walk-in and online mental health support for 12–25-year-olds without referral and distress fell among returning users.
- Priorities: one-stop shops combining health, employment and social support; free health care and medicines for young people; and more social participation.

Working-age adults (99 million falling behind)

Many adults face several barriers at once: insecure, low-paid and hazardous jobs with weak social support push people into illness and out of work.

The gap:

- The least-affluent are more than twice as likely to report a long-term activity-limiting illness (34% of women and 33% of men, versus 15% and 12% among the most affluent). Between 2010 and 2023, poor health among low-income adults has risen from 36% to 43% for women and from 32% to 42% for men, while staying broadly the same among the most affluent.

What works:

- Investing 0.1% of gross domestic product in health, jobs, housing and social protection would keep about 300 000 working-age adults out of long-term illness in a country of 80 million people. Austria's fit2work gives free counselling and case management to people whose health threatens their job, and participants had higher rates of employment without sick leave than matched controls; and Iceland cut public-sector working hours from 40 to 35–36 a week with no loss of pay, with less stress and burnout and productivity maintained.
- Priorities: cap and exempt health-care co-payments for low-income groups, scale up "good work, good health" policies, link active labour-market programmes with health support, and strengthen social connectedness and safe neighbourhoods.

Older people (34 million falling behind)

In later life, barriers can add up: unaffordable care, unsafe homes and loneliness speed up the loss of independence.

The gap:

- Without pensions and social transfers, 87% of older women and 83% of older men would live in poverty.

What works:

- In the Netherlands (Kingdom of the) nurse-led neighbourhood teams help people stay independent at home, with fewer emergency admissions and lower system costs than traditional home care; and Poland's annual financial benefits that guarantee income floors and extra annual support against rising costs of living and care.
- Priorities: protect minimum pensions and remove charges for publicly funded home care.

A gender lens

Women live about 6 years longer than men but spend more of their lives in poor health. Older women live about 12 years with poor health or disability, against just under 9 years for older men. Unpaid caregiving, pay gaps and lower pensions only add to the burden.

Men are roughly twice as likely as women to die early from noncommunicable diseases such as heart disease and cancer before age 70 years. Dangerous work, social isolation and putting off seeing a doctor are among the reasons.

The report calls for specific health strategies and income policies for women and men designed around these differences. Such an example includes Sweden's gender-equal parental leave, which reserves a non-transferable share for each parent and has fathers taking around 30% of all paid parental benefit, helping women stay attached to the labour market. For men, Ireland's Men's Sheds offer community spaces where men build friendships and skills, with improved self-reported health, well-being and social connection sustained for 12 months, and which proved cost-effective.

What the health sector can do

Most of the causes of health inequity lie outside health care, but the health sector has a big part to play. The report calls on governments to keep "two hands on the wheel": acting on key determinants such as income, housing, education and work, while making sure health care reaches the people who need it most.

- Public health: track who is falling behind and why, and bring housing, employment and social protection partners together around shared targets for closing the gaps.
- Primary health care: act as the front door to wider support through multidisciplinary teams that connect patients to housing, jobs and social services.
- Hospitals and specialist care: work with partners so patients aren't discharged into the conditions that made them ill.
- Across the sector: remove cost barriers to care for people on low incomes and involve people with lived experience in designing services.

The call to action: "equity by design"

This report asks governments to build equity into how policies are funded, prioritized, designed, delivered and evaluated. It sets out eight areas for action, in three groups.

Spend where it closes the gap.

1. Budgets: allocate funding according to need and let ministries pool budgets for shared goals such as housing and health.
2. Innovative financing: use public purchasing and investment to create local jobs, and partner with social impact investors and responsible businesses to fund prevention.
3. Prioritization: cut out-of-pocket health costs for people on low incomes, add equity to the environmental, social and governance criteria used by investors, and check the effect on health gaps before cutting services.
4. Safety nets and springboards: keep benefits that protect people from poverty without stigmatizing them and pair them with support that opens new routes to thrive, including training, apprenticeships and supported employment alongside income and mental health support; early childhood programmes and parenting support alongside child benefits.

Know what's working.

5. Better data: routinely collect health data disaggregated by age, sex, socioeconomic status, ethnicity, disability and place, and link it across sectors.
6. Accountability: monitor health gaps at local, national and regional levels, and build equity into digital, technological and climate reforms from the start.

Work together.

7. Joined-up policy: use coordinated baskets of interventions and collaborative governance for people facing multiple vulnerabilities.
8. Participation: embed lived experience through advisory bodies, participatory budgeting and community-led evidence.

1 Introduction



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What is the second iteration of the European Health Equity Status Report Initiative (HESRi2)?

Background

HESRi2 represents the latest milestone in WHO's long-term commitment to reducing health inequities and acting on the social determinants of health across the WHO European Region. HESRi2 builds directly on the landmark 2019 Regional Committee resolution on health equity *(1)* – the first dedicated WHO resolution of its kind globally – the baseline first iteration of the European Health Equity Status Report (2019) *(2)* and its mid-term review in 2023 *(3)*.

This commitment is reinforced by the *Second European Programme of Work 2026–2030 – "United Action for Better Health" (4)*. HESRi2 supports the implementation of major regional and global frameworks, including the WHO European child and adolescent health and well-being strategy for 2026–2030 *(5)*, *Ageing is living: a strategy for promoting a lifetime of health and well-being in the WHO European Region 2026–2030 (6)*, the WHO European Well-being Economy Initiative *(7)*, the United Nations Sustainable Development Goals (SDGs) and the European Union (EU)'s Anti-Poverty Strategy *(8)*.

HESRi2 confirms that prosperous economies do not automatically translate into well-being and prosperity for everyone equally. Investing in health equity remains one of the WHO European Region's greatest untapped opportunities to improve population health, strengthen social resilience and foster sustainable, balanced growth. Health equity is not a downstream by-product of development, but a prerequisite for sustainable prosperity, territorial cohesion and social stability.

The three HESRi2 products

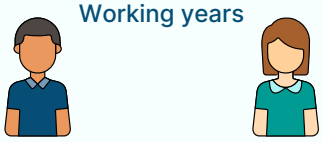
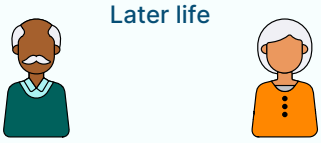
HESRi2 comprises three complementary resources designed to provide decision-makers with comparative assessments, policy tools and actionable solutions to accelerate progress across the WHO European Region.

- This policy report, *Policy action for health equity from early years to later life*: *the second WHO European Health Equity Status Report*, focuses on strategic policy entry points, governance mechanisms and cross-sectoral investments across the life-course, translating empirical evidence into actionable country guidance.
- The HESRi2 data report (*Status and trends in health equity across the WHO European Region*: *the second WHO European Health Equity Status Report (9))* establishes the empirical foundation across Member States, presenting comparative baseline data, measurement methodologies and indicator trends for each life stage, as well as detailed operational definitions of indicators and variables.
- WHO European Health Equity Atlas *(10)* delivers a dynamic visual and data-mapping tool to explore geographical, socioeconomic and life-course disparities within and between countries.

The life-course lens and the five essential conditions

For the first time, HESRi2 adopts a comprehensive life-course approach by tracking health equity from early years to later life. This framing demonstrates how health and well-being compound positively or negatively over time (Table 1), as well as how timely, equity-oriented actions at critical life transitions fundamentally improve health trajectories for women and men, delivering durable dividends for communities and the wider economy.

Table 1. Gap in the percentage of people reporting poor or fair health between highest and lowest income quintiles, 2023[a]

	Childhood 	Working years 	Later life 
Women	6	22	18
Men	6	24	18

[a] Or the latest available year.

Note: where an estimate for the highest or lowest income quintile was not available, the gap was calculated from the closest income quintile value.

Sources: authors' own compilation based on 2022 data (or latest available year) for 45 countries for children from the Health Behaviour in School-aged Children (HBSC) survey *(11)*. For adults, based on data from the European Union Statistics on Income and Living Conditions (EU-SILC) *(12)*, the European Social Survey (ESS) *(13)* and the World Values Survey (WVS) (2023 or latest available year) for 43 countries at working ages and 31 countries in later life *(14)*.

HESRi2 focuses on the five essential conditions that consistently shape health, well-being and opportunity across the WHO European Region (Fig. 1). These represent fundamental public health goods that every individual needs to lead a healthy, flourishing life.

- **Equitable access to affordable, high-quality health services.** This means providing universal health coverage (UHC), removing financial, geographical and organizational barriers to timely and high-quality care (including medicines and medical products), protecting households from impoverishing or catastrophic out-of-pocket (OOP) payments and delivering integrated health promotion, disease prevention and treatment.
- **Safe, secure and affordable housing and neighbourhoods.** These encompass safe and energy-efficient homes, clean indoor and outdoor air, accessible green spaces, safe walking and cycling infrastructure and resilient local environments.
- **Income security and social protection to meet everyday needs.** Achieving this involves ensuring social-protection floors, pensions and living wages that protect families against poverty, cushion economic shocks and ensure access to adequate nutrition, heating and basic essentials.
- **Opportunities to build human and social capital and supportive connections.** These are enabled by providing high-quality early childhood education, lifelong learning, health literacy and supportive social networks that promote trust, civic engagement and social belonging.
- **Decent work, healthy working conditions and secure livelihoods.** Underpinning these are fair employment standards, safe physical and psychosocial workplaces, protection against precarious contracts and active labour-market policies/programmes (ALMPs) that support sustainable employment transitions.

Fig. 1. The essential conditions for living a healthy, prosperous life



Sources: authors' own compilation.

Methodology

Analysis

Underpinned by a life-course approach, this report recognizes that health is shaped by the cumulative influence of social, economic and environmental conditions from early childhood to older age. It identifies the principal drivers of health inequities at each stage of life and synthesizes evidence on effective interventions, governance approaches and investment strategies to identify policies that improve health while strengthening human capital, economic participation, social cohesion and resilience.

The principal analytical foundation of HESRi2 is the database of 132 indicators, based on internationally comparable vital statistics and harmonized survey data. The complete list of indicators, equity stratifiers, data sources and country coverage can be found in Annex 6.1 of the accompanying HESRi2 data report.

The number of countries included in any analysis varies by indicator according to data availability (explained in the Annex). For some indicators, the most recent observations fall during or shortly after the coronavirus disease pandemic and should therefore be interpreted in that context.

Information based on these indicators is combined with other evidence from a variety of sources, including WHO normative guidance, systematic reviews, peer-reviewed literature, international policy frameworks, implementation research, return-on-investment analyses and examples of policies and programmes from Member States. Both HESRi2 reports were informed by consultations with WHO technical programmes, external experts and Member States. This integrated analysis also drew on modelling for HESRi2 and published economic evaluations.

The report focuses on socioeconomic inequities across the whole social gradient, although frequently highlights the gap between the least and most advantaged. Socioeconomic position was assessed, where possible using two stratifiers: income and educational level. For some indicators, other stratifiers were used (see the HESRi2 data report). Changes over time are based on whatever data were available for the years since 2010, which can vary by indicator, country, age and sex. Reporting of increases or decreases are based on a statistical test for trend, which is described in the HESRi2 data report *(9)*.

Return-on-investment and macroeconomic modelling

Where available, the report incorporates return-on-investment and macroeconomic modelling undertaken as part of HESRi2, together with published economic evaluations, to demonstrate the broader value of investing in health equity across the life-course. These analyses examine the potential effects of improved health on educational attainment, labour-market participation, productivity, household income, social protection and public finances, as well as further potential impacts of policy interventions, such as strengthening pension systems. Details of the modelling are included in the Annex.

What the HESRi2 policy report delivers

Designed as a practical, action-oriented guide for decision-makers, this report fulfils four core functions.

1. **Charting progress across the life-course**: the report tracks how health equity evolves across four primary life stages – early years, adolescence and youth, normal working ages, and older age – highlighting where progress has been achieved and where girls, boys, women and men remain at greatest risk of being left behind.
2. **Explaining the conditions shaping health within countries**: the report examines how structural determinants and policy choices drive health disparities across the five essential conditions for living a healthy, prosperous life.
3. **Signposting practical solutions for countries**: the report combines life-course evidence with country case studies, demonstrating how governments can adapt, scale and sustain enabling legislation, governance frameworks and place-based interventions.
4. **Demonstrating the value of equity-transformative investment**: the report uses illustrative scenario-building, selected country examples and pilot data to demonstrate the potential social, health and economic returns of equity-oriented policy choices, providing inspiration for what targeted investments across the life-course can achieve.

Why now? The changing European landscape and structural megatrends

Megatrends shaping health equity

The WHO European Region is undergoing profound demographic, economic, technological and social change. Population ageing, shrinking workforces, climate change and rapid digital transformation are reshaping the policy landscape. Without deliberate action, technological advances, artificial intelligence and the platform economy[1] risk reinforcing existing social, economic and health inequities. Ensuring that emerging technologies are governed, designed and implemented equitably – with ongoing assessment of their impacts among different population groups – will be critical *(15,16)*. At the same time, demographic change is increasing long-term care needs, widening gender inequalities in unpaid care and increasing the risk of social isolation, exposure to violence and barriers to essential services. Financial insecurity, insecure employment and digital exclusion can further undermine institutional trust, social cohesion and resilience to future shocks. Together, these trends are transforming how people live and work, requiring governments to rethink the relationships between health, prosperity and resilience.

The scale of the challenge: health inequities across the WHO European Region

Across the WHO European Region, countries are taking actions to protect and promote health and to secure conditions for people to live healthy, independent, productive and secure lives. However, demographic shifts, fiscal constraints and security threats – alongside social and technological developments – are challenging policy-makers' ability to close gaps in health and well-being and to expand healthy life expectancy for all women and men in communities throughout the WHO European Region.

The scale of the challenge is not insignificant, with an estimated 187 million people unable to reach their full potential due to avoidable health and social inequities (see Box A1 for the calculation). These are represented at every stage of life; currently 35 million children, 19 million young people, 99 million working-age adults and 34 million older adults are being left behind. These inequities also accumulate over life, with the effects of multiple and chronic health and social vulnerabilities in one stage of life spilling over to the next stage, where they shape the levels of risk and opportunities to prosper.

The implications for the WHO European Region extend far beyond the people who are falling behind and impact far beyond the health sector. Because health is a fundamental human right and one of the Region's greatest social and economic assets, healthy children and adults are better able to learn, work, care for others, participate in their communities and contribute to the economy. They are also more resilient in the face of demographic, economic and environmental change.

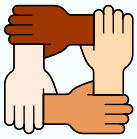
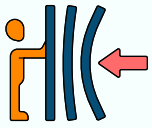
[1] The platform economy is an economic system in which digital platforms create value by connecting multiple user groups and facilitating interactions, transactions and services at scale

Conversely, when inequities prevent people from achieving good health and participating fully in life, this weakens human capital, constrains civic and economic participation and increases dependency and demand on public services and health systems. Amid population ageing, migration, geopolitical instability and declining trust, these inequities further undermine societies' ability to respond collectively to shared challenges. Reducing health inequities is therefore essential; not only for improving health, but also for strengthening the Region's social cohesion, resilience and security.

How health equity delivers a stronger Europe, today and in the years to come: five key pillars of a stronger Europe

Up to 89% of gaps in health can be narrowed and the WHO European Region can be made stronger, with investments in health equity delivering substantial co-benefits across five strategic pillars of European society, as detailed in Table 2.

Table 2. Strategic pillars and their policy value from reducing health inequities

Strategic pillar	Strategic policy value from reducing health inequities
1. Stronger demographic prospects 	Increases the number of healthy years people can learn, work, contribute, care for others and live independently for longer. This helps society to adapt to population ageing and transforms demographic change from a pressure into an opportunity
2. Stronger health services 	Prevents avoidable illness and unmet needs from escalating into complex and costly crises. This eases pressure, reduces demand, releases capacity and builds more resilient and financially sustainable health systems that can respond better to everyone: when needs arise and during periods of peak demand or crisis
3. Stronger social cohesion 	Enables more people to participate fully in society and engage in civic and community activities. It also reduces exclusion and fosters a sense of belonging and having a shared stake in society, and people are more willing to support decisions on universal and public good
4. Stronger economic competitiveness 	Releases human capital and creates a stronger and more mobile workforce, with the skills and capacity to adapt to changes in the labour market. It also drives regional cohesion, making regions more attractive places to live, work and invest. Both these co-benefits enhance the WHO European Region's competitiveness and sustainable development
5. Stronger security and resilience to future shocks 	Build more resilient people who are able to withstand social economic and environmental stressors and to recover from shocks

Source: authors' own compilation.

2 Children and adolescents



Where we want to be

Children's health, learning and well-being are shaped early and, when we get it right, the impacts multiply through the whole of life for the child, their well-being and prosperity, as well as for the whole of society's resilience, capabilities and progress. Good health and well-being in the early years and adolescence are shaped through nurturing relationships, secure homes and safe, supportive neighbourhoods with easy access to services and protection from physical and digital harms. This sets up all children to thrive from the start of life and to develop the necessary life skills needed for learning and to navigate adolescence.



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Summary

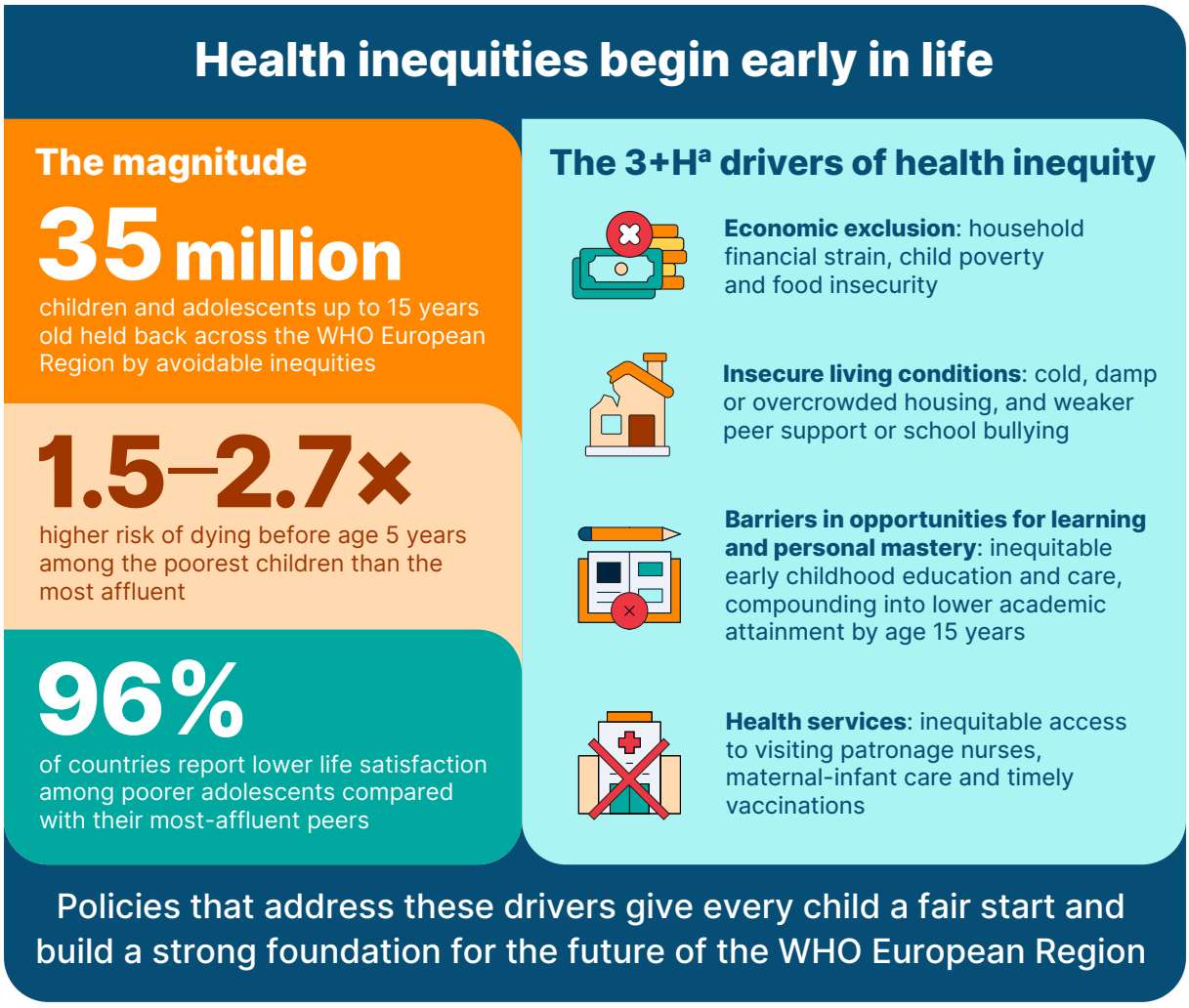
Childhood and adolescence are where health inequities first take root, shaping health, development, learning and future opportunities long before adulthood *(17)*. Across the WHO European Region, an estimated 35 million children up to age 15 years (the least affluent 20% of the population at this age) are being held back by multiple insecurities and missed opportunities needed to ensure a healthy life (Fig. 2).

Health inequities in childhood are driven largely by unequal exposure to and consequences of child poverty; higher risk of living in poor-quality housing, food insecurity and bullying; and barriers to participating in high-quality early-years learning and care.

Disadvantage has long-term consequences for health, education and employment. Yet, early investment in families, learning, housing, nutrition, mental and social well-being, and safe (digital) environments can change life trajectories and deliver a return on investment of up to eight-fold over a child's lifetime (Fig. 3) *(22)*.

Reducing these inequities is therefore not only a matter of fairness. By preventing disadvantage before it becomes entrenched, the WHO European Region can ensure its future social and economic vibrancy in the coming decades.

Fig. 2. Drivers of health inequity in children and adolescents in the WHO European Region



[a] The three main living conditions plus equity-focused health services.

Source: authors own compilation based on 2024 World Bank population estimates (see the Annex), data from HESRi2 data report and the WHO European Health Equity Atlas *(9,10)*, HBSC survey data from 2022 (or latest available year) for 47 countries *(11)*, and articles from the 2024 Lancet Series on the next 1000 days *(18–21)*.

Fig. 3. Lifetime return on investment from policies and interventions that support children and adolescents

Health and social authorities – working together with voluntary and community-based organizations, parents and schools – are key to **healthy years for all children and adolescents**

Family generosity policies
Maternity pay, child benefits, unemployment protection and housing

Community-based affordable services
Prenatal and early years care for children, and health and social support for parents

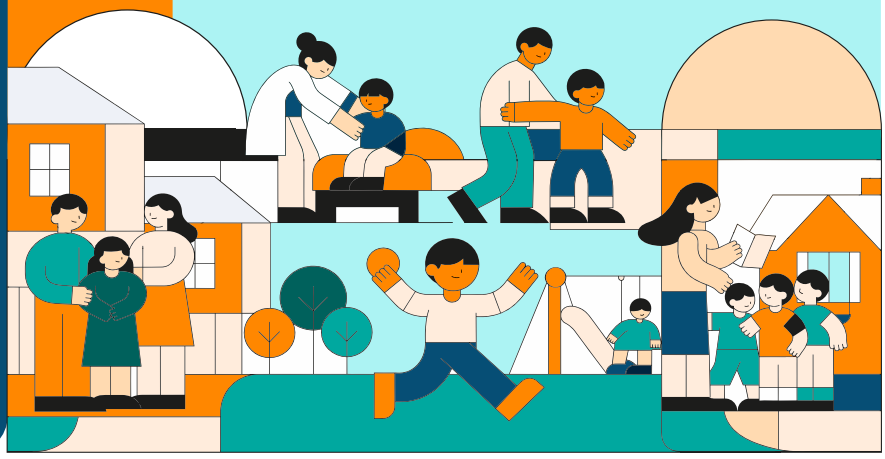
Parenting support programmes

Early-years and preschool programmes
Increasing personal mastery, language and socialization

Housing and neighbourhood policies
Safe and affordable homes and places to play

8×

return on investment over every child's life



Sources: based on articles from the 2024 *Lancet* Series on the next 1000 days *(18–21)*; Heckmann and Mosso, 2014 *(22)*; and Marmot and University College London Institute of Health Equity, 2014 *(23)*.

Four priorities to level up the health, well-being and life chances of children and adolescents in Europe

Countries can take the following actions to reduce health inequities. The order of the following priorities is purely sequential and does not denote their importance.

① Invest in integrated health, early-years and family support closer to home for all.

- Reduce barriers to access and quality for underresourced households and communities.
- These services should be delivered through integrated hubs or one-stop shops located in everyday, easily accessible settings.

② Make public health goods for a healthy childhood affordable for all families.

- Non-stigmatizing social transfers remain essential for mitigating the effects of poverty and poor-quality homes on the well-being and development of children. Not only can they reduce child poverty by up to 50% but they also have a strong equity effect when combined with parenting support, childcare services and access to local family resource centres that remove barriers hindering parents from providing high-quality food, warm and secure homes, and participation in well-designed early childhood education.

③ Design schools and learning settings to nurture the whole child.

- A nurturing school environment is an important buffer that protects children's health opportunities and capabilities from being harmed by growing up in a disadvantaged home environment, while having a positive effect on the well-being and learning outcomes of all children. This requires a whole-school approach encompassing the formal curriculum, school culture and provision of nutritious food and warm and safe learning environments – designed to support the health and social literacy, cognitive skills and sense of personal mastery for every child and adolescent.

④ Create and implement safe and inclusive physical and digital spaces for children and adolescents using a two-pronged approach.

- Strengthen children's capabilities, while requiring digital platforms and technology companies to demonstrate that products and services used by children are safe by design (including protection from sexual harassment, image-based abuse and other forms of technology-facilitated violence).
- Expand equity-focused digital access and protections, alongside equal access to programmes that build children's skills to recognize and navigate cyber risks and online abuse. This can empower disadvantaged children and adolescents to participate safely and confidently in both physical and digital spaces.

These priorities are reinforced by the European Child Guarantee, the European Care Strategy for caregivers and care receivers and the WHO/United Nations Children's Fund (UNICEF) child and adolescent health and well-being strategy (2026–2030) *(5,24,25)*. Together, they provide countries with a strong framework for translating priorities into practical support for families, stronger community services and shared accountability for children's health and well-being.

At a glance: the health and well-being of children and adolescents

Mortality at age under 5 years

More children in the WHO European Region are living beyond their fifth birthday, with survival rates improving across all 15 countries with trend data *(26)*. However, substantial inequities remain. Children from the least wealthy households face between 1.5-2.7 times the risk of dying before age 5 years than those among the most wealthy groups, while some groups – including Roma children – experience particularly high mortality in the first years of life. There are wide variations between countries in the magnitude of the gap in under-5 mortality rates, comparing the number of deaths per 1000 live births in the least and most affluent families. The smallest gap between children in the most and least affluent households in any of the 15 countries with data is from 1.7 to 3.5 deaths per 1000 live births and the largest gap from 29.5 to 50.3 deaths per 1000 live births *(2,26)*.

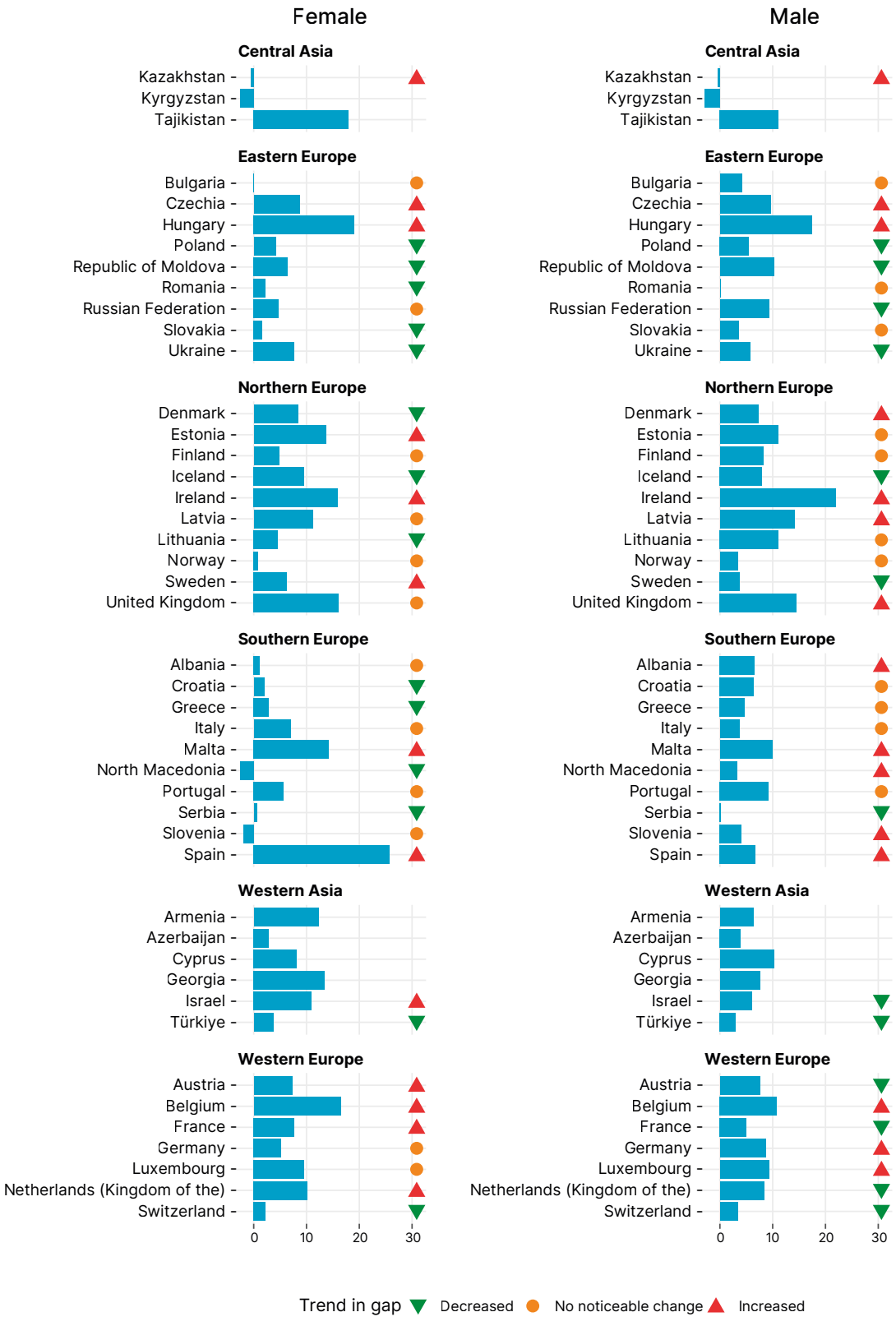
Morbidity and illness

Levels of reporting of poor health are greatest among girls in poor families. Poor health is more common among the least affluent than the most affluent in 41 out of the 45 (91%) countries with data for girls and in 43 of 45 (96%) countries with the same data for boys (Fig. 4). The largest gap ranges from between 13% and 33% for girls in one country and between 14% and 31% for boys in another: a gap of more than double for both girls and boys. Poor health is also more common among girls than boys at every level of affluence in 93% of countries. Over time, these inequities have shown mixed progress. The gap has successfully narrowed in 14 of these 45 countries for girls (31%) and 13 of 45 for boys (29%), while it has increased in similar numbers of countries (13 and 15 of 45 countries; 29% and 33%, respectively) *(11)*.

The direction of change also varies depending on where a child is born and grows up in the WHO European Region. For example, eastern Europe (nine countries with data) demonstrates the most consistent positive momentum, achieving net narrowing across both girls and boys (five countries narrowed versus two that widened for girls; four narrowed versus two that widened for boys). Western Europe (seven countries with data), on the other hand, presents a polarized picture, showing the Region's highest rate of progress for girls (narrowing in four countries; widening in one), alongside the highest rate of worsening for boys (widening in four countries; narrowing in three). Northern Europe (10 countries with data) shows the least overall progress, characterized by stagnation for girls (narrowing and widening in three countries each) and worsening for boys (widening in four countries, narrowing in two) (Fig. 4) *(11)*. These data suggest that national economic prosperity does not automatically translate into narrowing child health disparities.

The marked differences in progress between and within European subregions show that child health equity is also a matter of territorial cohesion. A stronger WHO European Region requires children's opportunities for health and development not to be determined by where they are born or grow up.

Fig. 4. Gap in 2022[a] in the percentage of children aged 11–15 years reporting poor or fair health between those in the least and most affluent families, and changes since 2010[b]



[a] Or the latest available year.

[b] Or the earliest available year.

Notes: the Family Affluence Scale *(28)* asks participants about a series of material assets as indicators of socioeconomic status. The gap is from 20% of children in the least affluent families to the 20% in the most affluent families. Trend indicator shows if there was a statistically significant change in the gradient since 2010 (or earliest available year). No traffic light indicates insufficient data to assess a trend.

Sources: data from the HBSC survey *(11)* for 2010–2022 (or latest available year), except for ALB (2014–2022), ARM (2010), AZE (2018), BGR (2014–2022), CYP (2022), GEO (2018), KAZ (2018–2022), KGZ (2022), MDA (2014–2022), MLT (2014–2018), RUS (2010–2018), SRB (2018–2022), TJK (2018) and UKR (2010–2018). For the full list of three-letter country codes and regional subgroups used in the report, see Annex, Table A1.

Well-being and mental health

In 96% of countries (45 out of 47 with data), children aged 11–15 years who are from the least affluent families are more likely to report poor life satisfaction than children from more-affluent families. Trend data for 46 countries shows the gap in poor health between least and most affluent children has narrowed in 14 countries (30%) but widened in nine countries (25%) for girls and in seven countries (20%) for boys. Narrowing of the gap in the majority of countries in a subregion was only seen in eastern Europe (in five out of nine countries, for both girls and boys) *(11)*.

Drivers of inequity in the early years of life

From conception to a child's second birthday, the first 1000 days provide one of the most important opportunities to shape health, development and future opportunities *(26)*. This is when children most need good nutrition, protection, responsive care and early support to survive, grow and thrive. It is also when inequities can first take root. Poverty, poor housing, insecure livelihoods for parents and carers, and limited access to high-quality local services can quickly place children on a trajectory of disadvantage.

The first 1000 days are both a window for child development and establish the early foundations for a child's future prosperity. Investing early builds health literacy and the social, emotional and cognitive capabilities that support learning and personal mastery.

These capabilities underpin educational success, healthy transitions into adulthood and the future human capital on which the WHO European Region's demographic and economic prospects depend.

Access to health care in the first 1000 days

Maternal, newborn and early childhood services are among the strongest tools for reducing health inequities. They provide one of the earliest opportunities to identify risks, support parents and caregivers, and connect families with wider services and social support. High-quality, non-stigmatizing care during pregnancy, birth and the postnatal period prevents maternal and newborn deaths, supports breastfeeding and good nutrition, strengthens immunization uptake and enables the early identification of developmental needs *(5,26,28)*.

- **Skilled birth attendance by health professionals** reduces preventable maternal and newborn complications. Coverage is generally high across the WHO European Region, reaching 95% or higher in 39 of the 53 countries with data (74%). However, 14 countries (26%) do not report on this SDG indicator, creating a blind spot in monitoring the delivery of essential maternal and newborn health services.
- **Home-visiting programmes** help to bring health services closer to families in their everyday lives, regardless of their income or where they live. Around 80% of countries have systems involving home-visiting nurse or midwife programmes, although coverage and the range of services vary considerably. These programmes provide breastfeeding and parental support, monitor child growth and development, identify maternal physical and mental health needs and detect family risks (such as domestic abuse) at an early stage. They connect families with wider services, helping parents and carers to navigate different providers, preventing children from falling through service gaps and ensuring continuity of care.

- **Breastfeeding** within the first hour of birth ranges from 10% to 99% across the 24 countries with data, but monitoring remains weak, with 21 countries not responding to the survey (47%) *(26)*. The WHO European Region has the world's lowest rate of exclusive breastfeeding at age 6 months (around 25%). This reflects not only individual choice and cultural norms but also the availability of breastfeeding support, the implementation of baby-friendly hospitals and community support settings, parental leave, the extent to which workplace policies enable breastfeeding and the regulation of the marketing of breast-milk substitutes.
- **Immunization coverage** is also a measure of whether local prevention services are reaching children consistently and equitably. Although national coverage is often high, more than half of countries report underimmunized populations at subnational level, highlighting persistent gaps in access and outreach *(29)*.

Countries across the Region are already demonstrating how these priorities for the first 1000 days can be put into practice, highlighting common implementation mechanisms that are effective. These include integrated family and child hubs, multidisciplinary teams, home-visiting programmes, coordinated referral pathways, routine developmental screening, parenting support and stronger links between health, education and social services. These have been adapted to different national contexts. In Kazakhstan, the Patronage Nursing Service provides integrated breastfeeding support, immunization, parenting advice and early child development through two visits during pregnancy and nine visits up to age 3 years, with additional support proportionate to family need *(30,31)*. In Belgium, one-stop shops provide integrated preventive child and family health services from pregnancy through early childhood, combining home visits, developmental screening and parenting support *(32,33)*. In France, the first 1000 days initiative is a national policy priority underpinned by a statutory duty for authorities to coordinate health, parenting and early childhood services from pregnancy to age 2 years *(34)*.

These approaches show how equity-by-design can make public services more preventive and effective by identifying needs early, coordinating support around families and reducing the likelihood that avoidable problems require more intensive intervention later.

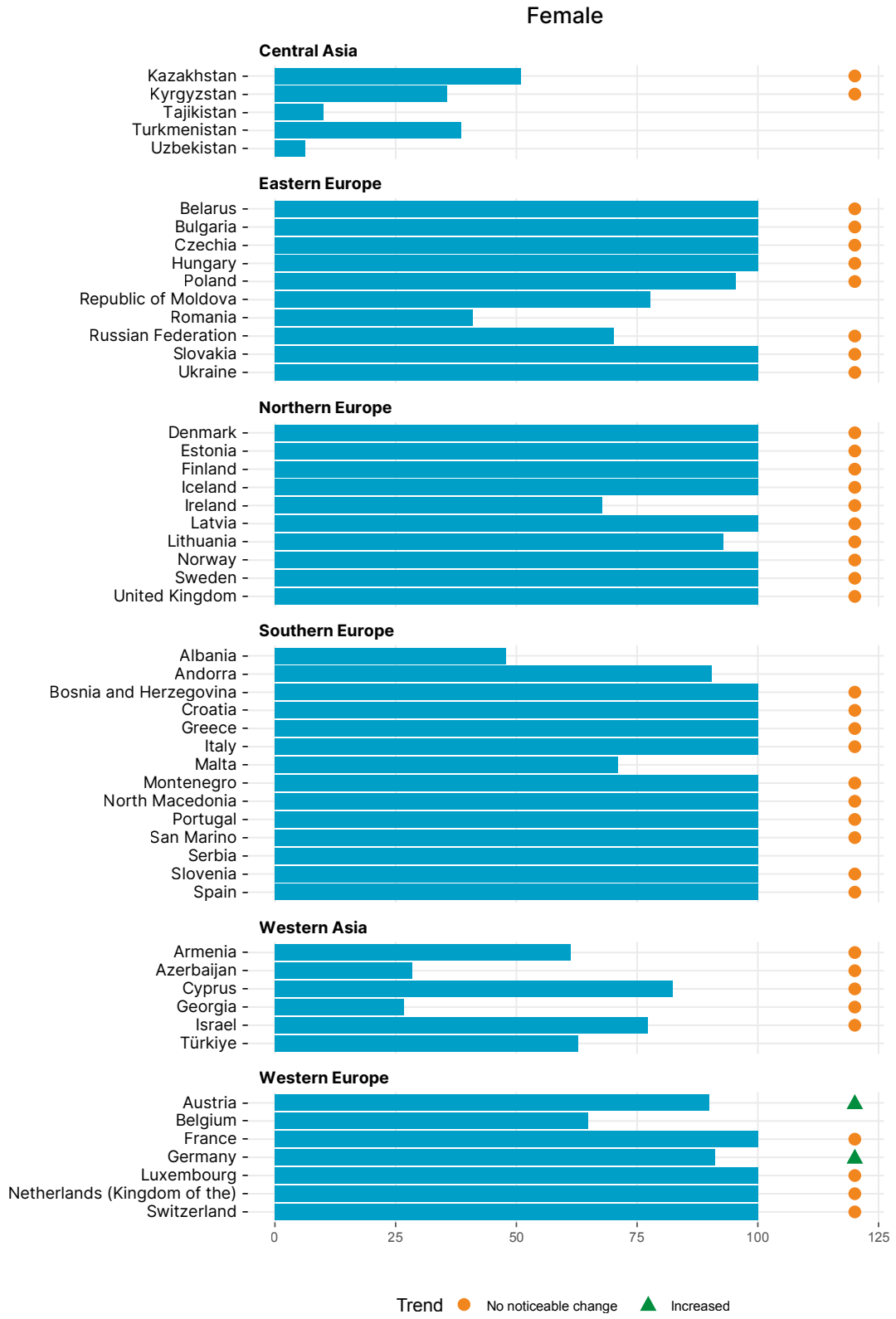
Well-designed parental leave policies – including adequately paid, individual and nontransferable leave for fathers and partners – are also examples of such investment in early-days nurturing that promote equal caregiving responsibilities between mothers and partners/fathers without sacrificing income.

The duration and generosity of paid maternity leave vary widely, from 6 to 59 weeks across the 33 countries with data. The majority of countries (29 of 53; 55%) provide full coverage through cash benefits, which help to cover the costs associated with caring for a young child. Among the remaining 24 countries (45%) coverage is variable, with less than 50% of mothers covered in one third of these countries, mainly in parts of central Asia and western Asia *(9)* (Fig. 5).

Paid paternity leave also remains limited in many countries, with 17 out of the 33 countries with data (52%) providing around two weeks' leave and only eight countries (24%) providing four or more weeks.

Implementation and accountability for policies and services across the first 1000 days can be strengthened through established regional and global frameworks, such as the WHO/UNICEF child and adolescent health and well-being strategy (2026–2030) *(5)*, the Baby-friendly Hospital Initiative *(36)*, the *Framework for action on the health and care workforce in the WHO European Region 2023–2030 (37)* and the European Immunization Agenda 2030 *(38)*.

Fig. 5. Percentage in 2022[a] of women giving birth who receive maternity cash benefits and changes since 2016[b]



[a] Or the latest available year.

[b] Or the earliest available year.

Notes: trend indicator shows if there was a statistically significant change in the gradient since 2016 (or earliest available year). No traffic light indicates insufficient data to assess a trend.

Sources: data from ILOSTAT, the International Labour Organization's database *(35)* are from 2016 to 2022, except for ALB (2019), AND (2020), ARM (2016–2021), BEL (2021), BIH (2019–2021), BLR (2019–2020), CHE (2016–2021), CYP (2015–2022), DEU (2016–2021), FIN (2016–2021), FRA (2016–2021), GEO (2016–2019), GRC (2016–2023), HRV (2015–2021), HUN (2016–2021), ISR (2019–2022), LUX (2016–2021), MDA (2022), MKD (2019–2020), MLT (2021), MNE (2019–2020), POL (2016–2021), ROU (2022), RUS (2016–2021), SMR (2019–2020), SRB (2021), SVN (2016–2021), SWE (2016–2021), TJK (2021), TKM (2021), TUR (2022), UKR (2016–2020) and UZB (2022). For the full list of three-letter country codes and regional subgroups used in the report, see the Annex, Table A1.



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A secure family environment in the first years of life is an essential condition for the health, development and well-being of all children. During this period, children depend on the time, quality of care, resources and learning opportunities that parents and caregivers are able to provide. Well-designed paid parental leave programmes – when combined with child poverty measures, flexible working arrangements and access to affordable, high-quality early learning – are estimated to generate benefits far exceeding costs, with benefit–cost ratios often reaching 8–19 times the original investment *(21,39)*.

These policies are most effective when combined with adequate child and family benefits, minimum-income protection, affordable and high-quality early childhood education and care (ECEC), flexible working arrangements and integrated family and child services that bring together health, social-protection, early childhood education and parenting support. Simplifying access through integrated service delivery, proactive outreach and coordinated referral pathways can help to ensure that families receive support early, before financial and social pressures escalate *(23)*.

Countries are already demonstrating how these approaches can be implemented. Finland has developed integrated Family Centres that bring together maternity and child health services, social support, family counselling and education, starting with ECEC *(40)*. Slovenia combines generous parental leave with universal access to ECEC. The health sector is supporting ECEC with the nationwide universal comprehensive programme, *ZDAJ!* [NOW!], specifically targeting identified vulnerable groups. Participation in the preventive programme is free of charge for children, as the costs are covered by the Health Insurance Institute of Slovenia. Mandatory health insurance ensures full coverage – with no co-payments – for preventive check-ups and health education for children and parents *(41,42)*. Spain is progressively expanding equal parental leave for both parents, while the United Kingdom has developed integrated family support models through Best Start Family Hubs and Healthy Babies, which coordinate health, early-years and wider family services *(43)*. Together, these examples demonstrate how coordinated policies and integrated delivery can improve children's development, promote more inequitable caregiving and support parents' participation in the labour market, thus strengthening both family security and the WHO European Region's economic resilience.

These approaches are supported by broader governance frameworks, including the European Child Guarantee, the European Care Strategy, the WHO/UNICEF child and adolescent health and well-being strategy (2026–2030) *(5,24,25)* and relevant International Labour Organization maternity protection standards, which provide countries with practical frameworks for strengthening family support policies and promoting gender equality.

Early learning

Investments in high-quality ECEC deliver benefits for all children far into the future *(22)*. More importantly, they have a strong impact on levelling learning opportunities and life chances for children living in disadvantage.

ECEC participation exceeds 75% in 32 of the 46 countries with data for both girls and boys. Access improved in 23 of these 46 countries for girls (50%) and 22 of 46 for boys (48%). However, it decreased in five countries for girls (11%) and four for boys (9%). The largest proportion of countries with increases was seen in northern Europe (eight out of 10 countries for girls and seven out of 10 for boys) *(9)*.

Investment in ECEC varies widely across the WHO European Region, with northern Europe spending up to US$ 15 000 per child *(9)*. Countries are also demonstrating innovative financing approaches. In Uzbekistan, multi-partner financing, guided by a national human capital strategy, supported a US$ 64 million investment that increased preschool enrolment from 30% in 2018 to 77% in 2025. By 2025, 93% of participating classrooms provided good or very good learning environments, generating an estimated benefit–cost ratio of 1.5 *(44)*. This demonstrates how sustained investment, supported by strong governance and international partnerships, can improve equal opportunities and access for all children, irrespective of the affluence of the family they are born into, thereby positively influencing both educational attainment and health equity.

Developmental readiness (SDG 4.2.1) – measured through literacy and numeracy, physical, social-emotional and learning development – reflects whether children are receiving the nurturing care and stimulation needed to thrive. At ages 3–5 years, girls from the least wealthy households are less likely to be developmentally on track than their more-affluent peers in four of the eight countries with data (50%) and, for boys, in six of the nine countries with data (67%).

Trend data for differing time periods in the years 2010–2019 are available for seven countries and show mixed progress. The developmental gaps narrowed between girls from the least and most affluent families in five countries (71%) and widened in the other two countries. For boys, progress was slower: developmental inequities widened in four countries (57%) and narrowed in two *(9)*.

Closing these early developmental gaps helps to ensure that talent and potential are not lost because of family income or geography. It strengthens future skills and educational attainment, while reducing inequities between communities, regions and generations.

Countries make the greatest progress to level up ECEC opportunities and benefits for all children by combining universal access to high-quality ECEC with targeted support and services designed to increase coverage and participation of children from disadvantaged families. This can include well-trained community parenting support, sufficient places with suitable opening hours, manageable fees and geographical coverage of ECEC seamlessly linked to developmental screening services, and integrated support across education, health and social services *(45,46)*.

Transition to school age and adolescence

Children do not choose where they are born or the conditions in which they grow up. Their health and development are shaped by the homes and neighbourhoods they live in and the opportunities and support available during their early years. Getting these foundations right gives every child and adolescent the best chance to thrive at this stage of their life and into the next.

Early inequities persist into adolescence. For example, by age 15 years, children with less-educated parents are less likely to achieve proficiency in reading and mathematics than their peers whose parents have the highest level of education in all 46 countries with data. The largest gap between these groups in any one country is from 17% to 82% for girls and from 19% to 70% for boys. In the 44 countries with trend data, these inequities among girls narrowed in the same number of countries that they widened (13 countries; 30% in each case). For boys they narrowed in 11 countries of 44 (25%) and widened in 14 of 44 (32%).

These gaps represent an avoidable loss of capabilities long before children enter the labour market. Reducing them strengthens the WHO European Region's future skills base and helps to prevent inequities in childhood from becoming lasting economic and territorial divides.

Healthy and secure homes

A safe, secure and affordable home is a crucial foundation for children's health and growth, providing protection from chronic stress and illness.

The least affluent people in the 36 countries with data are six times more likely to experience severe housing deprivation; namely, living in an overcrowded dwelling that also lacks a bath and indoor toilet, or is damp or too dark (12% versus 2%) (Fig. 6) *(9)*. Living in such conditions increases the risk of asthma, respiratory illness and poor mental health, while disrupting child development and learning.



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Fig. 6. Severe housing deprivation among children and adolescents in the WHO European Region



Source: authors' own compilation based on data from the HESRi2 data report *(9)* and EU-SILC *(12)*.

Where these conditions are concentrated in disadvantaged communities, they also reinforce inequities between places. Ensuring that every child grows up in a warm, secure home is therefore an investment in health, educational opportunity and more inclusive and balanced development between places.

Countries are beginning to treat warm, secure housing as part of child health and child poverty policy. In Scotland (United Kingdom), the *Bringing hope, building futures: tackling child poverty delivery plan 2026–2031* includes a range of actions intended to improve outcomes for children and families, including measures to reduce household costs. In 2026–2027, £64 million is allocated to area-based energy-efficiency schemes, prioritizing low-income households, including families with children at heightened risk of fuel poverty. This is complemented by an automatic Child Winter Heating Payment for eligible disabled children and young people, helping families to meet their higher heating needs over the winter period and to protect children's health and well-being *(47)*. These approaches show how housing improvement, energy support and social protection can be combined to protect children's health and development.

Nutrition and food security

Starting the school day without breakfast limits children's energy levels and learning ability. The largest difference among girls aged 11–15 years in any one of the 45 countries with data is from 70% in the least affluent families and 54% in the most affluent ones miss breakfast on any school day. Among boys the largest difference is between 51% and 31%. The inequity gap for missing breakfast narrowed for girls in 12 countries and for boys in 10 countries of the 38 with data (32% and 21%, respectively). The gap widened for girls in eight of 38 countries (26%), while it widened for boys in 14 of 38 (37%).

Countries are responding through complementary policies that improve both access to healthy food and its affordability. School food programmes act as nutritional safety nets when families are experiencing food insecurity. For example, schools in Tallinn (Estonia) provide free hot school breakfasts *(27)*, while Finland and Slovenia's long-standing universal school meal programmes ensure every child has access to a nutritious meal throughout compulsory education *(48)*.

Many low and moderately affluent households experience food insecurity during periods of economic pressure. Countries are also addressing the root causes, using fiscal and market measures. Croatia and France have introduced price control measures *(49,50)*. In Kazakhstan, regional stabilization funds and subsidized social food baskets help low-income households to afford nutritious food. These national approaches are complemented by broader strategies, such as the Northern Ireland (United Kingdom) *Healthy futures obesity strategic framework 2025*, which takes a life-course approach to improving children's nutrition and preventing obesity *(51)*.

Safe neighbourhoods, recreational spaces and physical activity

Access to safe green and blue spaces supports health. Opportunities for physical activity are shaped by children's social and physical environments. Barriers include fewer safe places to play and the costs of sports clubs, equipment and facilities. In all of the 45 countries with data, girls aged 11–15 years from the least affluent families are less likely to be physically active than their more-affluent peers. Boys from the least affluent families are less likely to be physically active in 43 of the 45 countries (96%), highlighting persistent inequities in opportunities for healthy development *(26)*.

Gender-responsive approaches are particularly important for adolescent girls, whose opportunities to be physically active may be constrained by safety concerns, restrictive gender norms, caring roles, lack of inclusive programmes and inadequate support for menstrual health *(52,53)*. In Scotland (United Kingdom), the Fit for Girls programme supported secondary schools to offer more inclusive and girl-responsive physical education and sport, including greater choice and girls' leadership *(54)*. Its evaluation found that 59.9% of physical education staff reported increased participation by girls in physical education, activity and school sport *(55)*.

The most promising child-friendly urban interventions for reducing health inequities are those that improve the quality and safety of everyday neighbourhood environments in disadvantaged communities *(56)*.

Evidence from Barcelona, Spain (Superblocks, Climate Shelters *(57,58)*); Paris, France (OASIS Schoolyards and School Streets *(59,60)*); Ghent and wider Flanders, Belgium (Play Streets and Green Schoolyards *(61,62)*); Rotterdam, Netherlands (Kingdom of the) (Green–Blue Schoolyards *(63)*); Tirana, Albania (School Streets *(64)*); and United Kingdom cities, including Bradford (JU:MP *(65)*) suggest that school and play streets,

green schoolyards, co-designed play spaces and traffic-reduction measures can enhance physical activity, social connectedness, perceptions of safety and opportunities for play. For example, in Barcelona, children's street play increased by 283% *(66)*, with notable gains among girls *(67)*; Bradford's JU:MP increased physical activity by over 70 minutes per week *(65)*; and a study of air quality in London's school streets showed reduced nitrogen dioxide levels by up to 23% *(68)*. Benefits may be greatest for children who lack access to private green space, organized recreation and other household resources.

By creating safe and welcoming places to play, learn and connect, these interventions also strengthen children's sense of belonging and participation. This further builds social bonds and a sense of responsibility towards others and for the communities in which they live. This is an investment in young citizens who are active guardians of the places where they live.

Poverty and social protection

The income security of parents and caregivers is one of the strongest determinants of children's health and well-being. Financial insecurity places children from the least affluent families at greater risk of stress, anxiety, respiratory illness, poor nutrition and self-reported poor health. This link is significant in tackling inequities, given that around 22% of children in the 36 countries with data are at risk of poverty, with child poverty averaging 25% in 11 countries in southern Europe and with the lowest average rate (18%) found in both eastern and western Europe (six and seven countries, respectively) *(9)*.

Living in poverty, experiencing poorer health and facing social exclusion are also major barriers preventing the least affluent children and adolescents from accessing enriching opportunities that build skills, confidence, aspirations, social networks and future capabilities. Examples include sports, music, arts, travel, clubs, cultural activities, volunteering and other extracurricular learning opportunities.



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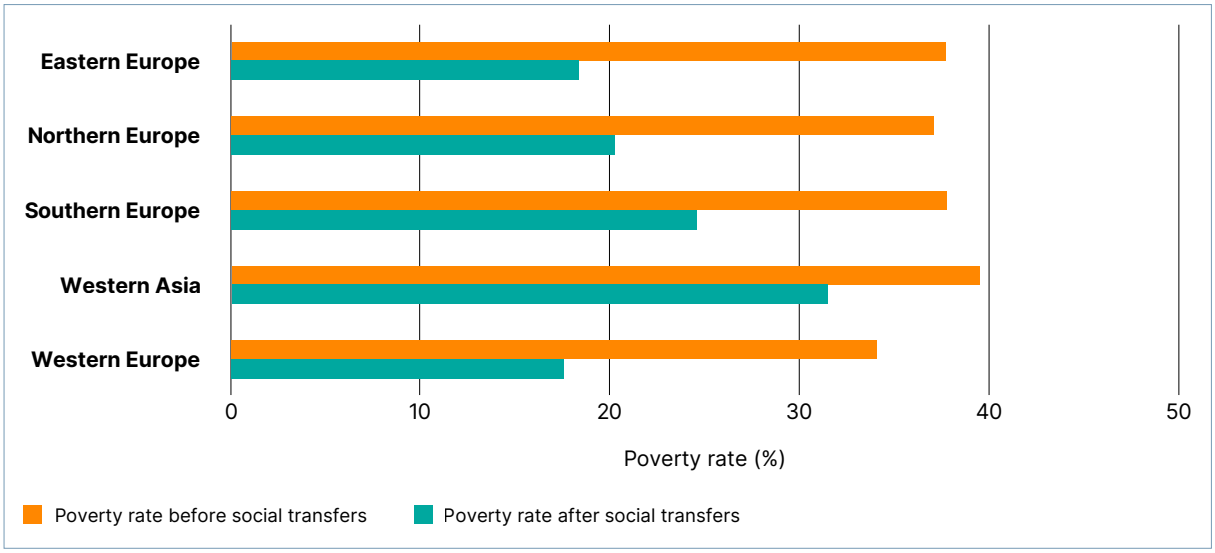
Fig. 7. Reduction in poverty for children aged under 18 years due to social transfers



Source: authors' own compilation based on data from the WHO European Health Equity Atlas *(10)*.

Despite these life-limiting effects, general government spending on social protection and social assistance for children and families remain modest in many countries, at below 2% of gross domestic product (GDP) in 16 of the 30 countries with data (53%). Moreover, undercoverage and non-uptake remain persistent challenges, limiting the ability of social-protection systems to reach vulnerable children and families and reduce child poverty effectively *(69–71)*. Allowing poverty to constrain children's health, learning and participation constrains the WHO European Region's future security and capability. As a route out of poverty, social protection is a smart investment into prosperity, by expanding opportunities and releasing every child's potential.

Countries can strengthen income security through a combination of policies improving social, child and family benefits; minimum-income protection; paid parental leave; decent wages and family-friendly employment that enable parents and caregivers to balance work and family responsibilities. These efforts can make a measurable difference. For example, social transfers and family welfare can reduce the risk of child poverty by up to 50% (Fig. 7) *(10)*, helping to ensure children grow up in secure homes with good nutrition, stable living conditions and better opportunities to learn and thrive.

Countries are demonstrating how these approaches can be implemented. In Scotland (United Kingdom), the Five Family Payments combine the Scottish Child Payment, Pregnancy and Baby Payments, Best Start Early Learning Payment, Best Start School Age Payment and Best Start Foods to support low-income families at key stages of childhood *(72)*. Evaluation evidence shows that the package of initiatives has reduced financial pressure, food insecurity and material deprivation, while improving access to essentials and healthy food *(73–75)*. In Spain, the *Ingreso Mínimo Vital* [Minimum Vital Income] provides a national income guarantee for households experiencing financial hardship, with additional support for families with children *(76)*. Innovative financing approaches can further accelerate progress. Iceland, for example, has issued a €50 million sovereign gender bond to finance affordable housing for low-income women and to strengthen parental leave, recognizing both as investments in maternal and child health *(77)*. This illustrates how financing mechanisms beyond the health sector can support healthier starts in life, while advancing wider social and economic objectives: this investment approach has helped to sustain Iceland's position at the top of the Global Gender Gap Index for 17 consecutive years *(78)*. Together, these examples show how coordinated income-support policies can reduce financial stress and strengthen children's health and well-being.

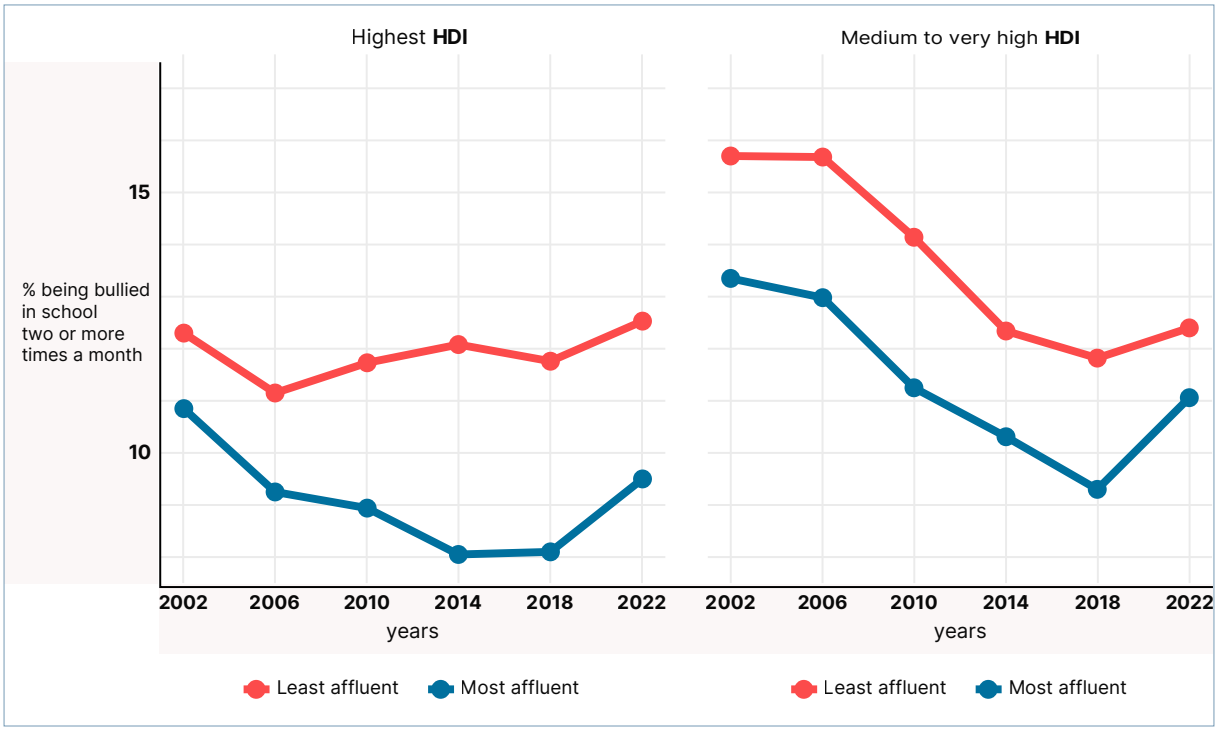
Supportive relationships and bullying

Outside the home, supportive families, schools, communities and peer relationships help children to build the confidence, resilience and social skills needed to navigate adolescence safely.

Adolescents from less-affluent families are more likely to report low peer support than those in the most affluent families: for girls, in the 43 of the 44 countries with data; and for boys, in the 40 of the 44 countries with data. The largest difference in any country is from 20% to 39% among girls and, in another country, from 25% to 44% among boys. This matters because social isolation is closely linked to poor mental health.

Although in-person bullying is declining across much of the WHO European Region, adolescent girls from less-affluent families continue to report higher rates of bullying at school than those in the most affluent families in 32 out of the 45 countries with data (71%). Among boys this is the case in 31 countries (69%). The largest gaps in any country are from 14% to 21% among girls and from 14% to 25% among boys. The most striking shifts in the inequity gap depend on a country's development level. In the WHO European Region's very high Human Development Index (HDI) countries, the socioeconomic gap has tripled between 2002 and 2022, leaving the least affluent adolescents 1.3 times more likely to experience bullying than the most affluent ones. By contrast, in medium- to high-HDI countries, long-term improvements have led to an almost complete elimination of this gap between the most and least affluent adolescents (Fig. 8) *(10)*.

Fig. 8. Trends in percent of adolescents bullied at school, by family affluence and the country's HDI, 2002–2022[a]



[a] Unless otherwise indicated.

Notes: data are from 33 countries with more than four sweeps of the HBSC survey. Country HDI levels are as follows: medium to very high is below 0.925 and highest is 0.925 and above. For the full list of three-letter country codes and regional subgroups used in the report, see the Annex, Table A1.

Sources: data are from the HBSC surveys for the years 2002–2022, except for CHE (2002–2010), ISL (2006–2022), LUX (2006–2022), ROU (2006–2022), RUS (2002–2018), SVK (2010–2022) and UKR (2002–2018) *(11)*.

Countries are strengthening whole-school approaches to prevent bullying and promote positive school environments. Evaluated initiatives such as Finland's KiVa antibullying programme and the Norwegian Olweus Bullying Prevention Programme – implemented in Lithuanian schools since 2008 – demonstrate how evidence-informed interventions can reduce bullying, improve school climate and strengthen students' mental well-being *(79,80)*. Evaluation of the KiVa Programme found reductions of 30–50% in bullying victimization, alongside improvements in anxiety, depression, school motivation and academic achievement *(81)*.

Safe and inclusive schools do more than prevent harm. They help children's mental well-being and resilience and develop their trust, belonging and sense of mattering: these are foundations for social participation and cohesion later in life.

Digital lives

Cyberbullying shows a different pattern than in-person bullying. In 27 countries of the 43 with data (63%), adolescent girls and boys in low-affluence families are more likely to experience cyberbullying than those in the most affluent families. However, this figure is geographically patterned, particularly for girls. In all 11 countries in eastern Europe, girls in the least affluent families are more likely to experience cyberbullying, whereas the reverse is true in the three countries in central Asia, likely reflecting greater access to digital technologies *(9)*. Inequities widened in 23 countries for both girls and boys (51%) and narrowed in only four countries among girls (9%) and six among boys (13%). However, in countries with very high levels of human development in the WHO European Region – where access to digital technologies (internet-connected mobile phones and personal computers) is both more widespread and more well established – the data suggest adolescents from the less-affluent families are more likely to experience increases in cyberbullying.

Digital well-being and risks extend beyond cyberbullying. While the direction and magnitude of the proportion of adolescents showing signs of problematic social media use varies markedly between countries, the trend is clear. Inequities widened in 21 of the 44 countries with data for girls (48%) and narrowed in only 14 countries (32%). Similarly for boys, inequities narrowed in 20 of 44 countries (45%) and widened in 15 (34%). This highlights the need for safer digital environments alongside digital literacy and mental health support.

Countries are strengthening legal and policy responses. Kazakhstan has introduced administrative liability for cyberbullying of minors, while Uzbekistan has recognized online harassment as a form of violence within child-protection legislation *(82)*. At regional level, the EU Action plan against cyberbullying supports coordinated action through common reporting mechanisms and measures to improve children's online safety *(83)*. In the United Kingdom, the Social Switch Project supports vulnerable young people in navigating online harms and building digital skills, while young participants from the United Kingdom in the European youth-led Ctrl+Alt+Reclaim movement are helping to shape technology policy and advocate for safer, more inclusive digital spaces *(84,85)*. Together, these approaches show how legislation can be reinforced by practical support and meaningful youth participation, enabling young people – particularly those most exposed to harm – to stay safe and exercise greater control over their digital lives. Building these capabilities across all social groups strengthens children's resilience to rapidly evolving digital risks and helps the WHO European Region to develop a safer, more inclusive and trusted digital environment.

The seeds of a stronger WHO European Region are planted when all children have the health, security, relationships and opportunities needed to develop, grow, learn and take an active role in their communities and social networks. This is the dividend from investing in an equally healthy, prosperous, future generation.

Concrete actions countries are taking to accelerate progress

The following country examples are intended to inspire action and promote knowledge exchange across the WHO European Region (Box 1). They showcase practical policies and programmes that countries are implementing to improve health equity for children, demonstrating how evidence-informed action can strengthen the conditions for healthier, more secure transitions into the next stages of life.

Box 1. Examples of national accelerators and their key enabling frameworks for children and adolescents

Priority for action 1

Improve family incomes.

Providing direct financial lifelines reduces daily stress. When families have enough resources, children are more likely to eat well, sleep well, live in a stable home and do better at school.

Illustrative country accelerators (what countries are doing)

Scotland (United Kingdom)
Under the Social Security (Scotland) Act 2018, the Five Family Payments combine regular income support, grants at key stages of child development and healthy food support to strengthen the essential conditions for a healthy start in life *(72)*. Independent evaluation found that both material deprivation and food insecurity would have been between 8 and 9 percentage points higher in Scotland without the Scottish Child Payment *(73–75)*, while the latest Scottish Government modelling projects the programme could lift around 50 000 children out of relative poverty in 2026–2027. This coordinated life-course approach demonstrates how integrated policy packages can achieve greater health equity than isolated interventions.

The *Bringing hope, building futures: tackling child poverty delivery plan 2026–2031* includes a range of actions intended to improve outcomes for children and families, including measures to reduce household costs. In 2026–2027, £64 million is allocated to area-based energy-efficiency schemes, prioritizing low-income households, including families with children at heightened risk of fuel poverty. This is complemented by an automatic Child Winter Heating Payment for eligible disabled children and young people, helping families to meet their higher heating needs over the winter period and to protect children's health and well-being *(47)*.

Slovenia
Slovenia provides 105 days of paid maternity leave, 15 days of paid paternity leave and 320 days of parental leave. Each parent is entitled to 160 days, including 60 days that must be taken by each parent; the remaining leave can be shared. Benefits replace 100% of previous earnings, subject to the applicable ceiling. Employment protection, flexible working arrangements and breastfeeding breaks further support parents to combine care and work *(41)*. Parental leave is extended in the event of the birth of twins (or more children at the same time), a prematurely born child or a child who needs special care. Together, these measures provide time and income security during a child's first year, supporting early bonding, child development and shared caring responsibilities.

Estonia
Estonia provides one of the WHO European Region's most generous and flexible parental leave systems, with 475–515 days of income-related shared parental benefit. By improving income security, supporting early bonding and protecting labour-market attachment while enabling shared leave, the package promotes healthy child development and more equitable opportunities from birth *(86)*. Estonia is consistently ranked among the most family-friendly OECD and EU countries for its combined parental leave and early childhood policies *(87,88)*.

Poland
Family 800+ provides a universal monthly benefit of 800 zloty per child to help families to meet the costs of raising children *(89)*. By strengthening household income security, the programme helps families to afford essential needs, including food, clothing and children's everyday participation in social life, reducing the risk that financial hardship undermines children's health, development and learning. Since it was introduced, the incidence of poverty and social exclusion among children in Poland has fallen by almost 10 percentage points between 2015 and 2023 *(90)*.

Key enabling frameworks (that support countries to accelerate progress)

- ***Ageing is living: a strategy for promoting a lifetime of health and well-being in the WHO European Region 2026–2030*** *(6)* provides a shared direction for acting earlier and more fairly for children's health and well-being.
- **European Child Guarantee** *(24)* supports access to ECEC, health services, healthy nutrition and adequate housing.
- **European Care Strategy** *(25)* supports investment in high-quality care services and carers across the life-course.
- **EU Work–Life Balance Directive** *(91)* establishes minimum standards on parental leave, carers' leave and flexible working arrangements.

Priority for action 2

Make services easy to reach.

By bringing early-years, health and family support together into easy-to-reach community hubs, small problems can be stopped before they escalate.

Illustrative country accelerators (what countries are doing)

Wales (United Kingdom)
Community Focused Schools bring learning, family support and links to health and social care into one trusted place. By improving access to multi-agencies, improving access to integrated services and strengthening relationships between schools, families and communities, they help to identify needs earlier, reduce barriers to support and improve children's health, well-being and educational outcomes. A Welsh Government evaluation found early evidence of improved learner well-being and educational equity, with 15 of 22 participating schools reporting progress in addressing socioeconomic inequities and 19 of 22 reporting stronger family and community engagement *(92)*.

Belgium
Kind en Gezin [Child and Family] (Flanders) and *Office de la Naissance et de l'Enfance* [Birth and Early Childhood Service] (Wallonia-Brussels Federation) provide universal preventive child and family health services from pregnancy through early childhood, combining home visits, breastfeeding support, developmental screening, immunization, parenting advice and referral to specialist services. By bringing maternal and child health services together through a trusted, community-based model, they help to ensure that every child receives an equitable start in life, while identifying developmental and family needs early *(32,33)*.

Kazakhstan
Kazakhstan's universal progressive patronage nursing model strengthens home visiting from pregnancy through early childhood, combining support on breastfeeding, immunization, child development and early identification of family needs *(30,31)*. Implemented through primary health-care settings with WHO/UNICEF support, the model provides two visits during pregnancy and nine visits until age 3 years, with additional support for families facing higher risks. Evaluations and a UNICEF documentation report improved early detection of risks, ensured better coordination with social services and increased contributions to reducing infant and child mortality and morbidity *(31)*.

Netherlands (Kingdom of the)
@Ease provides free, anonymous walk-in and online mental health support for young people without referral, making early support easier to access *(93)*. By removing barriers to care, it helps to prevent mental health problems from escalating and supports young people's well-being, education and participation. Evaluation found significant improvements in psychological distress and social functioning, with 43.2% of young people moving to a better clinical category and 39.6% of improvement in social and occupational functioning *(94)*.

Key enabling frameworks (that support countries to accelerate progress)

- **Declaration of Astana on primary health care** *(37)* reinforces primary health care as the foundation for accessible, integrated, community-based services and early intervention.
- **WHO European Healthy Cities Network** *(95)* supports cities in creating healthier urban environments, strengthening participation and reducing health inequities.

Priority for action 3

Support parents and families early.

When parents get help early, children are more likely to feel safe, settled and supported. This is good for mental health, development and learning.

Illustrative country accelerators (what countries are doing)

England (United Kingdom)
Best Start Family Hubs and Healthy Babies bring maternity, health visiting, infant feeding, perinatal mental health, parenting and family support services together in one place, making it easier for families to access help early and before problems escalate. By strengthening early child development, parental mental health and family well-being, the programme helps to reduce inequities in children's health and development from the earliest years of life. The programme was rolled out across 75 local authorities, with around 400 Family Hubs supported by over £300 million in government investment, including dedicated funding for perinatal mental health, parent–infant relationships and infant feeding *(43,95–98)*.

Austria
Frühe Hilfen [Early Intervention] showcases how the health sector can lead action on health equity by coordinating home visiting and multidisciplinary family support across health, social care and community services for expecting parents and families with children aged 0–3 years living in vulnerable circumstances *(99)*. By identifying families early, strengthening parenting and improving access to support, the programme creates healthier and more equitable starts in life. National evaluation found that the programme successfully reaches families most at risk of poor health and social outcomes, with almost one third enrolled during pregnancy and nearly 60% entering before their child reached 1 year old, while also reducing family stress, strengthening parenting confidence and improving access to services *(100)*.

Finland
Let's Talk about Children showcases how the health sector can lead action on health equity by supporting early conversations with families through primary health care, schools and early childhood services. By strengthening parenting, identifying concerns early and connecting families to timely support, it promotes children's mental health, resilience and healthy development before problems escalate. The value of early, integrated support for children and families is demonstrated by studies showing improvements in children's psychosocial well-being and family functioning, along with a significant reduction in referrals to child-protection services since implementing the model *(101)*.

Priority for action 4

Strengthen early learning and emotional skills.

Schools can protect children by implementing antibullying programmes, teaching emotional and digital skills early, and ensuring every student receives basic daily nutrition.

Illustrative country accelerators (what countries are doing)

Barcelona, Spain
1, 2, 3, Emoció! [1, 2, 3 Emotion!] helps children aged 3–5 years to develop emotional regulation, empathy and social skills through structured activities in early childhood education *(102)*. By strengthening emotional resilience and healthy relationships from an early age, the programme supports children's mental well-being, readiness to learn and healthy development. Evaluation found significant improvements in children's emotional competence and overall classroom climate. This programme has been effective regardless of the neighbourhood's socioeconomic status, and has also proven effective for girls and boys, as well as children with autism spectrum disorder *(103,104)*.

Finland
KiVa is a whole-school antibullying programme that strengthens children's safety, social inclusion and emotional well-being. By creating safer and more supportive learning environments, it improves children's mental health, school engagement and educational outcomes *(79,81)*. Evaluation found bullying victimization reduced by 30–50%, together with improvements in anxiety, depression, school motivation and academic achievement *(81)*.

Kazakhstan
The Adolescent Mental Health and Suicide Prevention Programme – implemented by the National Centre for Mental Health together with the Ministry of Healthcare and the Ministry of Education and Science and supported by UNICEF and WHO – strengthens schools' capacity to promote emotional well-being, identify mental health concerns early and provide timely support *(105,106)*. By equipping teachers, school psychologists and health professionals to respond early, the programme strengthens resilience, emotional skills and

access to care, particularly for vulnerable adolescents. Independent evaluation of the pilot in Kyzylorda found a 36.1% reduction in suicidal ideation, an 80.6% reduction in anxiety symptoms, a 56.1% reduction in depression symptoms and a 65% reduction in stress among participating adolescents *(107)*. Parental engagement also improved substantially, with refusal to consent to mental health screening falling from 5% to 1% over the course of the programme. These results supported the programme's expansion within Kazakhstan's education and health systems.

Slovenia
Slovenia has had a publicly supported school food system since 1962, providing broad access to school meals for all students *(108)*. Most schools prepare meals in their own kitchens, typically providing at least two meals per day. Public funding supports school food infrastructure, staffing and provision, while families pay the food cost of the nationally regulated mid-morning snack. Other daily meals are generally provided through a non-profit-making economic programme. Targeted subsidies ensure that meals are free or more affordable for approximately one third of children, mainly from lower-income households. Provision is regulated by the national School Food Law, including nutrition guidelines revised in 2024; the National Institute of Public Health is mandated to monitor, evaluate and report on outcomes *(109)*. Food and nutrition education is included in the compulsory home economics curriculum, with additional nutrition subjects available. The system also supports healthy food promotion through the EU School Scheme and initiatives such as the Traditional Slovenian Breakfast, while helping to enable parents' participation in the labour market *(110)*.

Tallinn, Estonia
Since 2025, all municipal schools in Tallinn provide free hot breakfasts, ensuring every child starts the school day with a nutritious meal, regardless of family income. By improving food security, reducing stigma and easing financial pressure on families, the programme strengthens the essential conditions for healthy child development and more equitable learning opportunities. The city has extended the programme to all municipal schools as part of its commitment to children's health and well-being *(27)*.

United Kingdom
Ctrl+Alt+Reclaim is a youth-led digital-justice movement enabling young people to shape technology policy and advocate for safer, more inclusive and empowering online environments *(85)*. Established through a creative campaign involving young people from across the WHO European Region, including the United Kingdom, it strengthens young people's voice and agency in decisions affecting their digital lives. As an emerging participation model, its longer-term reach and impact have yet to be evaluated.

London, United Kingdom
The Social Switch Project supports vulnerable children and young people to navigate online risks, build digital skills and access opportunities in the digital economy, while training front-line professionals to recognize and respond to online harm *(84)*. Backed by £3.9 million from London's Violence Reduction Unit, the programme aims to support 1000 young people and train more than 2000 practitioners. Early evaluation found that 67% of young respondents had progressed into employment and 74% considered the support very or extremely helpful, although the limited sample and absence of baseline data mean that longer-term impacts require further evaluation *(111)*.

Key enabling frameworks (that support countries to accelerate progress)

- **Schools4Health** in the WHO European Region *(112)* supports countries in embedding health promotion, equity and well-being through whole-school approaches, aiming to make every school a health-promoting school.
- The **EU School Scheme** supports schools to provide fruit, vegetables and milk alongside food and nutrition education, helping to ensure that all children have access to healthy food during the school day and develop healthy eating habits early *(113)*.

Priority for action 5

Improve housing and neighbourhoods.

Relieving household stress by funding home energy upgrades and creating safe, clean streets around schools dramatically improves daily living environments.

Illustrative country accelerators (what countries are doing)

Ireland

The Warmth and Wellbeing Scheme was a joint energy, social and health policy initiative led by the Department of Climate, Energy and the Environment, with the Department of Health, the Health Service Executive and the Sustainable Energy Authority of Ireland. The pilot scheme was established in 2016 to provide free home energy upgrades to vulnerable people at risk of energy poverty living with chronic respiratory conditions, in particular chronic obstructive pulmonary disease and asthma. By reducing cold and damp housing conditions and increasing energy efficiency, the scheme had the potential to lead to beneficial effects on the health of the home's residents. Over the course of the pilot, 1672 homes were upgraded. While participants experienced improvements in respiratory health, physical functioning, anxiety and depression, they also experienced fewer general practitioner visits and hospital admissions and received fewer respiratory medication prescriptions. The health benefits were sustained for at least 2 years following the intervention *(114)*.

Paris, France

Rues aux écoles [School Streets] aims to permanently pedestrianize and increase green spaces in streets around schools to create safer, cleaner and healthier environments for children *(115)*. By reducing traffic, air pollution and noise while encouraging walking, cycling, play and social interaction, the programme supports children's physical and mental well-being and creates healthier neighbourhoods in which to learn and thrive. Since 2020, more than 270 school streets have been permanently transformed, with around 25% prioritized in disadvantaged neighbourhoods to help to reduce health inequities. Evaluations found 10–30% reductions in NO_2 concentrations around participating schools, alongside safer journeys to school, increased walking and cycling, expanded space for play and cooler urban environments *(60)*.

Vienna, Austria

Vienna's social housing programme demonstrates how affordable housing can be a powerful investment in health equity *(116)*. By reducing housing insecurity, financial stress and overcrowding while improving neighbourhood quality and access to green space (in schools, playgrounds and outdoors), Vienna's model addresses several of the essential conditions that shape children's physical health, mental well-being and healthy development *(117)*. Today, around 50–60% of Vienna's residents live in municipal or subsidized housing, helping to keep housing costs among the lowest in western Europe, reduce socioeconomic segregation and promote more equitable living conditions.

Barcelona, Spain

The Superblocks programme and Climate Shelters network reclaim traffic-dominated and paved spaces for safer play, social interaction and heat protection, particularly in dense neighbourhoods where children lack private outdoor space *(57,58)*. Evaluation found an 80% reduction in motor traffic and a 283% increase in children's street play, with notable gains among girls *(66,67,118,119)*.

Paris, France
The OASIS Schoolyards and School Streets programme transforms paved school grounds and surrounding roads into cooler, greener and safer spaces, with pupils involved in their design and some schoolyards opened to communities *(59,60)*. These measures expand access to green space and heat protection for children without private gardens; evaluations also found lower temperatures and reduced traffic-related air pollution *(60)*.

Ghent, Belgium
Over 140 seasonal Play Streets supplement school streets and child-centred neighbourhood planning, while region-wide Flemish programmes support schools to replace paved grounds with greener, natural play spaces co-designed with children and parents. These measures provide play opportunities close to home, particularly for children unable to access private gardens or organized activities. In Ghent, moderate-to-vigorous physical activity during Play Street hours increased from 27 to 36 minutes *(61)*. Flemish schools also reported more active play and improved social behaviour following schoolyard greening *(62)*.

Rotterdam, Netherlands (Kingdom of the)
The Green–Blue Schoolyards programme supports schools in neighbourhoods with limited natural space to replace paved yards with vegetation, natural play and water features, co-designed with children and communities and accessible beyond school hours *(63)*. Assessment of 34 schoolyards found widespread opportunities for active and nature-based play, although health and equity impacts have not yet been directly evaluated.

Bradford, United Kingdom
JU:MP is a whole-systems physical-activity programme developed with children, families and communities in ethnically diverse and disadvantaged areas. Evaluation found that the programme increased children's physical activity by over 70 minutes per week. London's School Streets (including schemes in deprived boroughs) reduced NO_2 by up to 23%, helping to improve the local environment for children's independent mobility *(65,68)*.

Tirana, Albania
The School Streets model reclaims road space for safer walking, play and community use, using young people's feedback to inform improvements to playgrounds and school surroundings. The WHO Regional Office for Europe recognizes the city's progress in supporting children's health and fitness while a quasi-experimental evaluation is under way *(64,120)*.

Priority for action 6

Strengthen governance for health equity.

When health, education, housing and social-protection services work to shared goals, children are less likely to fall through gaps. Using equity data and listening to children and families helps governments to direct support where it is most needed.

Illustrative country accelerators (what countries are doing)

Wales (United Kingdom)

The Well-being of Future Generations (Wales) Act demonstrates how governance can accelerate health equity by embedding prevention, long-term thinking, cross-sector collaboration, accountability and public participation into decision-making *(121)*. Supported by the independent Future Generations Commissioner for Wales, it helps to align policies and public investment around the conditions people need to live healthy, equitable and sustainable lives *(122)*. Independent reviews have found that the Act has strengthened cross-government collaboration, embedded long-term well-being into public policy and budgeting and established one of the world's leading governance frameworks for prevention and future generations *(123)*.

France

France has made the first 1000 days of life a national public policy priority: covering pregnancy until the child's second birthday and integrating perinatal health, parenting support, child development, mental health and early-years prevention *(34)*. The national approach includes the *1000 premiers jours* [First 1000 days] information platform and the development of *maisons des 1000 premiers jours* [Homes for the first 1000 days], designed as accessible one-stop support spaces for future and new parents. Evaluation evidence is still emerging, so this serves well as a governance and service-integration example, showing how countries can organize prevention, family support and early childhood services around a shared framework for the first 1000 days.

Key enabling frameworks (that support countries to accelerate progress)

- **United Nations *Convention on the Rights of the Child*** *(124)* provides the legal foundation for children's rights to health, development, protection and participation across all public policies.
- **Mechanisms for child and adolescent participation** help to ensure that policies and services are designed with children and young people, strengthening equity, accountability and responsiveness.

Notes: NO_2: nitrogen dioxide; OECD: Organisation for Economic Co-operation and Development.

3 Young people

Where we want to be

The move from childhood to adult life is a turning point for the health and well-being of young women and men. This life stage is shaped by opportunities to learn, work and connect with the services, relationships and supportive environments that help to build independent, healthy and thriving lives.



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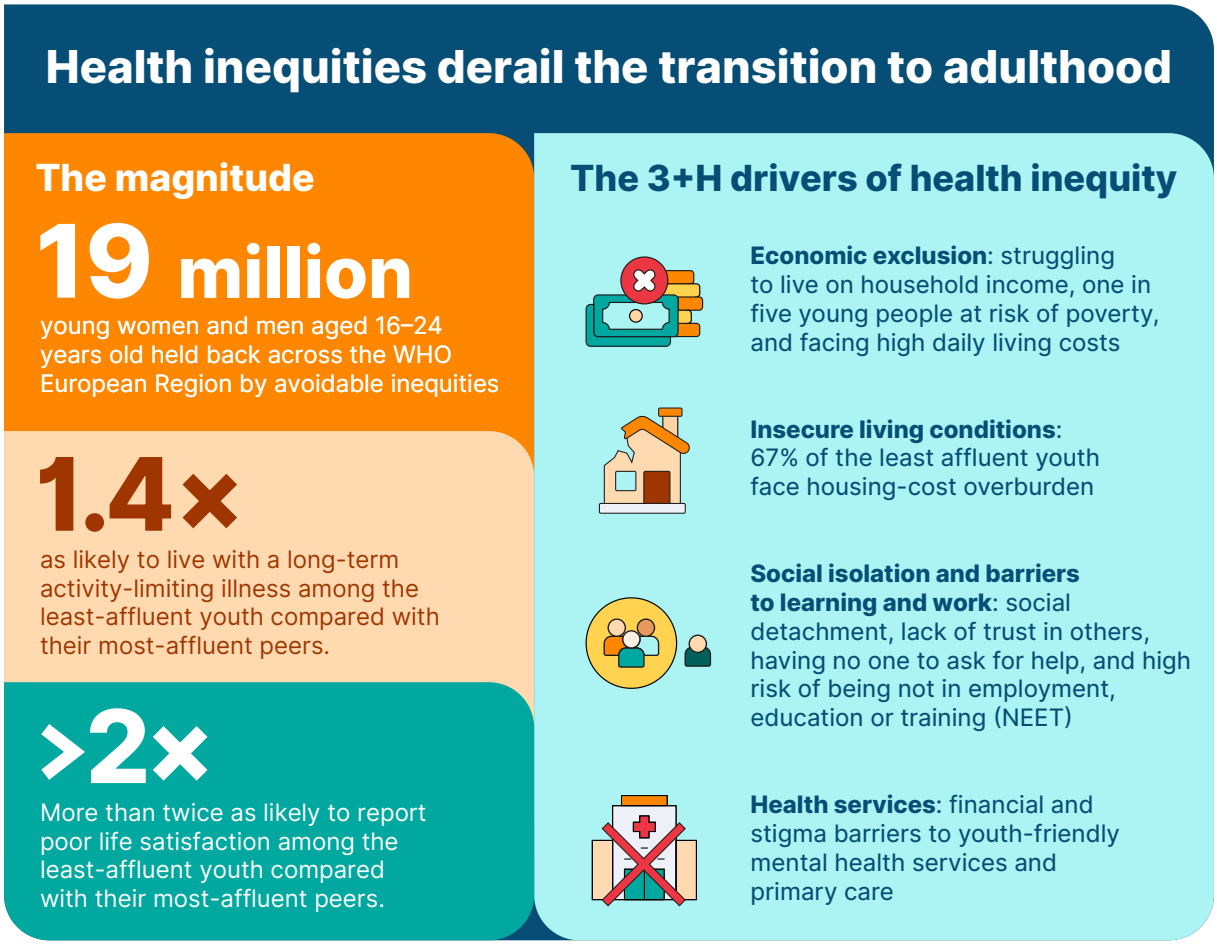
Summary

Between the ages of 16 and 24 years is a critical period of transition, as young people move into further education, employment and independent adulthood. The opportunities they have at this stage shape their future health, skills, employment and participation in society. Across the WHO European Region, an estimated 19 million young people (out of the total population of 95 million) lack the health and essential conditions needed to make this transition successfully (Fig. 9).

This matters not only for young people, but for the WHO European Region's strength and resilience. Poor physical and mental health, financial insecurity, unstable housing, exclusion from education or work, unsafe environments, limited control over one's life and barriers to health care can quickly derail life trajectories. They also weaken the Region's human capital, increase pressure on public services and deepen social and territorial divides. Conversely, enabling all young people to thrive strengthens the Region's demographic prospects, public services, social cohesion, economic and territorial cohesion and capacity to withstand future shocks.

Fig. 9. Drivers of health inequity in young women and men



Source: authors' own compilation based on 2024 World Bank population estimates (see the Annex), the HESRi2 data report *(9)*, WHO macroeconomic modelling and data from the WHO European Health Equity Atlas *(10)*, EU-SILC *(12)* and ESS *(13)*.

Five priorities to level up the health, well-being and life chances of young people in Europe

Countries can take the following actions to reduce health inequities. The order of the following priorities is purely sequential and does not denote their importance.

① Put youth mental health support where young people are.

- Expand low-threshold, stigma-free and affordable formal mental health services alongside informal community support, in the local settings where young people learn, work and socialize, ensuring higher intensity in low-resource neighbourhoods.
- Train youth workers, employers, and religious, sports and other community leaders to be able to recognize young people in distress and refer them to local support.
- Co-locate health, vocational employment and social support in one-stop shops to prevent vulnerable young people with complex and multiple needs falling between the cracks in accessing different services.

② Keep routes into learning and decent, healthy work open and flexible.

- Ensure that youth guarantee programmes combine skills development, work experience, mentoring and personalized employment services with support for mental health, housing and financial security. This includes targeted outreach, trusted community and peer partnerships and flexible participation arrangements to reach young people furthest from opportunity.

③ Reduce the health effects of financial insecurity.

- Strengthen youth-sensitive social protection through adequate income support, student grants, living-cost assistance, wage subsidies, minimum-income protection and ALMPs.
- Remove financial barriers for young people to access to health care and medicines through expanding financial protection policies to cover people aged 16–24 years. Primary care, hospitals and community health services can routinely identify young people experiencing financial hardship and connect them with poverty-reduction support and services while monitoring the health effects on young people experiencing financial hardship.

④ Treat housing as part of youth health policy.

- Expand affordable housing, rent assistance and first-home support while integrating housing with mental health, education, employment and social support. Health services can play a stronger role in the referral pathways for young people into secure homes and are important advocates, working with the housing sector and local councils to promote healthy, safe and energy-efficient housing.

⑤ Give young people a meaningful voice in decisions that affect them.

- Embed youth participation in health and wider public policy-making through youth councils, co-designed approaches, participatory governance and support for youth-led organizations.
- Actively support the voices and lived experiences of disadvantaged young people in these processes through targeted involvement through mentoring and training mechanisms.
- Back these up through supportive legal (acts) and fiscal mechanisms (budgets).

Together, these five priorities provide a practical agenda for strengthening the WHO European Region: investing in young people's health and capabilities, improving how public services respond during major life transitions, widening participation in education and decent work, reducing inequities between places and strengthening young people's trust, belonging and participation in society.

At a glance: the health and well-being of young people

Mortality

Mortality at this stage of life remains relatively low, but among young people aged 15–29, suicide is now the leading cause of death. Youth suicide rates have been increasing since 2017, with a notable spike between 2021 and 2022. Rates of attempted suicide are higher among young women, while death by suicide is higher for young men. This may reflect differences in help-seeking behaviour and norms in expressing feelings between women and men. The underlying risk factors associated with these tragedies include severe mental distress, struggling financially, risk of homelessness, experiencing trauma and abuse (including cyberbullying) and limited access to mental health support. In all cases there is a clear social gradient with the least affluent women and men having the highest risks *(125)*.

Morbidity and illness

Poor physical and mental health creates a cumulative disadvantage, where health limitations reduce access to education, employment and income, which in turn further reinforce poor health and constrain overall independence and active participation in all areas of life.

Preventing this cumulative disadvantage is central to the WHO European Region's demographic prospects. It enables more young people to build healthy, independent and productive lives and protects the human capabilities on which the Region's future workforce and prosperity depend.

In the long term, activity-limiting illness begins to derail trajectories and the process starts early in life. For young people aged 16–24 years in 27 countries, the rate of living with a long-term activity-limiting illness is 1.42 times higher for the least affluent young women compared to their most affluent peers and 1.52 times higher for the least affluent young men (Table 3).

Table 3. The social gradient in long-term activity-limiting illness among women and men aged 16–24 years across the WHO European Region

	High affluence	Moderate affluence	Low affluence
Women	26%	31%	37%
Men	23%	26%	35%

Source: authors' own compilation based on 2025 data for 27 countries from the EU-SILC *(12)*.

Well-being and mental health

There is a clear gap in poor life satisfaction, which is more than double for the least affluent young women (23% versus 10%) based on data for 28 countries and young men (20% versus 11%) based on data for 17 countries, compared to their most affluent peers. The data also reveal a strong social gradient with poor life satisfaction increasing as affluence decreases (Table 4).

Table 4. Self-reported poor life satisfaction among young women and men, by level of affluence

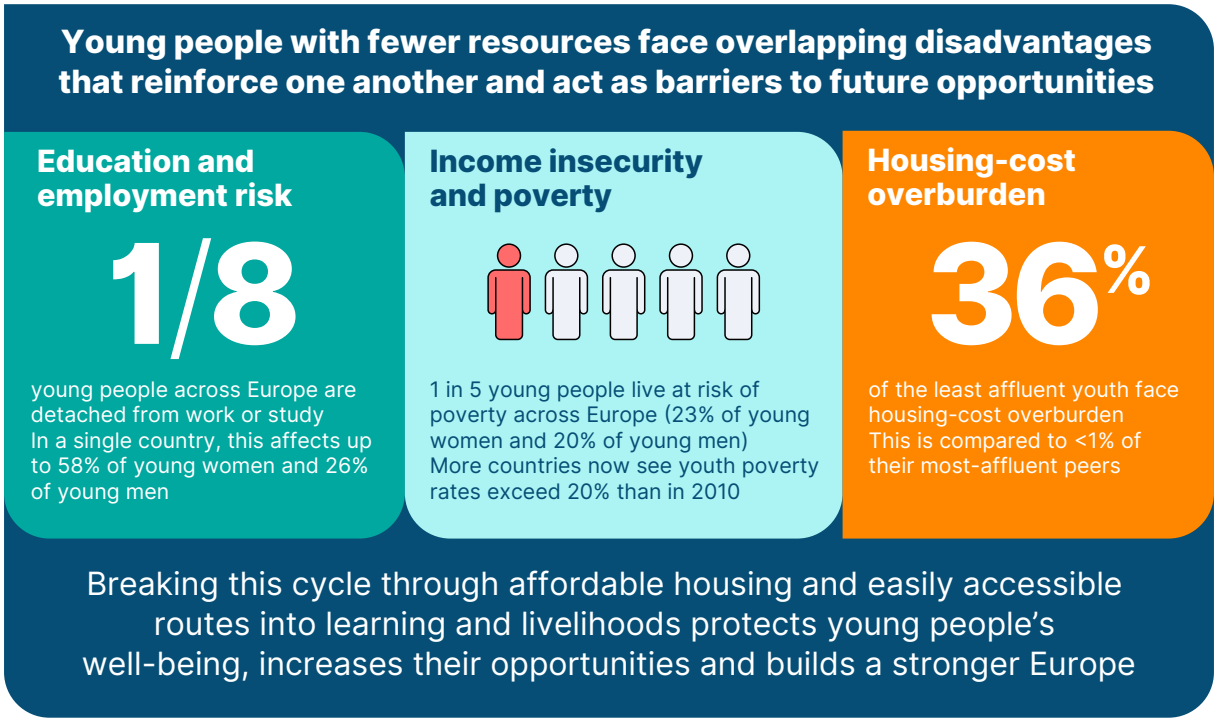
	High affluence	Moderate affluence	Low affluence
Women	10%	21%	23%
Men	11%	14%	20%

Source: authors' own compilation based on 2023 data (or latest available year) for 28 countries for women aged 18–24 years and 17 countries for men aged 18–24 years from the ESS *(13)* and WVS *(14)*.

Transition to adult life and independent living

Health and well-being during the transition to adulthood are shaped by access to high-quality health care, education and decent work, income security and social protection, affordable and healthy housing, digital inclusion and supportive social relationships. These conditions are interconnected: disadvantage in one area, such as income or housing, increases the risk of disadvantage in other areas of a young person's life, such as poorer health, weaker labour-market participation and a higher level of social exclusion (Fig. 10). Removing barriers to essential services and expanding opportunities and support for learning, earning, inclusion and civic participation enables more young people to thrive, strengthening the WHO European Region's human capital, social cohesion, economic competitiveness and resilience.

Fig. 10. Compounding disadvantages faced by young people in the WHO European Region



Source: authors' own compilation based on data from the HESRi2 data report *(9)* and EU-SILC *(12)*.

Access to health care

Health is a basic right, yet access to health care remains uneven, with financial and structural barriers disproportionately affecting young people with fewer personal and economic resources.

The average gap in unmet needs for health care narrowed between 2010 (based on data for 31 countries) and 2023 (based on data for 36 countries), with access to care improving more rapidly among the least affluent young women and men (from 8% to 4% and from 7% to 3%, respectively) than their most affluent peers (from 3% to 2% for both women and men). Despite the overall improvements, significant inequities persist. The least affluent young people report higher levels of unmet needs for health than their most affluent peers (4% versus 2% among young women and 3% versus 2% among young men).

Combined with their higher rates of long-term activity-limiting illness, these findings show that the least affluent young people – who already experience the greatest burden of ill-health – are also the most likely to report unmet health-care needs.

These findings show that further progress will require more than reducing financial barriers. Expanding low-threshold, youth-friendly and stigma-free services is essential for all young people, but especially in levelling up access to prevention and early intervention for disadvantaged young people, helping them to remain healthy and engaged in education, training and the workforce. This is also a test of the capacity of public services to support young people through the transition to adulthood. Accessible and coordinated services can intervene before poor health, financial insecurity or exclusion become entrenched, reducing avoidable demand later in life.



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To prevent avoidable loss of human potential and reduce future pressure on health and social services, European countries are responding with new policies and service approaches. This includes barrier-free mental health support programmes with no user charges, delivered where young people frequently work, learn and socialize. These innovative services are bringing support closer to young people and addressing distress alongside its social causes: Sweden's *Ungdomsmottagning* [Youth Clinics] provide free psychosocial counselling *(126)*; Norway's *Rask psykisk helsehjelp* [Prompt Mental Health Care] offers rapid support before difficulties disrupt education or employment *(127)*; and free, anonymous drop-in mental health support services are the basis of the @EASE programme in Netherlands (Kingdom of the) *(93)*. These accessible, integrated models can improve well-being and protect life opportunities, with results from some of these programmes showing mental distress reduced by 19% *(128)*, recovery from anxiety/depression by 58% *(129)* and reduced dropout from learning by 61%. In Finland, timely access to cost-free and evidence-informed mental health care and support – with a focus on early intervention and preventive care – is reinforced with Therapy Guarantee, establishing a maximum waiting time for therapy for children and young people under 23 years old *(130)*.

Several countries are embedding suicide prevention within broader action on the social determinants of mental health. Spain's *Action plan for suicide prevention 2025–2027* explicitly links suicidal distress among young people to poverty, homelessness, violence, discrimination and social isolation, connecting health, education, employment, equality and social services alongside free national crisis support *(131)*. *Ireland's strategy to reduce suicide and self-harm: connecting for life 2026–2035* adopts a public health and whole-of-government approach to reducing suicide and self-harm, combining prevention, intervention and postvention measures with actions to address the social determinants of suicide. It calls for the embedding of trauma-informed and culturally appropriate prevention and support across schools, families and communities, with particular attention to populations experiencing disadvantage and heightened risk *(132)*.

Poverty

Around one in five young people in 30 countries is at risk of poverty (23% of young women and 20% of young men). This is a major driver of poor health, with young women at higher risk in northern Europe (based on 10 countries) and western Europe (based on seven countries) and in western Asia (based on two countries).

Active social-protection and assistance programmes that combine income support with skills development and personal support play a key role in mitigating poverty. For example, Germany's *Bundesausbildungsförderungsgesetz* [Federal Education and Training Assistance Act] (BaföG) provides living-cost support to ensure access to higher education regardless of family income *(133)*. Similarly, the *Enbek* [Work] programme in Kazakhstan combines wage subsidies, skills development and employment support to help young people to build financial security *(134)*. Recognizing the close links between mental health and exclusion from employment, Italy's *Bonus Psicologo* [Psychologist Bonus] reduces financial barriers to mental health care, supporting well-being, in response to an increase in mental health conditions such as depression, anxiety and stress. *(135)*.

Together, these approaches show how aligning social-protection, employment and health interventions can strengthen young people's financial security, well-being and opportunities to transition successfully to a better life.

Participation in employment, education and training

Young people from less-affluent backgrounds often have limited formal education, higher rates of mental and physical health problems and weaker social support. As a result, they frequently cycle in and out of employment and training, which increases their risks of social and economic exclusion, anxiety and depression *(136,137)*.

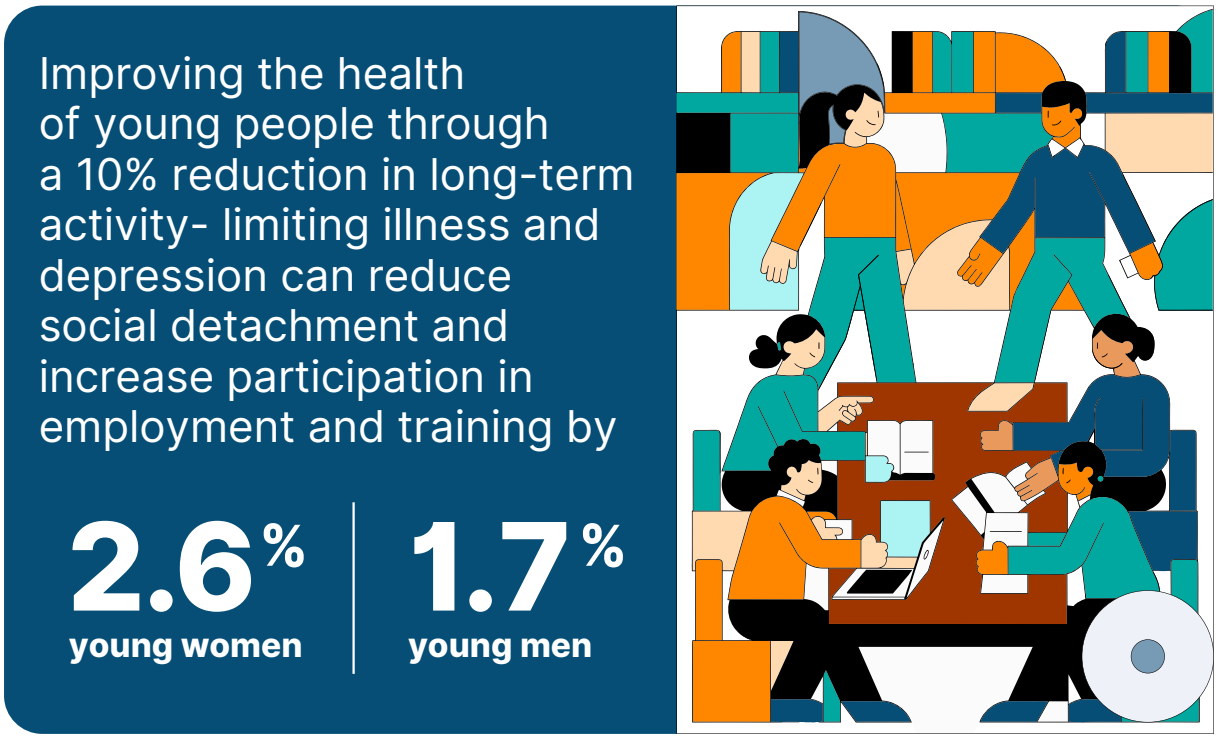
Despite a reduction in the numbers of young people who are not in employment, education or training (NEET) across much of the WHO European Region, with levels falling for young women in 31 countries and for young men in 25 countries (out of 45 countries with trend data), the overall numbers remain high. Around one in eight young people across the WHO European Region remain NEET (on average, 14% among young women and 12% among young men). NEET rates also vary widely depending on where a young person lives in the Region; for example, in the seven countries with data in western Europe, 4–11% of young women are NEET. These figures are almost tripled in the six countries with data in western Asia at 12–30%. Among young men the difference is less stark, at 4–15% and 7–24%, respectively.

When young people are living with multiple insecurities, such as no income, poor health and low levels of education, they often lack the skills, confidence, resources and support to access decent livelihood opportunities. There is a strong evidence base from Europe showing that the most effective employment interventions for disadvantaged young people are integrated approaches that combine skills development, work experience, mentoring, mental health support and personalized employment services, rather than job-search support alone *(138)*.

Supporting this comprehensive approach, data modelling for HESRi2 shows that there is a strong role for health interventions as part of NEET-reduction strategies. It illustrates how reducing long-term activity-limiting illness and depression among young people by 10% could reduce social detachment and increase participation in education, employment and training by 2.6% for young women and 1.7% for young men (Fig. 11). The modelling highlights the close relationship between health and economic participation: improving health can strengthen the WHO European Region's workforce and innovation capacity while reducing the social and territorial divides created when young people and places are disconnected from opportunity. The greatest returns come from systems that act early before mental ill-health, financial insecurity or unstable housing lead to long-term exclusion.

Building on this evidence, some of the most relevant large-scale examples of action to address youth exclusion and disengagement are the Youth Guarantee programmes implemented across much of the WHO European Region *(139)*. They offer a pathway out of social exclusion while supporting better health and well-being, particularly for young people who are struggling the most *(140)*. For example, the Netherlands (Kingdom of the) has switched to more caring, whole-of-life programmes, which explicitly address mental resilience, substance use, financial difficulties and psychological needs through vocational education, welfare safety nets prioritizing engagement and rehabilitation, and financial incentives that make it worthwhile for businesses to hire young workers. Meanwhile, multiple programmes in Slovenia use classroom-based or on-the-job training, private sector wage subsidies and public works. These have not only enhanced employment prospects and earnings but also improved self-reported health and reduced unplanned hospitalizations. In certain cases, evaluation shows improvements in sustained labour-market attachment and reduced migration to other countries. These outcomes matter in the context of demographic change: they strengthen young people's ability and confidence to participate in society and the economy, while helping regions to retain and benefit from their skills and potential.

Fig. 11. Return on investment from policies that improve the health of young people



Source: authors' own compilation based on the HESRi2 data report *(9)*, WHO macroeconomic modelling and data from the WHO European Health Equity Atlas *(10)*, European Union Statistics on Income and Living Conditions (EU-SILC) *(12)* and ESS *(13)*.

Housing and independent living

Stable, affordable and healthy housing is a foundation for young people's health, independence and participation in education, employment and community life.

Housing affordability and quality are among the strongest drivers of health inequities among young people. Since 2010, there has been a reduction across the WHO European Region in the proportion of young people experiencing severe housing deprivation, unable to keep their homes warm and struggling with housing costs that are more than 40% of their disposable household income. Young people in almost all income groups have benefited from these improvements, with either reductions or little change in the inequity gradient for each indicator. However, this overall progress masks substantial and persistent inequities. Young people from the least affluent households are, on average, nearly seven times more likely to experience severe housing deprivation than the most affluent in the 31 countries with data (14% versus 2% of young women and 13% versus 2% of young men). The least affluent young people are, on average, also more than eight times more likely to be unable to afford to keep their home adequately warm (17% versus 2%). Severe housing-cost overburden affects around 37% of the least affluent young women and 36% of young men, on average, compared with less than 1% of their most affluent peers.

While these indicators illustrate the broader regional picture, their impact varies significantly at subregional level. For example, poor living conditions are a major driver of inequity for young adults in western Asia, where roughly 60% of the least affluent young people (61% of young women and 59% of young men) are unable to afford to keep their homes adequately warm, compared to less than 3% of their most affluent peers. These inequities affect more than housing conditions. They delay independent living, restrict participation in education and work, and limit young people's ability to pursue opportunities across regions. Addressing them therefore supports demographic, economic and territorial cohesion, as well as health.



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Countries are responding through integrated housing and support policies. Across Europe, Housing First for Youth is being implemented in settings including Spain, Wales, France, Ireland, Scotland and Denmark. Adapted from Housing First, it provides young people aged 13–24 who are experiencing, or at risk of, homelessness with immediate access to safe, appropriate housing and flexible, age-appropriate support for health and well-being, life skills, education, employment and social inclusion, helping young people make a healthy transition to adulthood *(141)*.

Loneliness and social connections

Loneliness and non-deliberate social detachment are risk factors for anxiety and depression. Although comparable data on social connection and loneliness among young people are limited across the 53 countries of the WHO European Region, available evidence on those aged 16–29 years consistently shows that loneliness and weak social connections are disproportionately concentrated among less-affluent young women and men *(142)*. They are also strongly associated with low income, lower levels of education, weak labour-market attachment, and limited peer and family support. Trends since 2019 indicate persistent or increasing levels of loneliness among many groups of young people *(143–146)*.

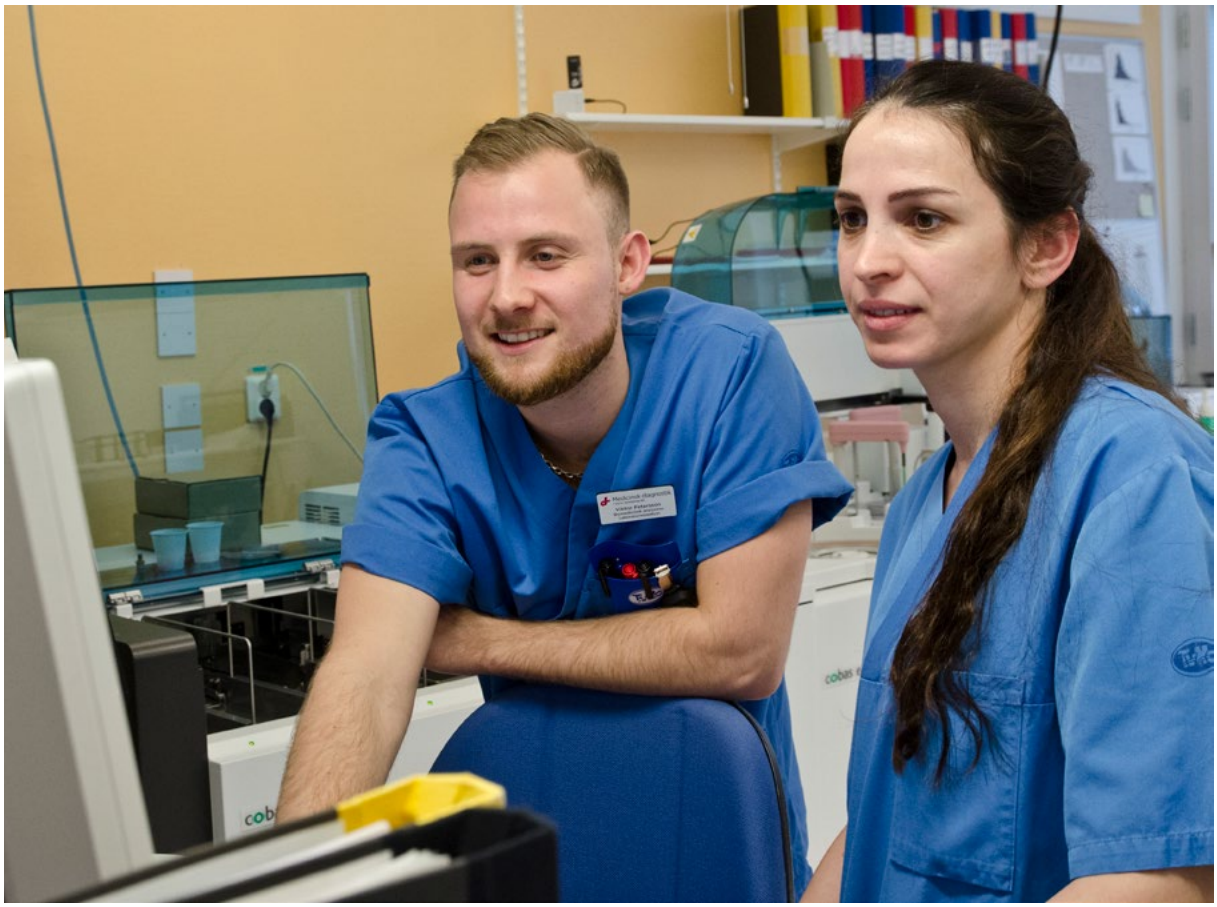
To address this, country policies and programmes to prevent young people from becoming NEET increasingly combine active social support (such as peer mentoring that strengthens social connectedness and helps vulnerable young people to stay engaged in education, training or work) with passive measures such as financial support.

Evidence also shows that social connection and participation among young people (particularly those who are most excluded and disadvantaged) can be strengthened by involving them in all areas of public life and creating meaningful opportunities for their voices and lived experiences to shape the design and implementation of policies and services. Evidence shows that such co-design approaches improve the impact of policies and have a positive effect on health and well-being *(147,148)*.

Croatia's Youth Councils Act gives young people a formal voice in local decision-making, treating participation as a requirement rather than an add-on *(149)*. In Norway, the Trondheim's *Innbyggernes modell* [Citizens Model] uses participatory budgeting to enable marginalized young people to identify priorities and decide how public resources invested in them are used *(150,151)*. Slovenia has institutionalized youth participation through two complementary legal instruments: the Youth Council Act (2000; strengthened in 2024) *(152,153)*, which establishes representative youth councils at the national and local levels and requires authorities to seek their views on legislation affecting young people; and the Public Interest in the Youth Sector Act (2010), which created an equally represented government–youth advisory council to review policies and proposed legislation, recommend measures and financing, and monitor whether young people's priorities are reflected across government *(154)*. By giving young people sustained influence over decisions and budgets affecting their lives, these mechanisms can strengthen agency, trust and belonging, while helping policies to respond more equitably to diverse and less-heard groups. Youth nongovernmental organizations complement these arrangements through peer-to-peer action. For example, No Excuse Slovenia supports young people's social participation while contributing to national public health goals as both stakeholders and rights holders *(155)*.

By enabling young people from all backgrounds to influence decisions and contribute to public life, they also reinforce democratic participation, institutional trust and the WHO European Region's capacity to respond collectively to future challenges.

Reducing health inequities among young people is therefore an investment in the Region's future strength. When all young people have the health, security, relationships and opportunities needed to learn, work, live independently and participate, the Region gains stronger demographic prospects, more effective public services, greater social and territorial cohesion, and societies that are better equipped to adapt to change.



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Concrete actions countries are taking to accelerate progress

The following country examples showcase practical policies and programmes that countries are implementing to improve health equity for young people across the WHO European Region, demonstrating the role of evidence-informed action in strengthening the conditions for healthier, more secure transitions into adulthood.

Taken together, they show that the greatest gains come from coordinated action. Low-threshold, youth-friendly health services, employment and skills programmes, affordable housing and social support are most effective when delivered as part of an integrated approach, reflecting the reality that challenges related to housing, income, education, employment, mental health and social participation often occur simultaneously in young people's lives rather than in isolation. The examples also illustrate practical accelerators that countries can adapt and scale to their own context. By protecting health and well-being while expanding opportunities for education, employment and participation, these measures help to reduce inequities and create stronger foundations for adulthood.

While national leadership is essential, progress is accelerated when European, regional and global frameworks provide a shared vision, sustained investment, practical implementation tools and opportunities for countries to learn from one another. Subregional cooperation can further strengthen progress, particularly where countries face common challenges related to youth employment, housing, mental health and access to services (Box 2).

Box 2. Examples of national accelerators and their key enabling frameworks for young people

Priority for action 1

Low-barrier, youth-friendly health and mental health services

When young people can get help quickly and without stigma, problems are less likely to turn into crises. This helps them to stay in school, training, work and thrive in everyday life

Illustrative country accelerators (what countries are doing)

Netherlands (Kingdom of the)
@Ease provides free walk-in and online mental health support for young people aged 12–25 years without referral, helping them to access support early before distress affects their health, education, work or relationships *(93)*. Delivered in youth-friendly community settings, the model reduces stigma and makes services easier to reach. Evaluation found around a 19% improvement in psychological distress among returning users, together with improvements in functioning and school participation, demonstrating the value of accessible early support *(128)*.

Sweden
Ungdomsmottagning [Youth Clinics] provide free, confidential sexual and reproductive health care, mental health support and psychosocial counselling for young people up to age 25 years, without referral or administrative barriers *(126)*. By offering integrated youth-friendly services in community settings, they encourage young people to seek help earlier, strengthening mental well-being and improving equitable access to care during the transition into adulthood.

Norway
Rask psykisk helsehjelp [Rapid Mental Health Care] provides rapid, free or low-cost cognitive behavioural therapy through primary care settings for people with mild-to-moderate anxiety and depression, with self-referral available in many municipalities *(127)*. By reducing waiting times and barriers to care, the programme helps young adults to receive timely support before poor mental health disrupts education, employment or everyday life. Evaluation found significantly greater improvements in anxiety, depression and daily functioning than the usual care pathways *(129)*.

Italy
Bonus Psicologo [Psychologist Bonus] provides national financial support for psychotherapy, helping to reduce the cost barrier that often prevents young adults from seeking help early. The scheme covers up to €1500 per person, depending on income, making psychological support more accessible for people experiencing financial hardship and helping to reduce inequities in access to mental health care *(135)*.

Key enabling frameworks (that support countries to accelerate progress)

- ***WHO European framework for action on mental health 2021–2025*** *(156)* supports countries to strengthen mental health promotion and prevention, expand community-based and youth-friendly services, tackle stigma, and intervene earlier to improve mental health and well-being across the life-course.
- **WHO's *Roadmap for health and well-being in central Asia (2022–2025)*** *(157)* supports countries to strengthen health systems, advance health equity and well-being, and address shared regional challenges through coordinated action, knowledge exchange and cross-border collaboration.
- ***CAREC health strategy 2030*** *(158)* provides a regional framework for strengthening health systems and health security across central Asia through cooperation on workforce capacity, emergency preparedness, digital health, cross-border health and access to medicines and services for vulnerable populations. By promoting joint investment, knowledge exchange and coordinated action, it helps countries to build more resilient, equitable and people-centred health systems, while improving health and well-being across the Region.

Priority for action 2

Youth-responsive employment and skills programmes

stop early setbacks becoming long-term exclusion

Illustrative country accelerators (what countries are doing)

Finland
Ohjaamo [Control Room] are one-stop guidance centres that bring employment, education, health and social services together under one roof for young people aged under 30 years. By addressing mental health, housing, education and employment needs simultaneously, the centres provide coordinated support during the transition into adulthood *(159)*. OECD evidence shows 22% of users moved into employment, 32% entered education or training and 7% secured housing, with consistently high satisfaction among young people *(160)*.

Croatia
Jamstvo za mlade [Youth Guarantee] implements the reinforced EU Youth Guarantee through personalized career guidance, vocational training, apprenticeships and employment support, with particular attention to young people who are NEET *(139,161)*. The programme brings together employment, education and social services to support smoother transitions into work while reducing inequities in labour-market opportunities. The European Commission's Employment Committee identifies Croatia as one of the stronger performers, with NEET rates falling from around 20% in 2013 to around 12% in 2024, alongside improved participation in employment and training measures *(162)*.

Germany
Bildungsketten [Education Chains] provides coordinated support for young people from school into vocational education and employment through career guidance, mentoring and personalized transition planning. By identifying young people at risk of leaving education early and connecting schools, employment services and employers, the programme helps to prevent long-term exclusion while strengthening skills, confidence and future employment opportunities *(163,164)*.

Austria
The fit2work initiative provides free personalized counselling, case management and reintegration support to people whose (mental) health threatens their ability to find, stay in or return to work. For young people with physical or mental health challenges, the programme helps to prevent early labour-market exclusion, supports sustainable employment and reduces the risk that ill-health permanently limits future opportunities *(165,166)*.

Key enabling frameworks (that support countries to accelerate progress)

- The **2020 EU Youth Guarantee** recommendation, *A bridge to jobs – reinforcing the youth guarantee (140)*, helps countries to ensure that every young person receives a good-quality offer of employment, continued education, an apprenticeship or a traineeship within four months of becoming unemployed or leaving education. By combining labour-market reforms, skills development and targeted investment, it helps to reduce youth unemployment and prevent long-term exclusion.
- **OECD Recommendation on creating better opportunities for young people (2022)** *(167)* supports governments to take integrated action across education, employment, housing, mental health and civic participation, recognizing that young people's well-being depends on coordinated policies across sectors.

Priority for action 3

Income security and support for study and training

Young people do better when they do not have to choose between paying bills and staying in education or training. A degree of security at this stage can change life trajectories

Illustrative country accelerators (what countries are doing)

Germany
Bundesausbildungsförderungsgesetz (known as BAföG) [the Federal Education and Training Assistance Act] provides means-tested financial support to students whose families cannot fully fund higher education or vocational training. By helping to cover living costs, the programme enables young people from lower-income households to continue their education, reducing financial stress and improving more equitable access to qualifications and future employment opportunities *(133)*. In 2024, around 613 000 people (including over 480 000 students in higher education) received BaföG support *(168)*.

Kazakhstan
Enbek [Work] supports young people's transition into employment through first-job placements, wage subsidies, vocational training and entrepreneurship support. By helping young people to gain work experience and financial independence early, the programme strengthens employability while reducing the long-term risks of unemployment, poverty and social exclusion *(134)*.

Priority for action 4

Inclusive governance and participation that builds "mattering"

Young people are more likely to trust services and use support when they feel listened to and taken seriously. This helps action to reach those who need it most and strengthens trust, agency and participation

Illustrative country accelerators (what countries are doing)

Trondhein, Norway
Road to the Driver's Licence (Citizens Model) uses participatory budgeting to enable marginalized young people to identify priorities and help to decide how public resources are invested. One initiative funded driving lessons identified by young people as critical for accessing employment *(150,151)*. Local evaluation found around two thirds of participants moved into education or employment, while youth crime in participating neighbourhoods fell substantially, demonstrating how meaningful participation can strengthen trust, agency and life opportunities.

Slovenia
Slovenia has institutionalized youth participation through two complementary legal instruments: (i) the Youth Council Act (2000; strengthened in 2024) *(152,153)*, which establishes representative youth councils at the national and local levels and requires public authorities to seek their views on legislation affecting young people; and (ii) the Public Interest in the Youth Sector Act (2010) *(154)*, which created an equally represented government–youth advisory council mandated to review policies and proposed legislation, recommend measures and financing and monitor whether young people's priorities are reflected across government *(169–171)*. By giving young people sustained influence over decisions and budgetary implications affecting their lives, these mechanisms can strengthen agency, trust and belonging, while helping policies to respond more equitably to the needs of diverse and less-heard groups. Youth nongovernmental organizations complement these arrangements through peer-to-peer action. For example, No Excuse Slovenia supports young people's social participation while contributing to national public health goals as both stakeholders and rights holders *(155)*.

Croatia
The Youth Councils Act (2014; strengthened in 2023) *(172)* creates a nationwide, three-tier system of youth councils across municipalities, cities and counties and at national level. These statutory advisory bodies enable young people to bring local priorities into public decision-making and connect them to national youth policy. This is complemented by the youth-chaired Government of Croatia Youth Council, which monitors and advises on youth-policy development and implementation across ministries. By embedding young people's voices throughout the governance system, Croatia strengthens civic agency and trust and supports policies that are more responsive to the diverse needs of young people: important foundations for health equity and well-being *(149,173)*.

Key enabling frameworks (that support countries to accelerate progress)

- **WHO European Regional Youth4Health Network** *(174)* empowers young people to participate directly in shaping health policies, programmes and advocacy across the WHO European Region, strengthening youth leadership, trust and more responsive, equitable health systems.
- **World Health Assembly resolution on social participation for UHC, health and well-being (2024)** *(175)* calls on countries to institutionalize meaningful participation in health decision-making, recognizing that involving people and communities leads to more trusted, responsive and equitable health systems.
- **United Nations *Pact for the future global digital compact and declaration on future generations*** *(176)* and ***Declaration on future generations* (2024)** *(177)* represent a global political commitment to invest earlier and more fairly in young people, recognizing them as partners in shaping the future and encouraging governments to consider the long-term impacts of today's decisions on future generations.
- **The European Commissioner for Intergenerational Fairness, Youth, Culture and Sport (2024–2029)** *(178)* reflects a growing commitment to embedding the interests of young people and future generations across EU policy-making, recognizing that today's decisions could contribute to healthier, fairer and more sustainable societies.

Notes: CAREC: Central Asia Regional Economic Cooperation (Programme); OECD: Organisation for Economic Co-operation and Development.

4 Normal working ages

Where we want to be

Good health and well-being during the normal working years are central to the WHO European Region's demographic strength, competitiveness, social cohesion and resilience. They are shaped by opportunities to learn and adapt throughout working life, healthy employment, accessible health and public services, adequate income security and supportive relationships. Ensuring these conditions for all enables more people to work, care, participate and build secure futures, thus strengthening the human, social and economic capital on which the Region depends.



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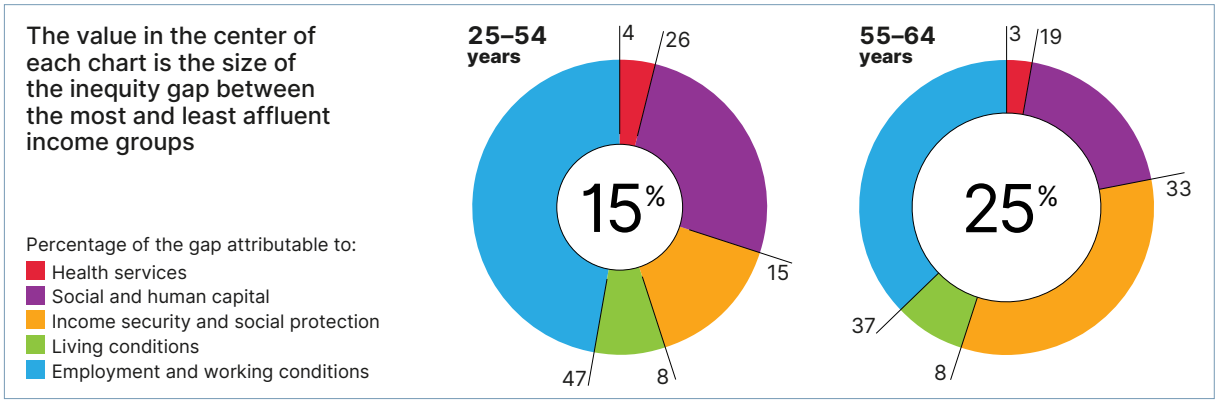
Summary

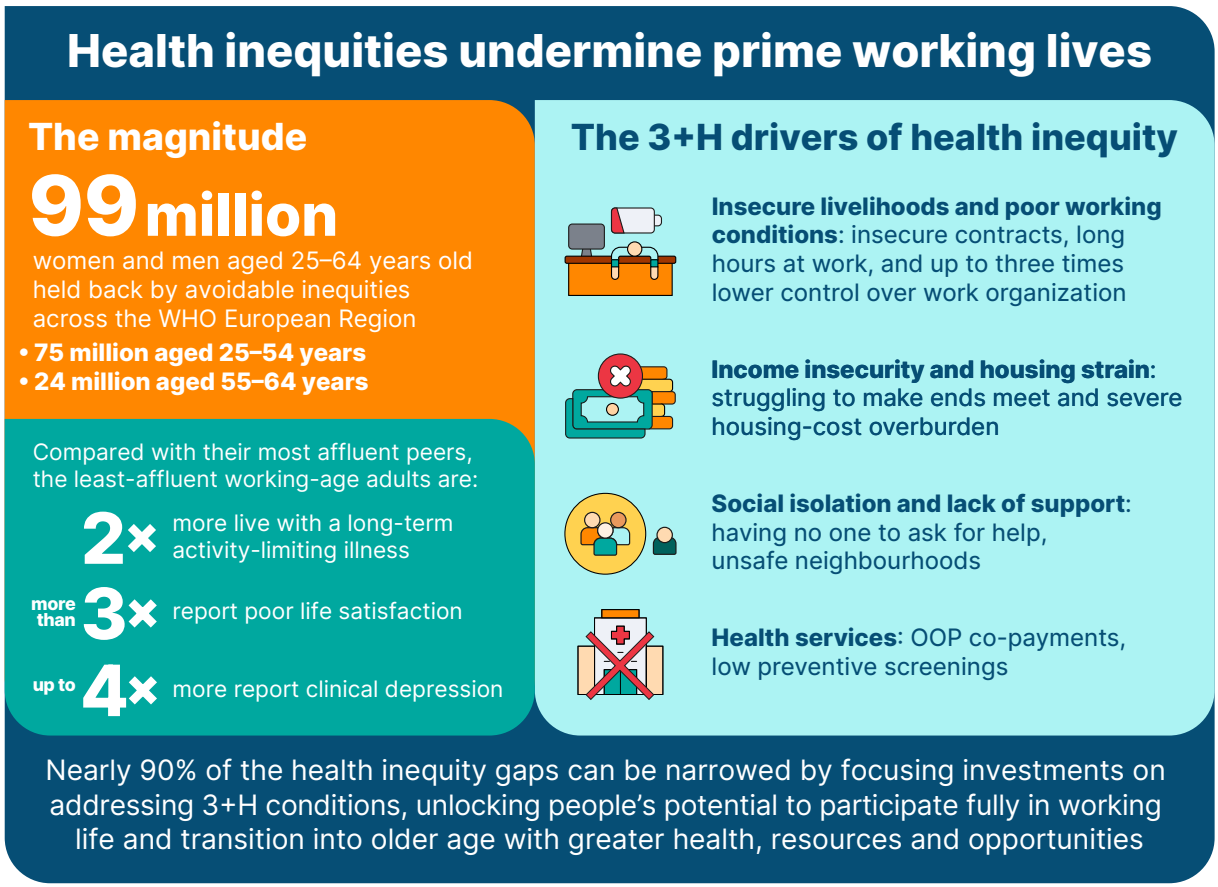
Across the WHO European Region, an estimated 99 million people aged between 25 and 64 years – representing the least affluent 20% of the working-age population – are at greater risk of not reaching their full potential because of inequities. Two thirds (75 million) are in their early and prime working years, when good health supports participation in work, family and community life, and helps people to seize opportunities to learn and develop. The remaining third (24 million) are approaching normal retirement age, a critical transition shaping financial security, health and independence in later life (Fig. 13).

Fig. 12. Inequity gap in long-term limitations in daily activities due to health problems for women and men of normal working age contributed by each essential condition, 2019–2023



Source: authors' own compilation based on data modelling for 34 countries for the HESRi2 data report *(9)*.

Fig. 13. Drivers of health inequity in the normal working ages

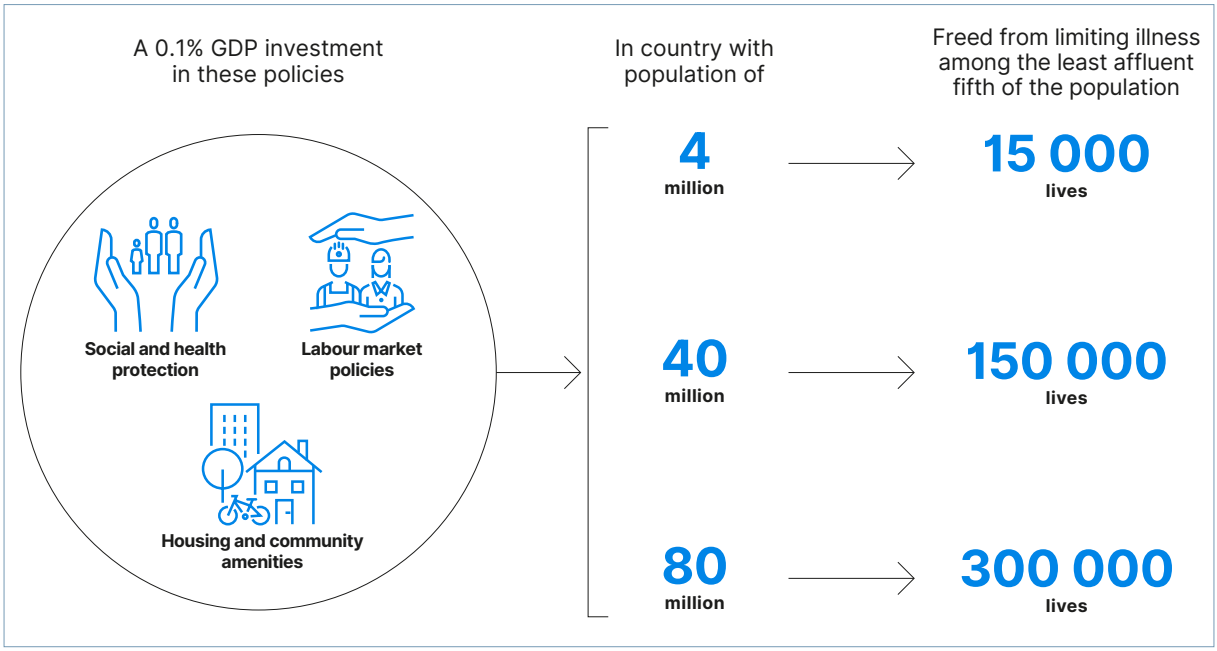


Source: authors' own compilation based on 2024 World Bank population estimates (see the Annex), the HESRi2 data report *(9)*, WHO macroeconomic modelling and data from the WHO European Health Equity Atlas *(10)* EU-SILC *(12)* and ESS *(13)*.

Nearly 90% of the health inequity gaps within the normal working ages can be addressed by focusing on 3+H or the three interconnected drivers, plus equity-focused health services. These manifest as concrete, everyday barriers to having secure incomes, decent and healthy employment, education and lifelong learning, and opportunities to build strong and supportive social connections.

Health inequities throughout the normal working years are not only a public health challenge. They weaken the productive capacity, public finances, cohesion and resilience on which a strong the WHO European Region depends. The investment case is compelling: modelling shows that investing just 0.1% of GDP in health and social protection, labour-market programmes, housing and community amenities can reduce long-term activity-limiting illness among the least affluent people (Fig. 14). In a country of 80 million, for example, this could improve the lives of 300 000 people, thus narrowing the health gap while strengthening workforce participation and reducing future pressure on public services.

Fig. 14. Investing in healthier working lives strengthens the WHO European Region's long-term economic resilience



Source: authors' own compilation based on WHO macroeconomic modelling using unpublished data for the years 2005–2018 and the Health Equity Dataset for first iteration of the Health Equity Status Report Initiative (2019) *(2)*.

Five priorities to level up the health, well-being and life chances of working-age women and men in Europe

Countries can take the following actions to reduce health inequities. The order of the following priorities is purely sequential and does not denote their importance.

① Adapt and innovate in achieving UHC.

- Use date systematically to identify the groups and types of service that drive OOP payments and financial hardship, use annual caps and exemptions from most co-payments for low-income groups and ensure continued access to care regardless of gender or socioeconomic status.
- Combine technology-enabled and community-based models of care that bring services closer to underserved populations and reduce geographical barriers in access. Health service design needs scaling up to address clinical and social needs in an integrated manner through, for example, social prescribing and caring neighbourhood models, telemedicine and mobile outreach services, using both professional and lay health connectors.

② Expand and scale up the implementation of good work–good health policies and partnerships. These focus on workers' well-being, prevent early detachment from work and provide easy routes back into healthy work, prioritizing workers most at risk of falling out of work due to the combined effects of ill-health and social vulnerabilities.

- Bring together occupation health services, employers, insurers and employee associations with the aim of early identification of workers most at risk of poor health, before long-term absence develops and of providing onsite and home-based health support.
- Adjust workplaces to focus on capacity rather than incapacity, including flexible working for caregivers, and placing a duty on employers for return-to-work planning.
- Promote fair and equal pay, prevent sexual harassment and violence at work, and ensure safe and healthy working conditions, including for workers in insecure, informal and female-dominated sectors.

③ Leverage the health and human capital effects of ALMPs.

- Target the design of and access to employment-support policies – such as ALMPs – to low-resource communities and places.
- Incorporate into job-seeking support practical health and life-skills counselling and opportunities for reskilling, upskilling and mentoring in the workplace.

④ Strengthen income protection.

- Promote adequate minimum wages, universal basic income programmes and accessible social assistance, along with broad social protection (including for people in low-paid, insecure and informal work), to improve economic security and protect households from severe material deprivation. In turn, this can reduce mental strain and loneliness and improve life satisfaction and perceived well-being.

- Leverage the health improvement and poverty reduction effects of innovative public spending on procurement, training and employment locally. This includes incentivizing for a percentage of spending to stay local and driving up job, skills-development and livelihood opportunities in low-resource places.
- Give greater weight to labour compensation measurement (the combined contribution of wages and social protection to economic growth) to help in targeting these efforts to reduce poverty, strengthen cohesion and improve well-being.

⑤ Promote social connectedness and safe neighbourhoods

- Create opportunities for people to meet, participate in community life and build supportive relationships, particularly in underserved urban, rural and remote communities.
- Promote strong social relationships and safe, supportive communities as essential foundations for health, building resilience, fostering social cohesion and to help to protect against loneliness and isolation.

These actions, together with low-wage subsidies, can reduce unemployment and economic inactivity and level up the opportunities for the least affluent to overcome earlier disadvantage (low education, poor health) by increasing capabilities that can open doors to more stable and better jobs, income and health.

Together, these priorities provide a practical agenda for strengthening the WHO European Region: keeping more people healthy and economically active; enabling public services to intervene earlier; supporting adaptation to labour-market change; reducing inequities between people and places; and rebuilding the security, trust and social connections on which resilient societies depend.

At a glance: the health and well-being of adults aged 25–64 years

Mortality

Women in the WHO European Region live about 6 years longer than men, with an average life expectancy at birth of 79.3 years compared with 73.3 years *(179)*. However, women, on average, spend more than 12 of these years in poor health, compared to just under 9 years for men. Despite steady improvements in both life expectancy and healthy life expectancy since the mid-2000s, substantial inequities persist across the Region. For example, at age 60 years, adults living in the country with the highest healthy life expectancy can expect to live seven more years in good health than those living in the country with the lowest life expectancy.

Noncommunicable diseases (NCDs) are the leading cause of premature mortality among working-age adults. Cardiovascular disease (CVD) and cancer account for the largest share of deaths, while chronic respiratory diseases and diabetes also contribute significantly to the burden of disease. Men face approximately twice (one in five) the risk of premature death from NCDs compared with women (one in 10). The underlying drivers include differences in exposure to health risks, the quality and security of working and living conditions and access to preventive and health-care services.

Morbidity and illness

A clear social gradient gap is evident among adults aged 16–64 years who are living with a long-term activity-limiting illness (Table 5). The least affluent women and men are, on average, more than twice as likely to report long-term activity-limiting illness than their most affluent peers in the 35 countries with data. Geographical inequities further compound this burden. Among the least affluent, long-term activity-limiting illness affects 21% of both women and men in the nine countries with data in southern Europe, compared with 41% of women and 47% of men in the 10 countries with data in northern Europe.

Table 5. Social gradient in long-term activity-limiting illness among women and men across the WHO European Region

	High affluence	Moderate affluence	Low affluence
Women	15%	24%	34%
Men	12%	21%	33%

Source: authors' own compilation based on 2023 data (or latest available year) for 38 countries from EU-SILC *(12)* and ESS *(13)*.

Trend data on people living with CVD from 34 countries suggest that inequities in self-reported CVD are increasing in many parts of the WHO European Region. Inequities have widened in 18 countries for women and 20 for men. For women, increases in inequity were most common in southern Europe (five out of seven countries), while northern Europe more often saw a narrowing of the gap (six out of nine countries). For men, increasing inequities were concentrated in northern Europe (six out of nine countries), whereas countries achieving reductions were spread across all subregions.

Levels and trends in inequities in self-reported diabetes at ages 18–64 years follow a similar pattern to those for CVD, which may suggest that disparities extend across the major NCDs.

Poor work-related health, including issues such as musculoskeletal disorders, stress, depression or anxiety and eye strains, are significant across almost all European countries with data, and adults aged 15–64 years with the lowest levels of education report the highest rates of poor work-related health *(180)*. This gap is evident among women in 90% of countries (26 out of 29 countries with data) and among men in 97% (29 out of 30 countries with data). Since 2010, modest progress has been made in reducing these inequities. The education gap narrowed in more than half of countries for women (14 out of 25 with trend data) and widened in 11 countries, while among men it narrowed in only half of countries (12 out of 24 countries with trend data) and widened in the remainder.

Well-being and mental health

Across the normal working ages, poor mental well-being is widespread and closely associated with financial insecurity, poor-quality employment and weak social support *(181)*.

Self-reported poor health follows a clear social gradient, with over double the occurrence among the least affluent women and men than those that are most affluent on average in the 43 countries with data (Table 6). These inequities have widened as self-reported poor health has increased among the least affluent – from 36% in 2010 (based on 31 countries with data) to 43% among women and from 32% to 42% among men – while remaining broadly stable among the most affluent women and men.

Table 6. Social gradient in self-reported poor health among women and men across the WHO European Region

	High affluence	Moderate affluence	Low affluence
Women	21%	31%	43%
Men	18%	28%	42%

Source: authors' own compilation based on 2023 data (or latest available year) for 43 countries from EU-SILC *(12)*, ESS *(13)* and WVS *(14)*.

Clinical depression follows a clear social gradient by affluence level on average in the 23 countries with data (Table 7). As a result, the least affluent women are around 2.5 times more likely and the least affluent men more than four times more likely to report clinical depression than their most affluent peers.

At this scale, unequal mental health is not only a health-system concern: it is a constraint on the WHO European Region's competitiveness and fiscal resilience. The Organisation for Economic Co-operation and Development projects an average 1.7% reduction in the EU's GDP between 2025 and 2050 due to reduced labour-force participation and productivity associated with mental health conditions *(181)*. Closing the gap would protect people's capacity to work and participate, while reducing avoidable costs across health, welfare and labour-market systems.

Table 7. Social gradient in self-reported risk of clinical depression among women and men across the WHO European Region

	High affluence	Moderate affluence	Low affluence
Women	13%	22%	33%
Men	7%	15%	31%

Source: authors' own compilation based on 2023 data (or latest available year) for 23 countries from the ESS *(13)*.

Poor life satisfaction also follows a clear social gradient across levels of affluence, with the least affluent women and men more than three times as likely to report poor life satisfaction as their most affluent peers, on average, in the 41 countries with data (Table 8).

Table 8. Social gradient in self-reported poor life satisfaction among women and men across the WHO European Region

	High affluence	Moderate affluence	Low affluence
Women	10%	17%	31%
Men	9%	17%	35%

Source: authors' own compilation based on 2023 data (or latest available year) for 41 countries from the ESS *(13)* and WVS *(14)*.

Looking across countries with data in the WHO European Region, the gap in poor life satisfaction is greatest, on average, in the eight countries with data in eastern Europe, where poor life satisfaction affects up to 48% of the least affluent women and men, while among the most affluent it is reported by 16% of women and 12% of men.

Progress to reduce the gradient in poor life satisfaction has been mixed in the 38 countries with trend data. For women in 15 of these countries (39%) there has been an improvement; conversely, in eight countries (21%) or inequities have increased. For men, the gap narrowed in 12 countries (32%) and widened in 13 (34%).

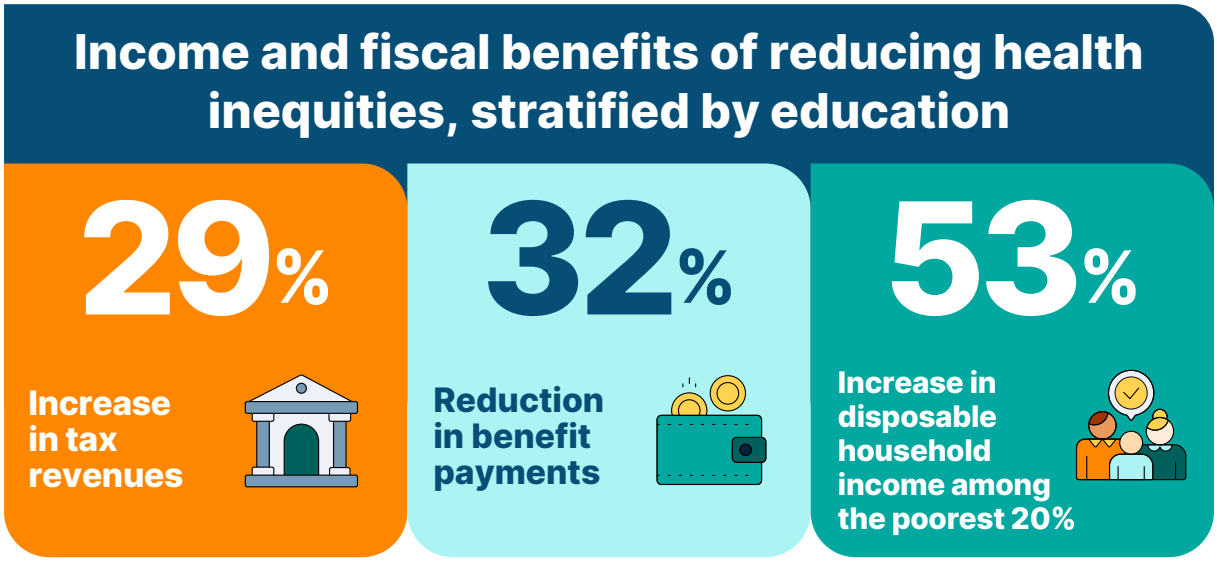
Economic gains from investing in health equity

Economic modelling across six countries (France, Finland, Ireland, Poland, Spain and Türkiye) shows that if health inequities were eliminated by improving the health of all who have not received tertiary education to that of those with this highest level of education, then this could increase tax revenues by around 1–29% and reduce benefit payments by around 0.5–32%, depending on the country (Fig. 15). These differences in the magnitude of the effect reflects both differences in the magnitude of educational inequities in each country and how each country's labour market and tax–benefit system translate better health into fewer benefits claims and higher taxable earnings.

These higher earnings are based on increases in household income. Better health improves people's chances of employment and increases earnings and hours worked, while reducing reliance on sickness benefits. The greatest gains (relative to pre-existing incomes) are among those households with the lowest incomes. Across the six countries, disposable household income among the poorest 20% increased by approximately 3–53%, with the effect being progressively lower at successively higher levels of income.

Reducing health inequities can therefore deliver a triple return: higher incomes for households, lower income inequity and stronger public finances through increased tax revenues and reduced demand on benefits. This positions health equity as a social investment that strengthens the WHO European Region's workforce, fiscal capacity and ability to finance shared public priorities.

Fig. 15. Income and fiscal benefits of reducing health inequities



Note: Modelling of data from six countries (Finland, France, Ireland, Poland, Spain and Türkiye)
Source: authors' own compilation based on *data* modelling for HESRi2 undertaken with the University of Galway and Adana Alparslan Türkeş Science and Technology University using the tax–benefit microsimulation model for the EU *(182)*.

Unmet needs for health care

Over the last decade, there has been mixed progress to achieve UHC, including for preventive screening across the WHO European Region. For many countries, and for some indicators, there have been improvements, but this varies depending on gender, level of affluence and geography, as data show that a significant number of subregions are backsliding in achieving their UHC targets.

Since the mid-2010s, inequities in unmet needs for health care at ages 16–64 years have narrowed for women in 24 countries (59%) of countries and for men in 25 countries (61%) out of 41 with data. Despite this progress, a clear social gradient remains, with the least affluent women and men more than twice as likely as the most affluent to report unmet needs for health care (Table 9). Geographical inequities also remain pronounced across the WHO European Region, reflecting differences in affordability, access to services, waiting times and cultural barriers. In central Asia, for example, on average, around one in five of the least affluent adults in the four countries with data reported unmet health-care needs (23% among women and 19% among men), compared with the 10% of the most affluent women and 8% of the most affluent men. In terms of access and availability, the supply of services is one barrier to achieving UHC. Within the country where this is most evident, physician availability ranges from 220 to 712 per 100 000 population: this gap is widening in 13 out of 25 (52%) of the countries with data.

Table 9. Social gradient in unmet needs for health care among women and men across the WHO European Region

	High affluence	Moderate affluence	Low affluence
Women	5%	6%	12%
Men	5%	6%	10%

Source: authors' own compilation based on 2024 data (or latest available year) for 44 countries from EU-SILC *(12)* and WVS *(14)*.

Preventive services also remain unequally distributed. For example, for cervical cancer screening, more than 80% coverage is achieved in 32 countries for women with the highest level of education (76%), but in only 19 countries for women with the lowest level of education (45%). The inequity trend across the Region shows that out of 34 countries with data, the equity situation is worsening in 19 (56%) and improving in 15 (44%).

Countries are addressing inequities in access to health care, particularly in rural, remote and disadvantaged areas, by strengthening primary health care, expanding telemedicine and digital health services, deploying mobile outreach programmes and investing in community-based models of care. These approaches aim to bring services closer to underserved populations, reduce geographical barriers and support progress towards UHC. For example, Estonia and Finland have expanded digital health, telemedicine and integrated primary care services to improve access and continuity of care *(183–186)*. In Kyrgyzstan, building on previous experience with high-altitude medicine, the Health in the Mountains Agenda focuses on strengthening primary health care, improving financing, expanding access in remote mountain communities and attracting health workers to underserved rural areas *(187,188)*. In Scotland (United Kingdom), the National Health Service (NHS) Near Me programme uses video consultations to improve access for

people living in remote and island communities *(189)*. Portugal is strengthening primary care through family health units and integrated local health units, alongside investments in digital capacity and interoperability to support coordinated, accessible care amid health-workforce pressures. solutions to address workforce shortages and improve service access in underserved areas *(190,191)*. Together, these initiatives demonstrate how countries are combining technology-enabled and community-based approaches to reduce geographical inequities in health-care access.

By aiming to strengthen access to universal health care across the country, combined with targeted health and well-being investment in underserved places, these approaches strengthen both public services and territorial cohesion. They help to ensure that people can remain healthy and economically active, regardless of where they live, while preventing workforce shortages and weak service provision from compounding regional disadvantage.

Financial protection

Financial protection is central to UHC, yet OOP payments for health care account for between 8% and 79% of current spending on health across the WHO European Region. Although catastrophic health spending is declining in 43% of countries, between 1% and 15% of households still spend more than 40% of their disposable income on health care.

Government health expenditure ranges from < 1% of GDP in one country to just over 10% in another; around half of countries spend 5% or more. This spending increased as a share of GDP in 55% of countries and decreased in 9% (data from 53 countries). Regardless of the cross-country variations, many people in vulnerable situations are still being left behind due to higher inequities in coverage, access and affordability live.

This is of concern to countries who are reviewing and adapting their health financing policy to make health care more affordable *(192)*. For example, in 2024 Slovenia abolished almost all co-payments (user charges) for health care, including most co-payments for outpatient medicine *(193)*. Montenegro provides residence-based health coverage and exempts low-income groups from most co-payments, helping to protect people in informal or precarious employment *(194)*. In 2018, Spain restored access to publicly financed health care for undocumented migrants who have been in the country for more than 90 days; in 2026 it removed the 90-day requirement and administrative barriers to entitlements *(195,196)*. Together, these approaches demonstrate how targeted policy reforms can improve access to care and reduce the risk of financial hardship associated with ill-health.

At Regional level, a WHO European Region platform called UHC Watch helps countries to strengthen UHC by providing comparable evidence on financial hardship, unmet needs for health care, health spending and coverage policies across Europe and central Asia *(192)*. It is particularly valuable for policy-makers because it shows who is being left behind, which services drive financial hardship and OOP spending and which reforms are most effective in improving financial protection and access to care. By combining data, country comparisons and practical policy guidance, UHC Watch supports evidence-informed reforms to reduce OOP spending, enhance equity and accelerate progress towards UHC.

Work and working conditions

The working years are often marked by competing demands as people balance employment, caregiving and family life, while adapting to rapid labour-market change and maintaining the financial security needed to live well.

Labour-force participation varies considerably across different stages of working life. Across the EU countries, participation is highest among adults aged 25–54 years, reaching 83% for women and 92% for men in 2025, compared with 38% and 43% among those aged 15–24 years. Participation declines among those aged 55–64 years, particularly for women, although rates have steadily increased since 2023, reaching 64% for women and 76% for men in 2025 *(197)*.

Quality of work strongly influences health and well-being. Long working hours, insecure employment, low job control and poor working environments increase the risk of stress, anxiety, depression, CVD (a 50% higher risk *(23)*) and social isolation.

Control over work

Large socioeconomic inequities are evident in how much control people have over their work. Compared with their most affluent peers, the least affluent women are almost twice as likely and the least affluent men almost three times as likely to report low control over how their work is organized (Table 10).

Table 10. Social gradient in low job control among women and men aged 16–64 years across the WHO European Region

	High affluence	Moderate affluence	Low affluence
Women	24%	34%	12%
Men	17%	30%	10%

Source: authors' own compilation based on 2023 data (or latest available year) for 32 countries from the ESS *(13)*.

Long working hours

Patterns in long working hours also show clear inequities. In 95% of countries (35 out of 37), women aged 16–64 years with the lowest level of education are more likely to work 45 hours or more per week than those with the highest level of education. Among men, this is the case in 92% of countries (34 of 37).

Progress to close gaps in working long hours is mixed. Looking at a period of more than 10 years in 33 countries with trend data, inequities in working excess hours between women with the lowest and highest levels of education have actually increased, with the gap widening in 13 countries (39%) and narrowing in only two countries (6%). A similar pattern is observed in the data for men in these countries, with inequities widening in 20 countries (61%) and narrowed in four (12%).

Insecure work

Temporary, seasonal and platform-based work is more common among people with the lowest levels of education in 83% of the countries with data (30 of 36 countries). In one country, women with the lowest level of education are four times more likely to be in temporary employment than those with the highest level of education (45% versus 11%). Among men, the largest difference in a single country is more than twice the rate (36% versus 13%).

Caregiving

Women bear the majority of care responsibilities in the EU, where 7.7 million women are out of employment because of care responsibilities *(25)*. Women, single parents and lower-income households are particularly affected. This "care penalty" reduces labour-market participation and interrupts savings and pension accumulation, while increasing the risk of poor health and poverty during the working years and in later life *(198)*.

Reducing this care penalty is central to the WHO European Region's demographic and economic strength. Policies that enable women and men to combine paid work and care responsibilities more equally can protect health, sustain labour-market participation and strengthen families' long-term financial security.

Good work, good health

The combined effects of four work-related drivers covering long working hours, insecure work, low control over working life and significant caring responsibilities cluster in the least affluent women and men in every European country. These drivers elevate their risk of poor health and consequently dropping out of the labour market, as evidenced by the higher rates of anxiety, depression and non-voluntary unemployment faced by the least affluent across the WHO European Region. While there are no comparable figures for the whole of the Region, tackling avoidable poor health and detachment from the labour market is a major priority for European policy-makers, due to the high direct and indirect costs. There are also concerns relating to the need to stem the negative impacts on competitiveness, alongside considerations around territorial and social cohesion. In a single western European country, the cost of early and avoidable exit from work due to ill-health has been estimated to involve about 2.8 million working-age people and the wider fiscal burden has been estimated at around 7% of GDP *(199)*.

Countries are responding by developing more comprehensive national "good work equals good health" strategies. These bring together the health sector (primary care and occupational health services), public and private employers, employment services, insurers, social services and employee associations with the aim of early identification of workers at risk of poor health, before long-term absence develops. Some strategies place a duty on employers for return-to-work planning, and many emphasize adjusting workplaces to focus on capacity rather than incapacity. These programmes are associated with much stronger employer participation and health improvements, and are effective in addressing work-related health inequities. Early intervention consistently outperforms late-stage disability management. This smart investment for a strong WHO European Region highlights the value of amplifying prevention and using innovative early intervention investment frameworks and budgets to drive results.

Keeping at-risk women and men healthy and attached to good work is therefore a competitiveness strategy as well as a health strategy. It protects livelihoods, skills and experience, reduces avoidable labour-market exit and helps employers and public systems to respond to demographic change and workforce shortages.

Unemployment and risk of falling out of work

Being out of work long-term is strongly associated with poor mental and physical health and premature mortality *(2,9,200)*. Across the WHO European Region, this is a major driver of health and social inequities and lost human capital, especially among women. In all but one of the 51 countries with data, those with the lowest level of education are less likely to be in work than those with the highest levels.

ALMPs that support job seeking, provide job counselling and subsidize low wages are effective in reducing unemployment and have significant health-promoting effects. These improve job and health outcomes for all workers, but have an accelerated effect for those falling behind by helping people to overcome earlier disadvantage (low educational achievement, poor health). They also open a door to more stable and higher-quality jobs, higher income and better health, increasing resilience to weather future shocks and bounce back. However, in the 27 countries with data, spending on labour-market policies ranges from 0.4% to 3.1%, with the lowest spending mainly in the four countries with data in eastern Europe (0.4% to 0.7%) and the highest spending in the seven countries with data in western Europe (1.1% to 2.5%) and in four of the five countries with data in southern Europe.

Countries are also demonstrating the potential impacts of such programmes. For example, Norway's Individual Placement and Support initiative embeds employment specialists within community mental health teams, helping people with mental health conditions to enter or remain in competitive employment *(201)*. Evaluations found substantially higher employment rates than traditional vocational rehabilitation, alongside improvements in recovery, functioning and quality of life *(202)*.

Upskilling and reskilling

As automation and artificial intelligence reshape labour markets, expanding equitable access to lifelong learning becomes more essential to help women and men of working ages to adapt to and benefit from new livelihood opportunities.

Access to lifelong learning (formal and vocational) is lower among those with the lowest levels of education than those with the highest levels in the 35 countries with data. For example, in one country, the education gap is 6–39% among women and 9–39% among men.

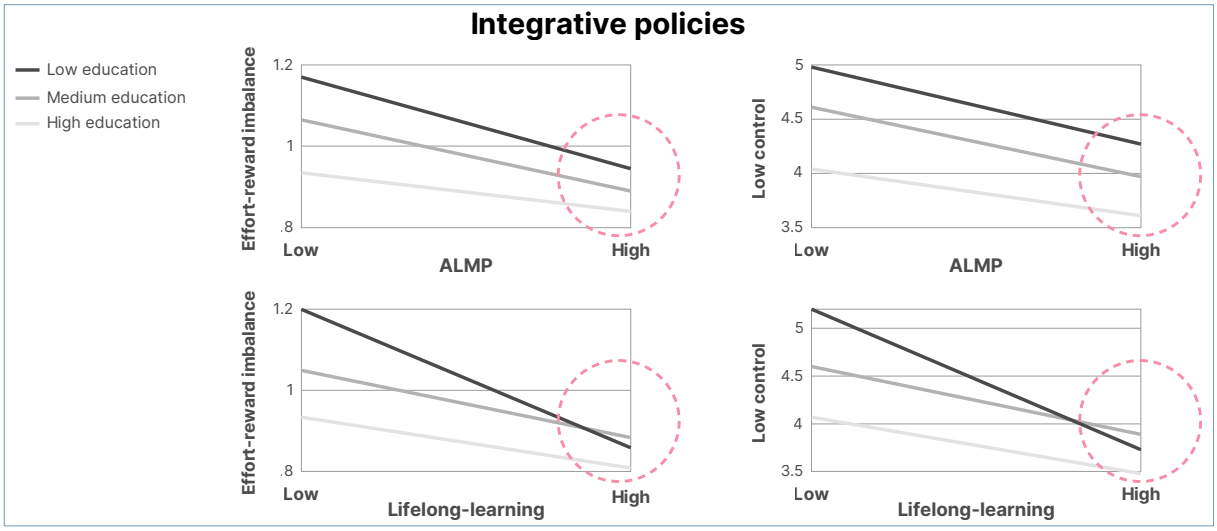
Digital inclusion is also increasingly essential for employment, lifelong learning and health. Yet substantial inequities remain among all those aged 16 years and over, with the least affluent women and men nearly three to four times more likely to never use the internet than their most affluent peers (33% versus 12% among women and 29% versus 8% among men).

Countries are responding by taking lifelong learning out of classrooms, bringing it closer to people in the communities where they live. The most effective programmes are being delivered in ways that make participating and receiving support an easy option. These benefit all working-age women and men, but are particularly effective in reaching the most vulnerable, as well as adults who have become detached from employment. In Slovakia, the Equality of Opportunity project combined employment, practical training and preventive health support for long-term unemployed Roma adults in disadvantaged communities. The approach strengthened skills, employment prospects, social inclusion and healthier living conditions *(203)*.

At system level, Norway embeds lifelong learning and adult education into national education policy, enabling adults to update their skills throughout working life. More than 60% of adults participate in learning activities, with accessible adult learning particularly benefiting people with lower levels of education *(204)*.

Programmes like these protect the WHO European Region's human capital by enabling more people – particularly those previously excluded from learning – to retrain, remain economically active and recover from health or economic shocks. Equitable access to lifelong and digital learning is therefore essential to ensuring that technological and economic transitions strengthen rather than widen health and social inequities between workers and regions (Fig. 16).

Fig. 16. The impact of integrative policies on reducing health inequities



Source: based on Lunau et al. *(205)*.

Income security and in-work poverty

Financial insecurity is a major driver of poor mental health and health inequities. For women and men aged 16 years and over, on average, the least affluent women are six times and men nine times more likely than their most affluent peers to face difficulty in making ends meet, in the 33 countries with data (Table 11).

Inequities have narrowed in 14 of the 33 countries with data for both women and men (42%) but progress remains uneven, with inequities worsening in eight countries for women and men (24%).

Table 11. Social gradient in difficulty living on their household income among women and men aged 16 years and over across the WHO European Region

	High affluence	Moderate affluence	Low affluence
Women	8%	25%	52%
Men	6%	22%	54%

Source: authors' own compilation based on 2023 data (or latest available year) for 33 countries from the ESS *(13)*.

Financial strain is further intensified by housing costs, with more than a third (34%) of the least affluent women and men aged 16 years and over being overburdened by severe housing costs compared with 1% of the most affluent.

Typically, high rates of in-work poverty are observed where the coverage and adequacy of social protection and minimum wage policies in any given country are low. In-work poverty is almost exclusively experienced by people with lower levels of education in almost all countries with comparable data across the WHO European Region (31 out of 32 countries). Within those 31 countries, in-work poverty affects 4% to 42% of women and 5% to 58% of men.

Social protection

Across the 47 countries with data in the WHO European Region, total government expenditure on social protection varies widely, ranging from 4% to 26% of a country's GDP, with specific spending on sickness and disability ranging from less than 0.5% to 6% in the 30 countries with data.

Currently, 25 out of 44 countries fully cover everyone living in poverty, while coverage in the remaining countries ranges from 2% to 89%. Well-designed, non-stigmatizing social-assistance policies also have a key role to play in protecting the well-being, health and human capital of people who are struggling to get by. Estimates for 36 countries indicate that social transfers reduce poverty rates among women aged 25–54 years, from 28% to 15%, and for men from 25% to 14%. At ages 55–64 years, the effect of social transfers is substantially larger, reducing poverty from 42% to 15% among women and from 34% to 15% among men. The larger figures for poverty before social transfers at this age likely reflect the 25% reduction in labour-force participation among women between these two age groups (19% reduction among men). As many of those who leave the labour force at this age receive neither wages nor pensions, these social transfers help to meet the costs of caring and household necessities important to health, such as food, fuel and transport. Poverty reduction is greatest among both women and men in western Asia (based on two countries with data) and southern Europe (based on 11 counties with data).

Unemployment protection is considerably less comprehensive: in 40 of 49 countries, fewer than 65% of unemployed people receive regular unemployment benefits, and in 21 countries coverage is below 30%. Among the 25 of 44 countries providing universal social-protection coverage for the least affluent people, relative poverty rates have fallen in 10 countries (40%) and risen in six (24%). Poverty rates still range from 2% to 33%, highlighting clear opportunities for focused policy action. In southern Europe, for instance, 19% of women and 17% of men between the ages of 25 and 54 years live in relative poverty. Targeting these specific demographics can protect people with low and moderate affluence levels from sliding into chronic economic exclusion and poor health.

Combined wages and salaries (in cash or in kind) and social insurance contributions payable by employers as a percentage of GDP measures the extent to which national economic growth is supporting inclusive prosperity (labour compensation). This reflects how gains are being shared with workers, going towards higher-quality jobs and incomes and supporting stronger household purchasing power. However, it does not include self-employed people, and this could affect between-country comparisons. Labour compensation currently varies across the 50 countries with data in the WHO European Region from 18% to 70% of GDP, and could be given higher weighting in efforts to reduce poverty, strengthen cohesion and improve well-being.

The least affluent and least educated people of working age are more likely to be living in low-resource settings with limited opportunities for secure livelihoods, secure wages and routes into reskilling and upskilling. Preventing them from being trapped in chronic financial insecurity requires effective social protection, ALMPs and innovation in building inclusive local economies.

Countries are responding in more innovative ways, especially in the context of an increasingly squeezed fiscal space and uneven development within countries. Some are testing elements of universal basic income schemes to reduce health, social and economic inequities *(198)*. Finland tested unconditional payments to unemployment-benefit recipients, while municipalities in Denmark and the Netherlands (Kingdom of the) tested greater autonomy, fewer benefit conditions and more individualized support. Barcelona's B-MINCOME combined a guaranteed minimum income with employment, social-economy and community-participation measures *(206)*, while Scotland (United Kingdom) modelled the potential health equity impacts of different income policies *(207,208)*. Others are leveraging public-sector "anchor institutions" to direct spending towards local employment and the procurement of goods and services. When systematically implemented, these approaches can build human capital, strengthen local economies and attract inward investment over time, while reducing poverty and unemployment and improving health, wages and household incomes *(209)*.

Assessments in North Macedonia, Serbia, Slovenia and the United Kingdom demonstrate the health sector's strong potential to act as an anchor institution, generating employment, income and wider economic value *(210)*. Mondragón in Spain and Preston in the United Kingdom further illustrate how locally rooted procurement and cooperative ownership can strengthen local economies and support working-age women and men (Box 3) *(211–213)*.

Box 3. Reversing in-work poverty through community wealth-building (Preston Model, United Kingdom)

Problem

Having a job no longer guarantees a decent living for many workers. Low pay, insecure contracts and rising costs trap families in stress that harms health.

Action

Preston's community wealth-building model shifted the procurement of local anchors (councils, hospitals, universities) to local suppliers and supported worker-owned businesses: so, public money creates good local jobs.

Results

The initiative is associated with higher median wages and life satisfaction and improvements in mental-health indicators and prescribing patterns compared with similar areas.

Lesson

Inclusive local economic strategies are public health strategies. Raising the wage floor and anchoring wealth locally can cut in-work poverty and improve population well-being.

Source: National Institute for Health and Care Research Applied Research Collaboration *(211)*.

These approaches turn public budgets into long-term investments in healthier people and stronger places. By retaining economic value locally and expanding access to jobs, skills and secure livelihoods, they can reduce territorial inequities and strengthen the resilience of communities that have benefited least from economic growth.

Social connections and neighbourhood safety

Strong social relationships and safe, supportive communities are essential foundations for health. They build resilience, foster social cohesion and help to protect against loneliness and isolation. Beyond its impact on mental health and well-being, loneliness is also linked to an increased risk of CVD and earlier onset of dementia.

Among working-age adults (25–64 years), the least affluent are more than twice as likely to report not having anyone to ask for help compared to their most affluent peers on average across the 29 countries with data (17% versus 6% for women and 19% versus 8% for men). However, there is some positive momentum. Among women: this gap narrowed in 13 of the 31 countries with trend data (42%) and widened in 10 (32%). Among men it narrowed in 14 countries (45%) and widened in 11 (35%).

Inequities in social connectedness are shaped not only by income, working hours and caring responsibilities, but also by the environments in which people live. Safe neighbourhoods create opportunities for people to meet, participate in community life and build supportive relationships. Yet safety itself follows a social gradient. Perceptions of personal safety show steep social and gender differences (Table 12). Women of all affluence levels are on average around twice as likely to report feeling unsafe walking alone after dark than men in the 32 countries with data. However, a clear social gradient exists for both women and men: the least affluent men are more than twice as likely to feel unsafe as the most affluent (19% versus 9%), while the least affluent women are 1.64 times as likely to feel unsafe after dark compared to their most affluent peers (37% versus 22%).

Table 12. Social gradient in feeling unsafe walking alone after dark among women and men aged 18–64 years across the WHO European Region

	High affluence	Moderate affluence	Low affluence
Women	22%	30%	37%
Men	9%	12%	19%

Source: authors' own compilation based on 2023 data (or latest available year) for 33 countries from the ESS *(13)*.

Financial insecurity, unsafe environments and poor physical and mental health can limit people's ability to participate in civic and community life. WHO evidence shows that this is particularly pronounced among people who are working yet continue to struggle on a daily basis to make ends meet and feel little benefit from public policies *(214)*. This can weaken belonging, mattering and trust in institutions. Left unaddressed, these inequities deepen social fractures and undermine the cohesion, democratic resilience and collective capacity on which the WHO European Region's security depends.

Countries are responding by investing in trusted community spaces and locally based support for working-age people experiencing isolation or disadvantage. Ireland's Men's Sheds provide welcoming, non-stigmatizing spaces where men can build friendships, learn new skills, rebuild confidence and develop a renewed sense of purpose. By strengthening social connections and creating pathways into volunteering, training and employment, they support both social inclusion and mental well-being *(215,216)*. In England (United Kingdom), Health Connections Mendip connects isolated people with community groups, activities and practical assistance through social prescribing *(217)*. In Slovenia, Health Promotion Centres work with social services, municipalities and community organizations to reach vulnerable adults with tailored support *(218)*. Together, these approaches remove barriers to support, replace risks with assets that increase people's sense of connection, safety and mattering.

Later working life and economic security

Later working life is a critical transition between employment and retirement. For around 24 million adults approaching retirement across the WHO European Region, health status, financial security and opportunities to remain healthy and economically active determine whether they enter older age with resilience or disadvantage. Healthy working conditions, lifelong learning, age-friendly workplaces, flexible employment and support to balance work and caregiving help people to maintain their health, skills and financial security for longer. These investments support healthier ageing, strengthen labour-market participation, reduce poverty and ease future demand on health and long-term care systems.

Social protection is particularly important during this transition. Pension coverage is universal for eligible women in 28 of 49 countries and for eligible men in 40 of 49 countries. Where coverage is not universal, it ranges from 41% to 99% for women and from 77% to 98% for men. Coverage increased in eight of the 45 countries with trend data among women (18%) and in five countries for men (11%), with a decrease in only one country for both women and men.

Social transfers, including pensions, substantially reduce poverty among people aged 55–64 years. Across all 36 countries in the WHO European Region with data, poverty rates would be 42% among women and 34% among men without these transfers, but are reduced to 16% and 15% after transfers. The largest reductions are seen in the two countries with data in western Asia, from 53% to 17% for women and from 44% to 16% for men. These findings highlight the importance of adequate social protection to prevent financial disadvantage in later working life from carrying into older age.

Countries are beginning to provide more tailored support during the later working years. Portugal's 55+ movement connects people aged 55 years and over with meaningful community roles based on their skills and interests, strengthening social connections, purpose and active participation *(219)*. Slovenia's *aktivno staranje delovne sile asi* [Active Ageing Support Initiative] has helped employers to adapt to an ageing workforce through health promotion, skills development, age-sensitive management and intergenerational knowledge exchange, reaching over 1000 companies *(220)*. Germany's former *Perspektive 50plus* [Perspective 50plus] programme used regional partnerships to provide unemployed women and men aged 50–64 years with personalized employment, health and social support *(221)*. Norway's Inclusive Working Life Agreement brings together government, employers and trade unions to prevent sickness-related labour-market exit, adapt workplaces and extend working life after age 50 years *(222)*. Latvia's Support for Longer Working Life project (2017-2020) targeted workers aged 50 years and over through assessments of working environments and individual capacity, workplace adaptations and measures to strengthen skills, health and safety *(223)*. Together, these approaches show how policies can protect health and economic security while maintaining people's skills, relationships, sense of purpose and participation during their later working years.

By enabling people to remain healthy, skilled and connected as they approach retirement, these policies strengthen the WHO European Region's demographic resilience, retain valuable experience in workplaces and communities and reduce avoidable pressure on health, social protection and long-term care systems.

Concrete actions countries are taking to accelerate progress

Box 4 shows examples of national accelerators and their key enabling frameworks.

Box 4. Examples of national accelerators and their key enabling frameworks for normal working ages

Priority for action 1

Join up employment and mental health support

When help with mental health and help with work come together, people are more likely to recover and get back on their feet sooner. This can stop a temporary problem becoming long-term hardship.

Illustrative country accelerators (what countries are doing)

Norway
The Individual Placement and Support initiative integrates employment specialists into community mental health teams to help people with mental health conditions to enter or remain in competitive employment *(201)*. By joining up employment and health support, the programme helps people to recover while maintaining financial security, social participation and good mental health. Evaluation found substantially higher competitive employment rates than traditional vocational rehabilitation, together with improvements in recovery, functioning and quality of life *(202)*.

Key enabling frameworks (that support countries to accelerate progress)

- **WHO/ILO guidelines on mental health at work** *(224,225)* help employers and governments to prevent stress at work, improve support early and make it easier for people to stay in work or return to work after illness.

Priority for action 2

Strengthen income security and local economies

A steady income helps people to cover the basics, lowers stress and protects health. Stronger local economies can also create better jobs and keep value in communities.

Illustrative country accelerators (what countries are doing)

Spain
Ingreso Mínimo Vital [Minimum Vital Income] provides a nationally guaranteed minimum income for households at risk of poverty and social exclusion, helping to reduce financial hardship and strengthen the essential conditions for health, well-being and participation in society *(76)*. By improving income security and protecting households from severe material deprivation, it addresses one of the most important social determinants of health. The Independent Authority for Fiscal Responsibility estimates that the scheme has reduced

the poverty gap among beneficiaries, although coverage remains below its full potential, reaching around 20% of the population living in poverty while identifying scope to reach many more eligible households. At local level, Barcelona City Council's B-MINCOME pilot complemented a guaranteed minimum income with employment and training, social-economy and community-participation measures, reaching 952 low-income households across 10 disadvantaged neighbourhoods. Around 84% of recipients were women *(206)*. Evaluation found reductions in severe material deprivation, food insecurity and residential exclusion, together with improvements in life satisfaction, sleep quality and perceived social support *(198,226)*.

Finland

The Basic Income Experiment (2017–2018) provided unconditional monthly income for unemployed adults, giving people greater financial security while reducing the stress associated with unemployment *(198)*. By improving income security and reducing financial strain, the programme strengthened an essential condition for health and well-being. Evaluation found lower mental strain, fewer depressive symptoms and less loneliness, alongside higher life satisfaction and perceived well-being *(227,228)*.

Netherlands (Kingdom of the)

Under a framework established by the Dutch Government, municipalities including Utrecht, Groningen, Tilburg, Nijmegen, Wageningen and Deventer tested alternative ways of supporting social-assistance recipients under the Participation Act *(229)*. Different groups received less intensive monitoring, exemptions from some work-related obligations, more personalized guidance or greater freedom to retain additional earnings. The experiments examined whether replacing sanctions and standardized activation with trust, autonomy and tailored support could improve well-being, social participation and movement towards employment *(198)*. They were particularly relevant to people facing multiple barriers to work, for whom strict conditionality can deepen insecurity without improving employment prospects.

Scotland (United Kingdom)

NHS Health Scotland – now part of Public Health Scotland – modelled how changes to income-based policies could affect mortality and health inequities across socioeconomic groups. This distributional approach showed how modelling can identify who is likely to benefit (or lose) from reforms before they are implemented, supporting the design of more equitable income protection. Separately, the Scottish Government funded Glasgow, Edinburgh, Fife and North Ayrshire to examine the feasibility of Citizens' Basic Income pilots, overseen by an independent steering group supported by NHS Health Scotland. The work concluded that pilots were desirable *(207,208,230)*.

Spain

The Mondragón worker cooperatives in the Basque Country uses shared worker ownership and intercooperative solidarity to protect employment, income and health *(213)*. Its no-layoff policy, joint redeployment and retraining service, and collectively financed health and well-being provision help to reduce the economic and psychological effects of unemployment. WHO reported industrial accident rates in Mondragón companies of 30–40% below the Basque average, while the area in which many cooperatives operate had particularly low poverty and unemployment *(231)*.

United Kingdom

Preston has a community wealth-building strategy, which uses local procurement and employment levers to improve residents' economic well-being, redirects public spending to local suppliers and supports cooperative business models. This approach, led by the public sector, was associated with a 9% increase in life satisfaction and an 11% rise in median wages, compared with expected trends. Health indicators also improved, with reductions in antidepressant prescribing and lower depression prevalence. This approach highlights how inclusive local economic strategies can enhance financial security and population health *(211,212,232)*.

Montenegro
The residence-based health coverage and low-income exemptions base entitlement to publicly financed health care on residence rather than payment of employment-related contributions, helping to ensure that people in informal or precarious work do not lose access to care. People with very low incomes are also exempt from most co-payments. Together, these measures strengthen financial protection for vulnerable working-age people and reduce the risk that illness compounds poverty. However, important gaps remain: OOP payments still result in catastrophic health spending for nearly 9% of households, driven particularly by outpatient medicines *(194)*.

Key enabling frameworks (that support countries to accelerate progress)

- ***European pillar of social rights and action plan*** *(233,234)* bring together fair working conditions, active support to employment, social protection, minimum income and access to services, all of which matter when people are trying to stay healthy, stay in work or recover after a setback.
- **ILO Convention C102 (*Social security (minimum standards) convention*)** *(235)* and **Recommendation no. 202 on social protection floors** *(236)* support countries to build comprehensive social-protection systems that provide income security throughout the life-course, helping to protect people against unemployment, illness, disability, maternity and old age. By strengthening financial security and reducing the risk that health shocks or caring responsibilities lead to poverty or exclusion from work, they reinforce the social determinants of health and of health equity.

Priority for action 3

Set and enforce healthy work standards

Work should not make people ill. Clear rules on stress, working time and recovery help to protect health, especially in jobs with high pressure and low control.

Illustrative country accelerators (what countries are doing)

France
Right to Disconnect gives employees the right to disconnect from work-related digital communications outside working hours, helping to protect time for rest, recovery and family life. By reducing excessive work demands, the legislation supports better mental health and healthier working conditions. Employees in organizations with a right-to-disconnect policy reported better work–life balance (92% versus 80%), fewer health problems (such as stress, anxiety and headaches) and higher job satisfaction than those without such a policy *(237,238)*.

Finland
The Mental Health at Work Programme shifts workplace mental health support from reactive, individual problem-solving to proactive, community-wide prevention of work ability issues. The programme supports workplaces to prevent mental health problems by offering tools, training and coaching *(239)*.

Key enabling frameworks (that support countries to accelerate progress)

- ***EU strategic framework on health and safety at work 2021–2027: occupational safety and health in a changing world of work*** *(240)* supports stronger prevention of work-related harm, including psychosocial risks.
- **EU Working Time Directive** *(241)* and **ILO working-time standards** *(242)* establish limits on working hours and rights to daily and weekly rest, paid annual leave and healthy working-time arrangements, helping to protect recovery, work–life balance and workers' physical and mental health.

Priority for action 4

Redesign work and reduce harmful long working hours

People need time to rest, recover and manage family life. When work is designed better, well-being improves and health is less likely to suffer.

Illustrative country accelerators (what countries are doing)

Iceland

In Iceland a large-scale public-sector working-time reform reduced working hours from 40 to 35–36 hours per week without reducing pay, giving employees more time for rest, recovery and family life *(243)*. By improving work–life balance while maintaining productivity, the reform demonstrated that healthier ways of working can benefit both people and organizations. Evaluation found improved well-being, lower stress and burnout, maintained or improved productivity and service delivery, and the reform subsequently universally enabled Iceland's workforce to gain shorter working hours or the right to request them *(244)*.

Priority for action 5

Make help easy to reach in the community

People are more likely to get help when it is close to home and easy to use. That matters most for those who are short on time, money or trust.

Illustrative country accelerators (what countries are doing)

Wales (United Kingdom)

Through the *National framework for social prescribing* (2023), the Welsh Government identifies social prescribing as an important approach to improving health and well-being, reducing health inequities, strengthening community connectedness and addressing wider social determinants of health *(245)*. The Framework aims to support more consistent, high-quality social prescribing across Wales. Evidence from Wales and the wider United Kingdom indicates improvements in mental well-being, confidence and social connectedness, alongside the potential reduction in avoidable demand on primary care services *(246)*.

England (United Kingdom)
The Frome Model and Health Connections Mendip link people to practical, social and activity-based support through social prescribing, connecting primary care with community organizations, volunteering, physical activity and peer support *(217)*. By helping people to address the wider social determinants of health, the programme can reduce isolation, strengthen resilience and support better physical and mental well-being. Evaluation of the wider Frome Model – of which Health Connections Mendip is a central component – found a 14% reduction in emergency hospital admissions over 3 years, compared with a 29% increase in the rest of Somerset *(247,248)*.

Ireland
Men's Sheds provide trusted community spaces where men can build friendships, learn new skills and support one another in an informal, non-stigmatizing environment *(215)*. By reducing loneliness and strengthening social connections, the initiative improves an important social determinant of health and helps men who might not otherwise engage with health services. Evaluation of the "Sheds for Life" programme found significant improvements in self-reported health, mental well-being, physical activity, healthy eating and social capital, with benefits maintained for up to 12 months *(216)*. An economic evaluation also found the programme to be cost-effective, with gains in quality-adjusted life-years *(249)*.

Slovenia
Health Promotion Centres have been established across all 61 primary health-care centres to combine individual lifestyle support with population-level prevention. The model was subsequently adapted to reach vulnerable groups through community outreach and partnerships with social services, nongovernmental organizations and other local actors *(218)*. These partnerships informed local strategies and action plans that identify underserved groups and reduce barriers to preventive services, helping to prevent existing social disadvantage from translating into poorer health.

Scotland (United Kingdom)
The "Near Me" programme was delivering around 40 000 consultations monthly in 2022; surveys have found an average saving of 36 miles per visit, while over 90% found it easy to use and would use it again *(189,250,251)*.

Estonia
Rural telemedicine has been piloted through nurse-supported video consultations in rural primary care centres, where shortages make it difficult to maintain a full-time family doctor *(183)*. Patients attend their local centre, where a nurse supports a remote consultation with a family physician. Building on earlier telemedicine use on Estonia's smaller islands, the model was intended to inform sustainable service arrangements for other underserved areas without permanent family-doctor coverage.

Kyrgyzstan
Building on Kyrgyzstan's strengths in high-altitude medicine, the Health in the Mountains Agenda brings government, WHO, development partners and local authorities together to address the health inequities experienced by rural, remote and mountainous communities. It promotes an integrated approach centred on primary health care, stronger community participation, local government action and cross-sector responses to the combined effects of geographical isolation, poverty, climate change, food insecurity and inadequate water and sanitation *(187,188)*

Key enabling frameworks (that support countries to accelerate progress)

- ***Framework for resilient and sustainable health systems in the WHO European Region 2025–2030*** *(252)* supports countries in building resilient, people-centred health systems that provide timely, integrated and financially accessible care while strengthening links between health, social and community services. This helps to ensure that people can access coordinated support when their health starts to affect their ability to work and participate fully in society.

Priority for action 6

Create inclusive labour markets

Everyone should have a fair opportunity to enter, remain in and progress in good work. Removing barriers for women, people with disabilities, carers and others facing disadvantage improves health, strengthens financial security and expands the workforce.

Illustrative country accelerators (what countries are doing)

Austria

The fit2work initiative provides free, nationwide counselling and multidisciplinary support for people whose health threatens their ability to find, remain in or return to work *(166)*. The programme combines occupational health and psychological assessments with tailored guidance and referral to appropriate health, rehabilitation and employment services to help to prevent temporary illness becoming long-term labour-market exclusion. By supporting sustainable employment, it strengthens financial security, social participation and health. Since 2014, the programme has been evaluated showing higher rates of employment without sick leave among participants in the individual counselling service, compared with matched controls, supporting its role in maintaining work ability and labour-market participation.

Sweden

Gender-equal parental leave in Sweden provides for 480 days of paid parental leave, with a dedicated nontransferable entitlement for each parent to promote a more equal sharing of childcare responsibilities *(253)*. By helping women to remain attached to the labour market while encouraging fathers to take a greater caring role, the policy strengthens financial security, promotes healthier work–life balance and supports more equitable opportunities across the life-course. Sweden was the first country to introduce gender-neutral parental leave (in 1974), and today fathers take around 30% of all paid parental benefit – one of the highest shares among countries globally – contributing to more equal caregiving and labour-market participation

Key enabling frameworks (that support countries to accelerate progress)

- **EU Council recommendation on integrating the long-term unemployed** *(254)* helps to keep the focus on early support, individual pathways back into work and better coordination between employment, social and support services for people at risk of being left out of the labour market for too long.

Priority for action 7

Tailored support during the later working years

People can remain in good work as they age when timely adjustments, skills support and protection are available for those affected by poor health, caring responsibilities or demanding work.

Illustrative country accelerators (what countries are doing)

Slovenia
The aktivno staranje delovne sile asi [Active Ageing Support Initiative] programme supported employers to manage an ageing workforce through age-sensitive workplace strategies, skills development and training for workers aged over 45 years. It also promoted healthier and more sustainable working conditions, with a focus on well-being, work–life balance and reducing age-related workplace strain. It reached 1087 companies, supporting longer, healthier working lives and intergenerational knowledge exchange *(220)*.

Germany
The *Perspektive 50plus* [Perspective 50plus] programme used regional employment partnerships to support unemployed people aged 50–64 years, combining job placement services with measures addressing health-related barriers such as long-term illness, reduced work capacity and mental health challenges *(221)*. Job centres worked with employers and community organizations to tailor support to individual needs, including rehabilitation pathways and workplace adjustments to improve employability and sustain participation in work. The programme reached over 200 000 participants by 2011, and later evaluations of similar policies in Germany have continued to emphasize the importance of integrating health and employment support for older workers, particularly as chronic conditions have become more common.

Norway
The Inclusive Working Life Agreement brings together government, employers and trade unions to prevent sickness-related labour-market exit and to enable people with reduced work capacity to remain employed. Workplace adaptations, early follow-up of sickness absence and action to extend working life after age 50 years combine to help to protect health, earnings and future pension security *(222)*.

Note: ILO: International Labour Organization.

5 Older people



Where we want to be

Healthy ageing is shaped by advantages and disadvantages accumulated throughout life. Yet, access to adequate incomes, affordable care, adapted homes, safe neighbourhoods, digital participation and social connections that can even out poor health remains inequitable, particularly for older people experiencing poverty, disability, isolation or living in underserved places.



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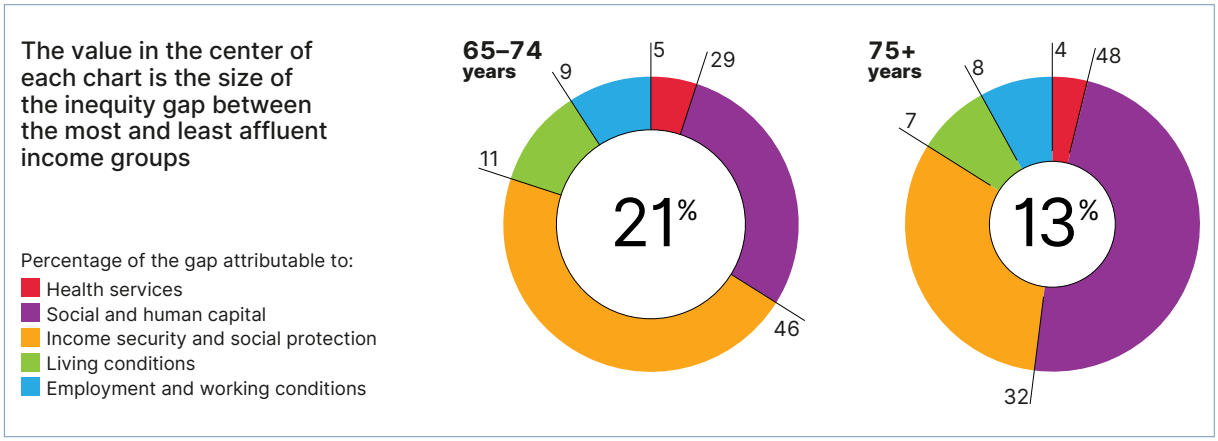
Summary

Population ageing is not the challenge; inequity in ageing is. Universal support, with greater investment where needs and barriers are greatest, can enable all older people to live healthy, independent and fulfilling lives. This unlocks their contributions while reducing avoidable pressure on families and public services, thus strengthening the WHO European Region's cohesion, resilience and shared prosperity.

Inequities rob an estimated 34 million women and men (the least affluent 20% across the WHO European Region) of a fair chance to enjoy a healthy, independent life in their later years. This includes around 19 million adults aged 65–74 years and 15 million aged 75 years and older. A strategic focus on addressing the three main drivers of inequity, in addition to priority health needs (3+H) at this life stage can help to reduce up to 86% of the health inequity gap between the most and least affluent older people, which in turn will boost efforts towards a socially and economically stronger WHO European Region (Box 5).

The main drivers of inequity that reflect the daily realities of older people include: income, social connections and participation, and living conditions (Fig. 18).

Fig. 17. Inequity gap in long-term limitations in daily activities due to health problems for older women and men contributed by each essential condition, 2019–2023



Source: authors' own compilation based on data modelling for 34 countries for the HESRi2 data report *(9)*.

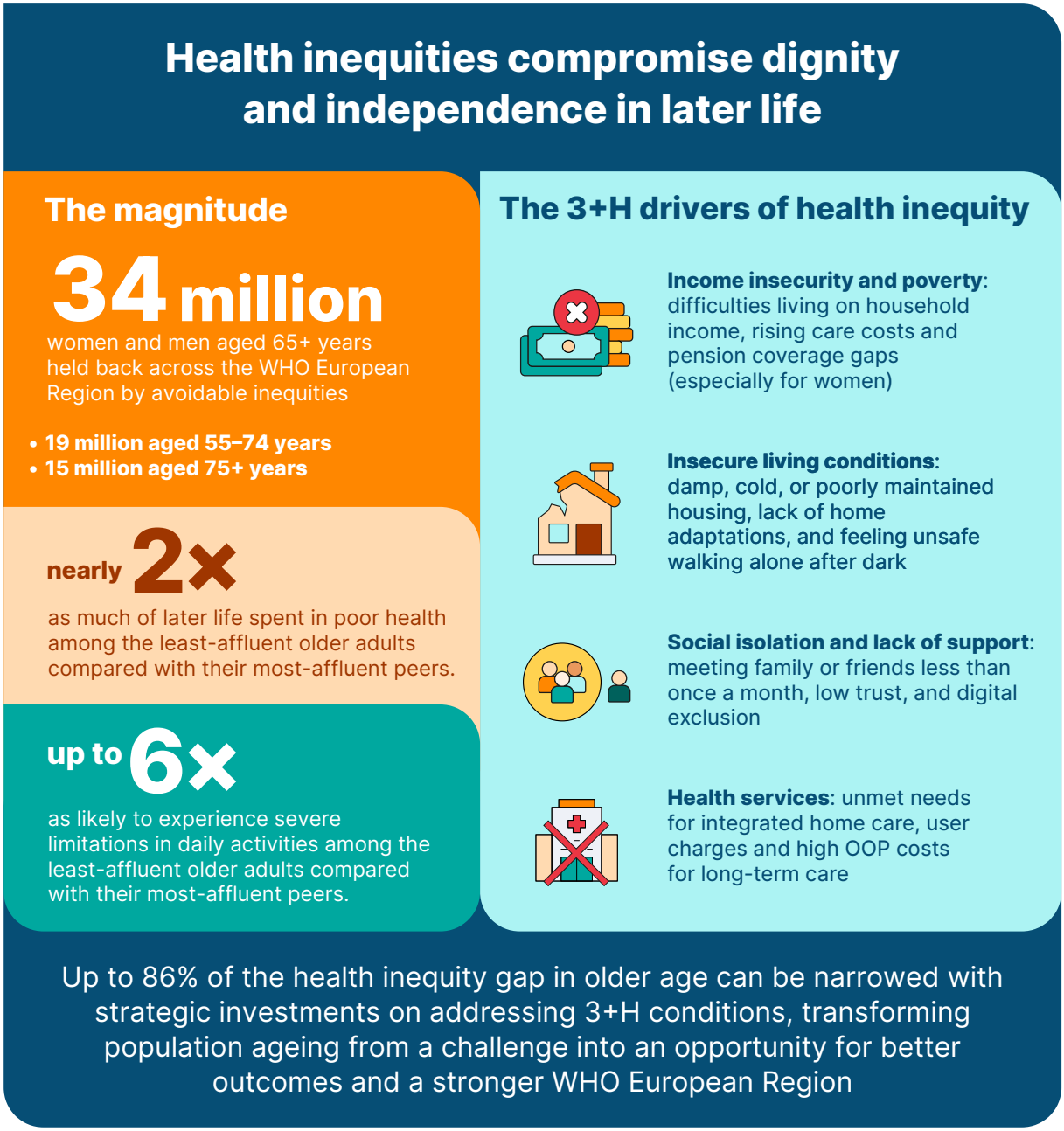
Box 5. Turning healthy ageing into an opportunity for a stronger WHO European Region

Evidence shows that the conditions shaping health in older age are largely determined by the opportunities, resources and support available throughout life. If rates of long-term activity-limiting illness across all levels of affluence were reduced to those experienced by the most affluent, 15 million fewer older people in the WHO European Region would be living with long-term activity-limiting illness, equivalent to 9% of the WHO European Region's older population *(12,255)*.

Closing this gap would enable millions more older people to remain independent, active and connected, and would help to turn population ageing from a perceived dependency challenge into an opportunity for a stronger WHO European Region.

Source: WHO modelling based on 2024 data from the WHO European Health Equity Atlas *(10)*, EU-SILC *(12)* and World Bank *(255)*.

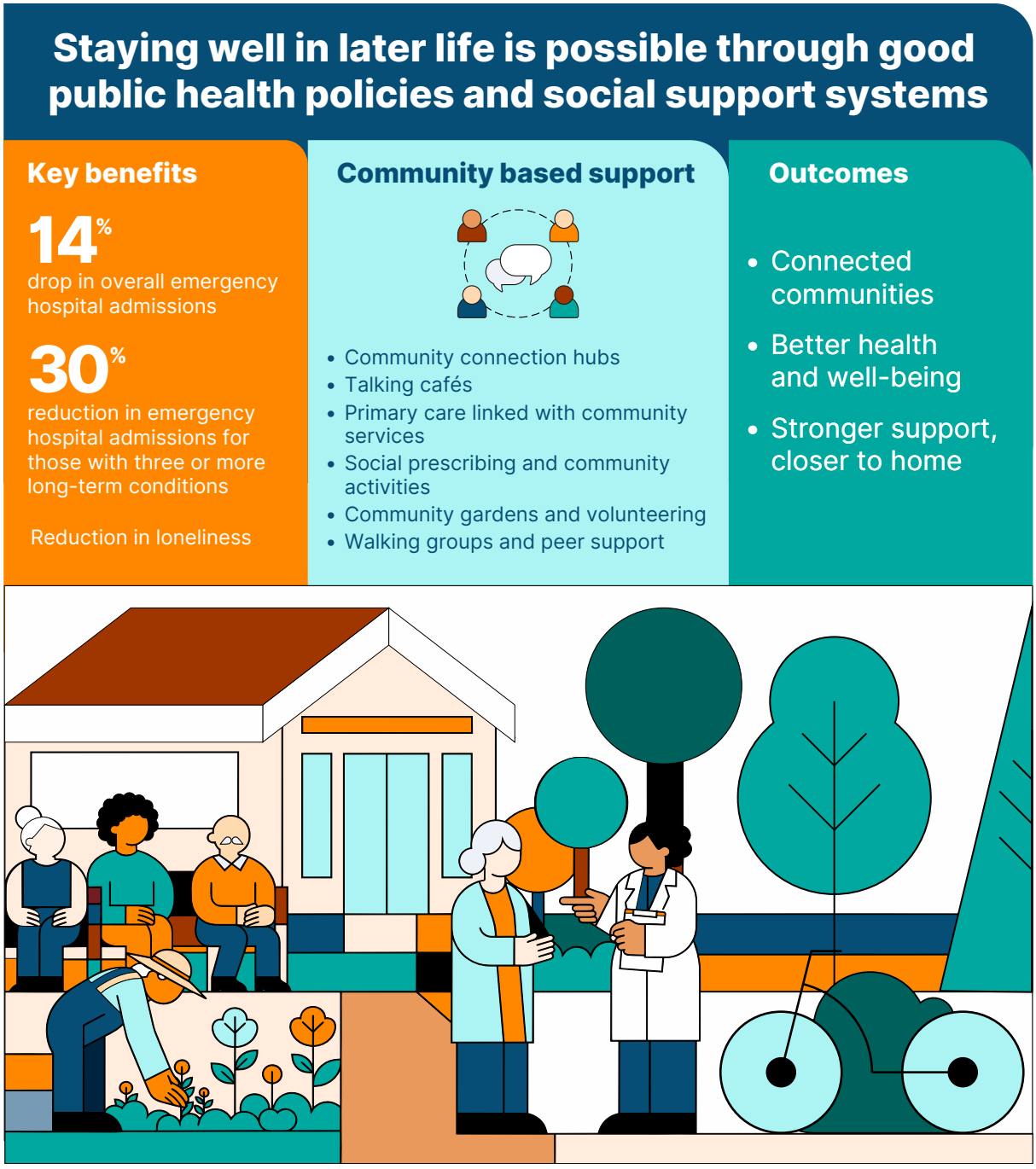
Fig. 18. Drivers of health inequity in older age



Source: authors' own compilation based on2024 World Bank population estimates(see the Annex), the HESRi2 data report *(9)*, WHO macroeconomic modelling and data from the WHO European Health Equity Atlas *(10)*, EU-SILC *(12)* and ESS *(13)*.

Fig. 19 illustrates the potential benefits that could be generated from investing in public health policies and social support systems. Frome in the United Kingdom saw a 30% reduction in emergency hospital admissions for those with three or more long-term conditions, while for the rest of the county the admission rates increased by 29%. A further benefit is the high percentage (88%) of those living with health problems who report feeling more able to self-manage these *(248)*. This example shows how investment in prevention, community connections and support closer to home can tackle loneliness and improve people's well-being while helping health and care systems to manage demand more effectively. Scaling such approaches is central to the resilience and sustainability of the WHO European Region's public services.

Fig. 19. The Frome Community Health Model (United Kingdom): return on investment from public health policies and social support systems for women and men



Note: Examples of new primary care models and social prescribing: the Frome Model, United Kingdom
Source: authors' own compilation based on data from the WHO European Health Equity Atlas *(10)*, Abel et al. *(247)*, and Health Connections Mendip *(248)*.

Four priorities to level up the health and well-being of older people in Europe

Countries can take the following actions to reduce health inequities. The order of the following priorities is purely sequential and does not denote their importance.

1. **Prioritize services to reduce unmet needs for health and social care for low-income older people – especially women with complex health, social and economic needs** and incorporate neighbourhood link workers and similar coordination mechanisms that join up needs assessment and care across provider and deliver interventions in the home or in a safe local facility.

2. **Test and adapt innovations in personal care budgets and the removal of user charges for publicly funded home-based health and social care services to prevent low-income older people from falling further into poverty.**

- Target the expansion of publicly financed community services for long-term care to older people living in low-resource neighbourhoods and left-behind communities.

3. **Shore up and boost the robustness of the silver economy and health of the (34 million) low-income older people through effective pensions and social transfers.**

- Use universal and top-up pension mechanisms to guarantee a minimum income and to buffer the financial security of older women and men against rising living and care costs, especially those whose employment histories were interrupted by unpaid care or insecure work.
- Link administrative data to channel support to older people at greatest risk and reduce non-take-up of social assistance among those with the greatest needs.

4. **Delay institutionalization, reduce avoidable hospital admissions, and long-term care dependency among vulnerable older people who are struggling, to remain active and independent within their communities.**

- Use social connectedness and safety as common goals in the design and delivery of local policies, including the use of routine and survey data, to ensure that local authorities and service providers systematically measure social connectedness and perceived safety as core outcomes of housing, transport, urban planning and community services.
- Scale up age-friendly neighbourhoods and adapted homes, deliver early interventions and care at home and in the community, and involve older, vulnerable people in designing and evaluating these approaches.

These benefits extend to the whole population through universal design, safer public spaces, improved walkability and better transport systems.

The same interventions also support demand-management and public-expenditure goals by delaying institutionalization, reducing avoidable hospital admissions and reducing long-term care dependency *(256)*.

Together, these priorities provide a practical agenda for a stronger WHO European Region: enabling more people to live independently, protecting older people and families from financial insecurity and strengthening community-based infrastructure that everyone living locally can benefit from. This fosters trust in institutions and greater support for collective investment in public goods such as UHC, education, safe public spaces and community amenities. This reinforces intergenerational fairness balancing the needs of today's citizens with the rights and duties of future generations, helping to ensure shared prosperity and democratic stability.

At a glance: the health and well-being of older people (aged 65+ years)

Mortality

Socioeconomic disadvantage shapes not only how long people live, but how many of those years are spent in good health. Across the WHO European Region, life expectancy averages at 76 years (79 for women and 73 for men); however, healthy life expectancy is shorter by 10 years for women (67 years) and by nearly 9 years for men (65 years) *(179)*. As a result, many older adults, particularly women, spend a substantial part of later life living in poor health, with disability or functional limitation.

Morbidity and illness

Long-term activity-limiting illness is strongly correlated with affluence (Table 13). Compared with those with the highest levels of affluence, older women and men with moderate levels of affluence are, on average, more than 1.2 times as likely to experience limitations in daily activities, rising to around 1.4 times more likely among the least affluent in the 30 countries with data.

Table 13. Social gradient in long-term activity-limiting illness among older women and men aged 65 years and over across the WHO European Region, by income

	High affluence	Moderate affluence	Low affluence
Women	41%	51%	58%
Men	37%	45%	53%

Source: authors' own compilation based on analysis of 2023 data for 30 countries from the WHO European Health Equity Atlas *(10)*.

At older ages, the least affluent are more likely to report long-term activity-limiting illness than those with the highest affluence level in all 29 countries with data for women and 29 countries with data for men. The gap is particularly wide in some countries. The largest gap in any one country was from 36% to 74% among women and 32% to 71% among men. The smallest gap was from 51% to 58% among women and 46% to 53% among men.

Progress across countries to reduce inequities in living with a long-term activity-limiting illness has been slow and mixed, with the regional average inequity remaining high at 50% among women and 46% among men in the 30 countries with data. These figures hide worrying increases in inequities among women in 48% of countries (15 out of 31 with trend data) and inequities among men in 47% of countries (15 out of 32 with trend data). This backsliding has been more notable among countries in northern Europe (six out of nine countries with trend data for women and five out of 10 countries with trend data for men). However, equity gains have been made, particularly in southern Europe, with the gap narrowing for women in five out of eight countries and for men in six out of eight countries.

These inequities determine whether longer lives are lived in health and independence or with avoidable limitations and dependence. Reducing them is essential to the WHO European Region's demographic sustainability: it enables a growing older population to remain active and engaged while easing future pressure on health, care and social-protection systems.

Self-reported poor health

Healthy ageing follows a clear social gradient (Table 14). In the WHO European Region, self-reporting of poor or fair health is greater among those with lower levels of affluence. Compared with the most affluent, the proportion of moderately affluent older women reporting poor or fair health is 1.3 times higher, rising to 1.4 times higher among the least affluent. Among men, the corresponding figures are 1.2 and 1.4, respectively.

Table 14. Social gradient in self-reported fair or poor health among older women and men aged 65 years and over across the WHO European Region, by income

	High affluence	Moderate affluence	Low affluence
Women	46%	61%	64%
Men	44%	53%	62%

Source: authors' own compilation based on analysis of 2023 data for 31 countries from the WHO European Health Equity Atlas *(10)*.

Self-reported clinical depression

In 18 out of 20 countries with data (90%), women with the lowest level of education are more likely to report being depressed than their peers with moderate or high levels of education. This pattern is also the same for men, with those with the lowest education level more likely to report depression compared with others in 86% of countries (18 out of 21 with data).

Progress to reduce inequities was mixed across the WHO European Region between 2010 and 2023. In 14 countries with trend data for women, inequities increased in seven countries (50%) and narrowed in four of countries (29%). Among men, in 16 countries with trend data, inequities increased in six (38%) and decreased in seven (44%).

Growing older with health, dignity and security

Unmet needs for health care

Access to health care remains unequally distributed in older age. In the 36 countries with data in the WHO European Region, on average, 7% of the least affluent older women and men report unmet needs for health care, compared to 4% and 3% of the most affluent women and men, respectively. Despite this significant gap, these figures represent an improvement in inequities in unmet needs for health care for all affluence levels since 2010 (when averages were based on 32 countries) but with the largest reduction for the most affluent women. Among women, the average rates fell from 12% to 7% for the least affluent and from 6% to 3% for the most affluent, while for men the reductions were from 11% to 7% and from 5% to 3%, respectively.

This regional improvement was reflected in significant reductions in inequity in many individual countries. Inequities in reported unmet health-care needs between the least and most affluent women narrowed significantly in 57% of countries (20 of 35 with trend data), Among men, there was a significant reduction in inequities in 46% of countries (16 out of 35). The subregions with the largest proportion of countries showing significant reduction in inequity were southern Europe, eastern Europe and western Asia (68% of the 19 countries in the three subregions among women and 58% of those countries among men).

Countries are showing that progress is possible through targeted investment, broader coverage and stronger primary and community care. In North Macedonia, a renewed primary health care model aimed at strengthening person-centred, multidisciplinary care and coordination between health and social services was designed and piloted to address unmet needs among older people. This model has promise and could subsequently be integrated into routine primary health care practice when national reforms are full implemented. Ireland's clinical case nurse managers similarly assess complex needs, coordinate providers and support older people closer to home. In Denmark, municipally led reablement provides short-term, goal-oriented rehabilitation following illness or functional decline, helping people with disabilities to regain mobility, confidence and independence in everyday activities *(257)*. Going forward, countries need to sustain and scale up these approaches, while targeting them more explicitly towards the least affluent older people – particularly women – so that future gains accrue to those experiencing the greatest unmet needs, rather than predominantly to middle-affluence groups.

By directing integrated health and social support towards people and places with the greatest unmet needs, these approaches strengthen public-service resilience and territorial cohesion. They help to ensure that healthy and independent ageing is not determined by income, geography or the local availability of services.

Poverty

Adequate incomes ensure healthy and independent ageing, and are key to a strong silver economy. These are important fiscal stabilizers in the context of ageing societies, particularly in northern, southern and western Europe. The ability to afford medicines, nutritious food, housing, transport, digital connectivity and care and to withstand financial shocks enables older people to use their spending power in volunteering and community engagement to contribute to a strong social economy and economic well-being in the places where they live.

Ensuring financial security in older age begins much earlier in the life-course. Pension systems, employment conditions and caregiving and health policies shape whether people enter later life with resilience or disadvantage. Groups with higher risks of financial insecurity and poor health when entering this stage of life include:

- older women affected by the care penalty: women facing the compounding impacts of interrupted careers, lower lifetime earnings and unpaid care responsibilities that heavily reduce pension entitlements, driving a higher risk of poverty and poorer health;
- low-paid and insecure workers: individuals stuck in low-paid, temporary or part-time employment with limited opportunities to save, leading to heightened risks of poverty and poor health; and
- early health-related labour-market exiters: those forced out of work prematurely due to poor health, leaving them with minimal savings and increased vulnerability to compounding health and financial challenges.

Currently, 20% of women and 15% of men on average are living in poverty in the 36 countries with data, where their incomes fall below 60% of median equivalized income after pensions and social transfers. The situation can also be better or worse, depending on where an older person lives in the WHO European Region. For example, in 11% of countries (four countries), poverty rates for older women exceed 40%, more than double the average, and in 6% of countries (two countries) rates are 30% and above for men. At subregional level, rates (after pensions and social transfers) are lower in the six countries with data in eastern Europe (18% for women; 11% for men) than elsewhere, although the rate among women is also 18% in the seven countries with data in western Europe.

Across the WHO European Region, trend data shows that the poverty rate for adults aged 65+ years has increased in more countries than it has decreased, with average poverty rates for women increasing in 42% of countries and for men in 58% of countries (across 36 countries with trend data). This pattern is especially widespread in eastern Europe, where poverty increased in four out of six countries for women and in five of six for men, while no country recorded a decrease.

Protecting older people from financial insecurity is essential to a strong WHO European Region. Adequate pensions and social transfers, protection from catastrophic health and care costs, and affordable essentials – including housing, transport, food and energy – protect health and independence, enable participation in community life, reduce avoidable pressure on public services and support spending in the local economy.

OOP payments for long-term care

Although unmet needs for health care has reduced, OOP spending on long-term care continues to place considerable strain on household budgets, data covering all age groups show that household spending on long-term care ranges from less than 0.1% of GDP in all six countries with data in eastern Europe to 0.9% in one of the nine countries with data in western Europe *(9)*. In western Europe, rising OOP payments for long-term care have emerged as an increasingly important source of financial pressure.

Total expenditure on long-term care also covers all age groups and varied across the Region (by more than a 10-fold difference) from less than 0.4% of GDP in 18% of the 33 countries with data (all located in eastern and southern Europe) to more than 4% in 30% of countries located in northern Europe *(11)* and western Europe (seven countries) *(9)*.

As care needs increase with age, inadequate financial protection and investment in care can delay access to essential services, accelerate loss of independence and place greater pressure on families, communities and health systems.

Financial protection remains a critical gap in home-based long-term care. A WHO study covering 14 European countries found that OOP payments can impoverish households or result in catastrophic expenditure *(258)*. In Greece, Italy and Spain, at least 20% of people using long-term care services at home experienced catastrophic spending, while in most countries this burden was concentrated among poorer households. Denmark – where publicly funded home-based long-term care does not require user charges – has illustrated how removing charges can protect people with care needs from additional financial hardship *(258,259)*.

Additionally, *Buurtzorg* [Neighbourhood Care] in the Netherlands (Kingdom of the) (Box 6) and *Zorgzame Buurt* [Caring Neighbourhoods] in Flanders (Belgium) integrate clinical and social care at home, helping to prevent complications and maintain independence *(259–262)*. These models are complemented by financial protection: people assessed as needing long-term care and with limited incomes can receive a personal budget to arrange appropriate care; overall, public benefits and services reduce the poverty risk associated with care costs among people aged 65 years and over by more than 70 percentage points *(259)*. Other countries are expanding publicly supported home care to reduce unmet needs. In Poland, Care 75+ co-finances municipal home-care services for people aged 75 years and over *(263)*. In addition, the new Senior Voucher (2026) provides financing support at home for eligible people aged 65 years and over with lower incomes, prioritizing municipalities with little or no existing provision *(264)*.

Affordable, high-quality support at home is therefore not only a care policy objective. It protects families from financial hardship, delays avoidable institutionalization and helps the WHO European Region to build more sustainable health and care systems around an ageing population.

Box 6. Securing independence by integrating clinical and social care (*Buurtzorg* [Neighbourhood Care], Netherlands (Kingdom of the))

Challenge
Fragmented medical and social services leave needs unmet and push older adults towards premature institutionalization.

Model
Buurtzorg [Neighbourhood Care] replaces rigid, task-based home care with small, self-managing nurse teams who provide holistic support and mobilize family/community networks *(262)*.

Why it matters
While hourly costs can be higher, holistic support prevents complications and builds independence, so total hours needed fall, and older adults can live at home for longer.



© Henri van Raalte

Source: Buurtzorg International *(262)*.

Together, these measures show how care budgets and publicly financed community services can reduce the costs borne by older people and families, close gaps in provision and support independence at home. The EU Council recommendation on access to affordable high-quality long-term care provides a wider framework for strengthening their affordability, quality and governance *(265)*.

Pensions and social assistance

The effect of pensions and social transfers in reducing poverty among older women and men cannot be underestimated. They are effective interventions that drive down demands for care by protecting health, and support a robust silver economy by protecting purchasing power locally and nationally. These benefits need to be reinforced, especially in the context of decisions amidst pressures to reduce public expenditure. In this context, pensions and social transfers should be understood as productive social infrastructure rather than expenditure alone. They protect health and purchasing power, sustain spending in local economies and reduce the need for more costly crisis, health and care interventions.

Pension coverage is high in many countries, but important gender gaps remain. While full pension coverage is achieved for men in 82% of the 49 countries with data (Fig. 20), the same is true for women in only 57%. In 8% of countries, fewer than half of older women receive a pension; all of them in southern Europe (four of the 13 countries with data in this subregion). Where coverage is not universal, women are generally less likely than men to receive an old-age pension, reflecting inequities accumulated across working lives, including interrupted or insecure employment histories.

Across the WHO European Region, pension expenditure per beneficiary has increased in 89% of the 37 countries with trend data (and decreased in 3% of countries), reflecting continued investment in income protection.

One guide to the adequacy of the pensions that are provided is the extent to which they replace pre-retirement earnings of recipients. In 82% of the 34 countries with data, net pension entitlement is 50% or more of net pre-retirement earnings among both women and men. In all seven countries with data in southern Europe, replacement rates are 60% or more, enabling many older women and men to maintain a standard of living closer to what they enjoyed during working life.

This illustrates an important policy lesson: protecting older people from poverty requires broad pension coverage, an adequate income and sufficient replacement of previous earnings.



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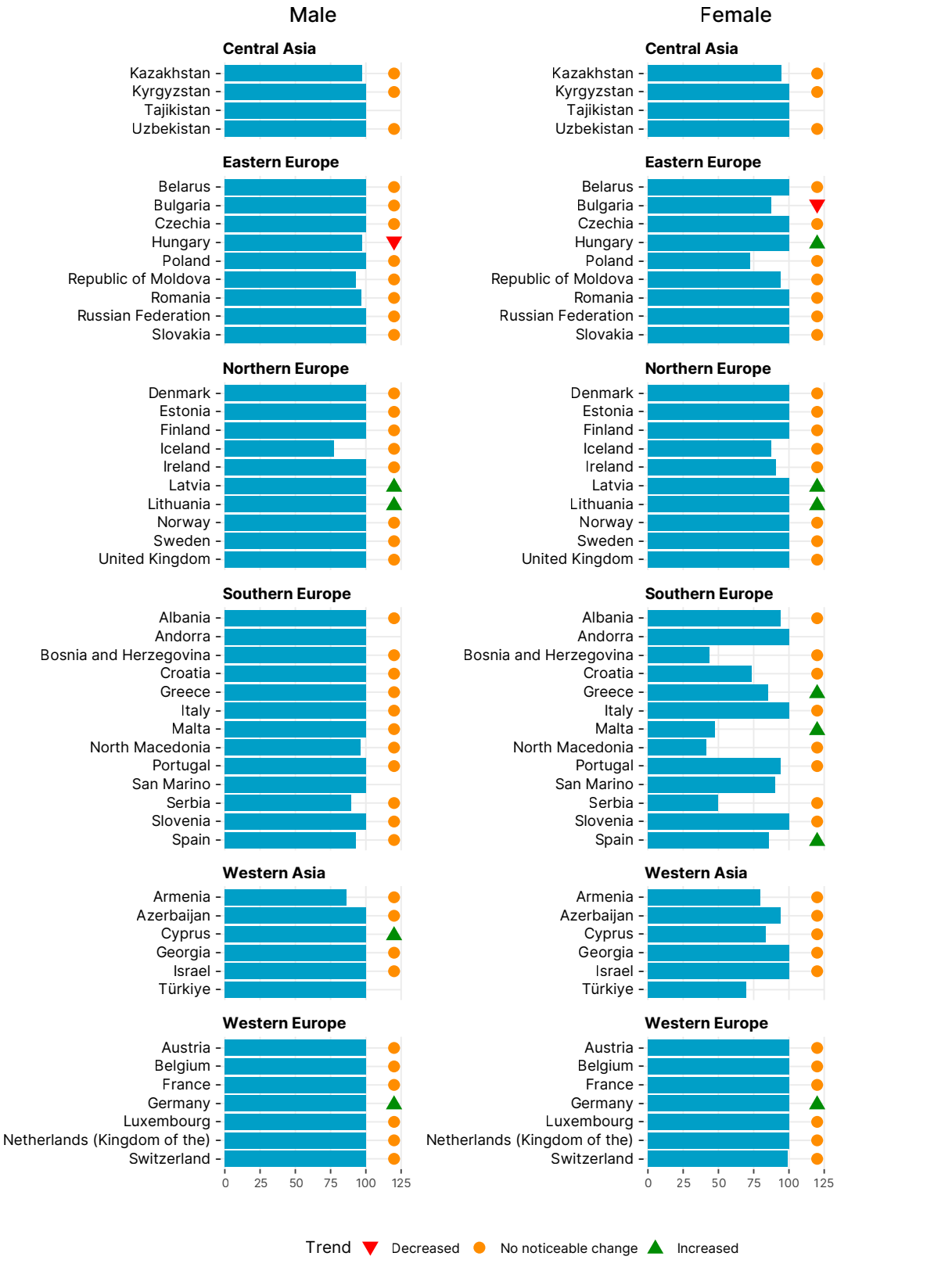
Fig. 20. Percentage in 2022[a] of women and men above statutory pensionable age receiving an old-age pension and trend since 2013, by country and sex



[a] Unless otherwise indicated.

Notes: the trend indicator shows whether there was a statistically significant change in the gradient since 2010 or earliest available year. No traffic light indicates insufficient data to assess a trend.

Sources: data from ILOSTAT, the International Labour Organization's ILO database *(35)* from 2013 to 2022, except for ALB (2011–2021), AND (2022), ARM (2015–2021), AZE (2015–2023), BIH (2019–2020), BLR (2015–2020), CHE (2013–2021), CZE (2013–2021), DNK (2013–2021), FRA (2013–2021), GBR (2013–2023), GEO (2015–2022), GRC (2010–2020), HRV (2010–2022), HUN (2013–2021), IRL (2014–2022), ISL (2014–2021), ISR (2018–2022), KAZ (2015–2023), KGZ (2015–2022), LUX (2013–2021), MDA (2020–2022), MKD (2019–2021), MLT (2013–2021), NOR (2013–2023), POL (2018–2022), PRT (2018–2021), ROU (2015–2022), RUS (2015–2022), SMR (2023), SRB (2010–2019), SVK (2013–2021), SWE (2013–2020), TJK (2021), TUR (2022) and UZB (2017–2021). For the full list of three-letter country codes and regional subgroups used in the report, see Annex, Table A1.

Social protection and assistance

Data show that in the absence of adequate pensions and social transfers for low-income older people, 86% of women and 83% of men aged 65 years and over would be living in poverty (based on analysis of 36 countries with data) *(12)*. However, combined pension and social protections have the potential to protect health and the silver economy. Pensions alone reduce poverty among women from 86% to 23% and in men from 83% to 19%. The effect of additional social transfers results in a further reduction, leaving 20% of women and 15% of men in poverty.

All countries can benefit from policies that strengthen pensions and social transfers, but those with the highest levels of poverty stand to gain the most. In the six eastern European countries with data, it is estimated that pensions and social transfers reduce poverty among older adults from 88% to 18% for women and from 82% to 11% for men (levels that are among the lowest in the WHO European Region). This demonstrates the substantial potential of these policies to reduce poverty, strengthen financial security and protect health in older age.

Countries are deploying targeted policy accelerators and enablers. For example, Georgia's universal old-age pension and Poland's annual financial benefits – the so-called 13th and 14th pension benefits – provide guaranteed income floors and extra annual support to buffer households against rising living and care costs *(266–269)*. Other countries are redesigning contributory pension systems to recognize unpaid care across the life-course. Albania and Belgium credit pension contributions for periods spent raising children, helping to limit the long-term pension penalties associated with caregiving, which continue to fall disproportionately on women. At the wider enabling level, the United Nations Global Accelerator on Jobs and Social Protection for Just Transitions supports countries to design and finance integrated national policies that extend universal social protection, thereby helping to strengthen the sustainable financing and delivery of pensions and social assistance for older people *(270,271)*.

Countries are also using linked administrative data to direct support towards older people at greatest risk and reduce non-take-up. In Estonia, data from the social-protection information system and population register are used to identify pension-age people who live alone and receive a pension below the eligibility threshold. The annual allowance is then paid automatically, without an application *(272)*.



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Social connection and participation

Feeling a sense of belonging, safety at home and in the neighbourhood, along with being valued by significant others (family, social and other networks) are important health determinants at all ages. But they are particularly significant at this stage of life, when work no longer offers these opportunities and older people are more attached to their immediate community.

Living independently and participating in volunteering, social and cultural activities underpin well-being and self-care at this stage of life by protecting mental well-being and reducing isolation and loneliness. However, opportunities and risks are unequally distributed within and across countries, making lack of social connection and participation key drivers of health inequities, affecting around 34 million older women and men across the WHO European Region.

Social isolation is more likely among the least affluent older people in the WHO European Region, where, on average, 33% meet with family or friends less than once a month, based on 33 countries for women and 32 for men. This is almost twice as much as the number of the most affluent, among whom 17% of women and 15% of men meet family and friends less than once per month.

This form of social isolation is most commonly reported in the least affluent people living in countries in eastern and southern Europe, where an average of 40–44% report meeting family and friends less than once a month (based on 14 countries with data for women and 13 for men in these two subregions). Trends suggest that inequities in reported social isolation between the least and most affluent women and men across the WHO European Region are narrowing, with improvements for women in 63% of countries (20 out of 32 countries with trend data) and for men in 61% of countries (19 out of 31 countries with trend data). However, in 16% of countries, the progress is less positive, where the inequity in social isolation between the most and least affluent people has increased.

Countries are taking the issue of social isolation seriously. They are scaling up policies and approaches that foster social connectedness and strengthen purpose, confidence and cognitive well-being. Common approaches across countries include local volunteering and befriending initiatives close to home, intergenerational mentoring, skills exchanges and co-housing, together with programmes combining peer support, community participation, social prescribing and action to address the stigma and mental health effects associated with ageing and loneliness, especially for poorer and more vulnerable older people. When implemented systematically and sustained over time, they demonstrate that loneliness in later life is not inevitable. Finland's *Ystäväpiiri* [Circle of Friends] is a strong evidence-informed peer-support model developed for older people experiencing loneliness, which is associated with poverty, functional decline, depression and exclusion *(273)*. Participants recruited through health and social care services join facilitated community groups that strengthen well-being and social connection. In the Netherlands (Kingdom of the), *Eén tegen Eenzaamheid* [One Against Loneliness] combines public awareness and anti-stigma action with municipal coalitions, home visits and early identification, recognizing that loneliness is concentrated among people facing social disadvantage, health problems and low participation *(274)*. England (United Kingdom) uses social prescribing to connect older people with befriending, peer support and community activities *(275)*, while Kazakhstan's Active Longevity Centres provide free physical activity, learning, psychological support and opportunities for participation *(276)*. At national level, Germany and England (United Kingdom) have adopted cross-government loneliness strategies *(277,278)*, while Spain and Ireland are expanding action through active-ageing, age-friendly and social-inclusion policies focused on older people at risk

of exclusion *(279,280)*. Enabling older people to remain connected and contribute through volunteering, mentoring, caregiving and civic participation strengthens social trust and intergenerational fairness. It also ensures that the WHO European Region continues to benefit from older people's experience, knowledge and leadership.

As health services, public administration and social life increasingly move online, digital exclusion risks can reinforce social isolation and loneliness and limit access to care, information, services and community resources and activities. Across the WHO European Region, substantial inequities in digital readiness and affordability persist among older people, with lower digital-skills levels, reduced internet access and cost barriers disproportionately affecting those who are older, poorer and less educated, increasing the risk of exclusion from health, social and public services *(281–283)*.

Countries are responding by increasing opportunities to bring digital literacy learning to older people through inclusive, lifelong-learning programmes that prioritize accessible design, universal digital-skills training and the guarantee of offline alternatives for essential services *(284,285)*. Others are capping broadband costs for low-income groups. Health and public services provide support in using telemedicine and other digital health apps. Equity and ageing considerations are being built into the design of new policies and services as requirements. Maintaining accessible offline alternatives while supporting digital participation is essential to ensuring that modernization does not become a new source of exclusion. Inclusive digital services strengthen access, trust and confidence in public institutions, while improving the WHO European Region's resilience to future technological change.

Quality of homes

Older people who live in poor-quality homes have an increased risks of falling and respiratory problems. Likewise, homes that are in places with crime and safety issues result in older people not meeting up with family and friends and not connecting with local services or participating in cultural and social activities. This combination of risk factors increases levels of anxiety and isolation, clustering among the least affluent older women and men across all European subregions.

Living in an overcrowded poor-quality home that is damp, inadequately maintained, heated or cooled, and lacking in basic amenities affects on average 3% of the least affluent older women and men (approximately 1 million people) compared to 1% of the most affluent (approximately 340 000 people) (32 countries with data).



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Where an older person lives in the Region also shapes inequitable housing-related health risks. For example, 6% of the least affluent older women and men living in eastern Europe are at risk compared to 2% of the most affluent (data for six countries), whereas the risks of housing-related ill-health affect 2% of all women and men living in northern and western Europe, regardless of their income (data for 17 countries).

Countries are responding to improve health and housing conditions, for example, through home adaptations, home-safety assessments, and strength and balance programmes. In the United Kingdon, National Institute for Health and Care Excellence recommends tailored falls prevention exercise programmes for older people at risk of falls, alongside assessment and action to address relevant individual risk factors, which may include hazards in the home *(286)*. The Netherlands (Kingdom of the) has also expanded evidence-informed *valpreventie* [falls prevention] programmes *(287)*, combining balance and strength training with risk assessment to help older people to maintain their independence and reduce fall-related injuries. Ireland's Healthy Age Friendly Homes Programme complements these approaches by providing older people with personalized assessments covering housing, health and community needs, and coordinating adaptations and other support that enable them to remain safely and independently at home *(280,288)*.

Safe neighbourhoods

Neighbourhood safety is equally important for maintaining mobility, independence and social participation. Many countries are investing in age-friendly neighbourhoods. For example, cities such as Greater Manchester (United Kingdom), Barcelona (Spain), Rotterdam (Netherlands (Kingdom of the)) and Dublin (Ireland) have introduced safer pedestrian infrastructure, accessible public spaces and community hubs that help older people to remain active, connected and independent for longer *(256)*. Increasingly, countries are also adopting participatory approaches to better understand the needs and risks of the most vulnerable, underserved and under-represented groups, ensuring that lived experience informs policy and service design. For example, Age Friendly Ireland is a programme engaging older people directly through local Older People's Councils, ensuring that lived experience informs local planning, housing, transport and service design *(289)*.

Creating age-friendly communities requires coordinated action across housing, transport, urban planning, health and social care. Alongside investments in age-friendly housing and safe public spaces, many countries are strengthening integrated community services that combine clinical and social support, helping older people to manage long-term conditions, maintain confidence and independence, reduce avoidable hospital admissions and remain active and connected in later life.

These investments benefit whole communities through safer public spaces, accessible transport, adapted housing and stronger local services. They support territorial cohesion and make cities, towns and rural communities more resilient and liveable for people of all generations.

Reducing health inequities in later life is not simply a health objective, but a foundational investment in a stronger WHO European Region. When older women and men have the health, security, care, connections and environments needed to live independently and participate, the Region gains more sustainable public services, stronger local economies, intergenerational cohesion and communities better prepared for future challenges. This transforms demographic change from a pressure into an opportunity.

Concrete actions countries are taking to accelerate progress

Box 7 shows examples of national accelerators and their key enabling frameworks.

Box 7. Examples of national accelerators and their key enabling frameworks for older people

Priority for action 1

Integrate health, social care and rehabilitation close to home

Older people do better when care is close to home, joined up and easy to use. This helps to prevent avoidable decline, reduces confusion and makes it easier to stay independent for longer.

Illustrative country accelerators (what countries are doing)

Netherlands (Kingdom of the)
Buurtzorg [Neighbourhood Care] provides nurse-led neighbourhood teams delivering holistic home care that integrates clinical support with practical assistance and mobilization of family and community networks *(262)*. By coordinating health and social care around people's needs, the model helps older adults to remain independent and live safely at home for longer while reducing fragmentation of services. Evaluations have shown high client satisfaction, fewer hours of care per client, faster recovery of independence, fewer emergency hospital admissions and lower overall system costs than traditional home-care models *(290)*.

Denmark
Municipal Reablement: provides short-term, goal-oriented rehabilitation following illness or functional decline, helping persons with disabilities to regain mobility, confidence and independence in everyday activities *(257)*. Led by municipalities through multidisciplinary teams, reablement shifts care from doing things for people to enabling them to do more for themselves. With the introduction of the Elderly Care Act, there is a similar emphasis on a rehabilitative approach, as it is a requirement that support be provided with a preventive, rehabilitative and maintenance-oriented focus. Rehabilitation has been associated with improvements in functional ability, greater independence, enhanced quality of life and reduced reliance on long-term home care *(291)*.

Key enabling frameworks (that support countries to accelerate progress)

- The ***United Nations Decade of healthy ageing* (2021–2030)** *(292)* supports countries to create age-friendly environments, strengthen integrated and long-term care, and enable older people to live healthier, more independent and connected lives.
- ***Ageing is living: a strategy for promoting a lifetime of health and well-being in the WHO European Region 2026–2030*** *(6)* serves as the localized European framework to realize the ambitions of the United Nations Decade of Healthy Ageing.
- The **EU Council recommendation on access to affordable, high-quality long-term care** *(265)* strengthens home and community-based care, affordability, quality and integrated service delivery.

Priority for action 2

Prevent avoidable decline and maintain physical and mental functioning

Loneliness and poor mental health can quickly damage health in older age. Easy routes into support and companionship can lift mood, reduce distress and stop problems becoming crises.

Illustrative country accelerators (what countries are doing)

England (United Kingdom)
The NHS Talking Therapies programme provides free, evidence-informed psychological support through primary health care and is available to adults of all ages, including older adults. By improving early access to treatment and reducing barriers to care, it helps to prevent mental ill-health from worsening and supports independent living *(293)*. National reporting shows recovery rates of around 50% among people completing treatment *(294)*.

Netherlands (Kingdom of the)
The National Falls Prevention Programme brings together municipalities, primary care providers and community organizations to identify older people at risk of falls and connect them with evidence-informed strength, balance and home-safety interventions *(287)*. By preventing falls – a leading cause of disability and loss of independence – the programme helps older adults to remain active, reduces avoidable hospital admissions and delays the need for long-term care *(295)*.

Ireland
The Housing Aid for Older People scheme provides means-tested grants to assist older people living in poor housing conditions to carry out necessary repairs or improvements to their homes *(288)*. The scheme is administered by local authorities and can support works such as structural repairs, roof repairs, electrical rewiring, window and door repairs or replacement, and heating repairs or improvements. By helping older people to remain living safely in their own homes, the scheme supports independent living and healthy ageing in the community.

Key enabling frameworks (that support countries to accelerate progress)

- **WHO Regional Office for Europe's mental health work** and the **WHO Commission on Social Connection** support action on mental well-being, loneliness and community-based support for older adults *(142)*.

Priority for action 3

Strengthen social connection, participation and digital inclusion

Enough income in older age helps people to heat their homes, buy food and medicines and stay part of community life. This matters most for people who spent years in low-paid work, unpaid care or insecure jobs.

Illustrative country accelerators (what countries are doing)

Flanders, Belgium
Zorgzame Buurten [Caring Neighbourhoods]
This initiative supports municipalities, primary care, social services and community organizations to create neighbourhoods where older people can remain independent, socially connected and supported close to home *(260)*. By strengthening local partnerships, informal care and early identification of vulnerability, the initiative helps to reduce social isolation, prevent avoidable institutionalization and support healthy ageing in the community. Since 2021, 133 Caring Neighbourhoods have been established across Flanders and Brussels, testing integrated community-based models of care and support *(261)*.

Kazakhstan
Active Longevity Centres provide older people with free access to physical activity, rehabilitation, lifelong learning, digital literacy, psychological support and social activities through municipally supported centres. By combining health promotion with opportunities for social participation and lifelong learning, the centres help to maintain physical and mental well-being, reduce loneliness and support independent living in later life *(276)*.

Estonia
The Digital Agenda 2030 promotes accessible digital public services, including health, social care and local government services, while strengthening digital skills and confidence among older people *(296)*. By reducing digital exclusion, the strategy improves access to essential services and supports independent living in an increasingly digital society.

Slovenia
Simbioza [Symbiosis] brings together young volunteers and older adults through nationally coordinated digital learning programmes that help older people to build the skills and confidence to use online public services, health information and digital communication *(297)*. By strengthening digital inclusion, the initiative improves access to health and social care, reduces social isolation and supports independent living *(298)*. Since its launch, more than 30 000 older adults have participated, making it one of the WHO European Region's largest intergenerational digital inclusion initiatives.

Finland
Ystäväpiiri [Circle of Friends] brings small groups of older people experiencing loneliness together for 12 facilitated weekly sessions combining peer support, shared activities and community participation. A randomized controlled trial found improvements in health and cognition and reduced health-care use; at 10-year follow-up, nine out of 10 participants reported that their loneliness had been alleviated *(273)*.

Netherlands (Kingdom of the)
The national One Against Loneliness programme combines public awareness and stigma reduction with local coalitions, community action and early identification of people experiencing loneliness. Established initially with a strong focus on older people, it has mobilized around three quarters of Dutch municipalities and more than 190 national organizations, businesses and institutions *(274)*.

Ireland
Established across Ireland's local authority areas as part of the Age Friendly Ireland Programme, Older People's Councils have been set up to provide a platform for skill-sharing and knowledge transfer. They enable older residents to identify priorities and influence decisions on housing, transport, health services and public spaces. By bringing lived experience into the development and monitoring of local age-friendly strategies, they help to ensure that policies respond to the needs of older people in both urban and rural communities *(280,289)*.

Key enabling frameworks (that support countries to accelerate progress)

- The **WHO Global Network for Age-friendly Cities and Communities** *(299)* supports local action on participation, inclusion, housing, transport and community life.
- **EU digital inclusion and digital public-service frameworks** help countries to ensure that digital transformation does not leave older people behind *(284,285)*.

Priority for action 4

Ensure income security and financial protection in later life

Safe, warm and accessible homes help older people to avoid falls, illness and isolation. Supportive neighbourhoods also make it easier to stay active, connected and independent.

Illustrative country accelerators (what countries are doing)

Georgia
The universal old-age pension provides a guaranteed income floor for all older people, helping to reduce poverty and financial insecurity in later life. By improving access to essential goods, medicines and heating, the pension strengthens one of the fundamental social determinants of healthy ageing *(266)*. Analysis estimates that the pension has reduced old-age poverty by around 15 percentage points, with particularly strong effects in rural areas *(300)*.

Poland
The so-called 13th and 14th Pension Benefits (additional annual cash benefit) provide additional annual income support to pensioners, with enhanced support targeted towards those with lower pensions *(267–269)*. By improving financial security among older people most at risk of poverty, the policy helps to reduce inequities in access to the essential conditions for healthy ageing, including adequate nutrition, medicines, housing and participation in community life.

Poland
Poland's Care 75+ programme provides municipalities with financial support for home care services, including specialized care services for people aged 75 and over.

In addition, the new Senior Voucher provides financing support at home for eligible people aged 65 years and over with care needs and monthly incomes below 3410 Polish złoty. The government has allocated 1 billion Polish złoty for 2026–2028, prioritizing municipalities with little or no existing provision *(263,264,301)*. Together, the measures aim to reduce unmet needs and the costs and care responsibilities borne by older people and their families.

Priority for action 5

Create age-friendly communities through governance, local action and national strategies

Strengthen coordinated national and local action so that communities enable people to age healthily, independently and with equal access to services, participation and support.

Illustrative country accelerators (what countries are doing)

Germany
The Federal Strategy to Counter Loneliness provides a national, cross-government framework to prevent and reduce loneliness through coordinated action across health, social affairs, housing, digital inclusion and community participation *(277)*. Led by the Federal Ministry for Family Affairs, Senior Citizens, Women and Youth, the strategy supports local initiatives that strengthen social connection, mental well-being and healthy ageing, particularly among groups at greater risk of isolation.

Italy
The National Strategy for Active Ageing promotes healthy and active ageing through coordinated action across health, employment, lifelong learning, digital inclusion, volunteering and social participation *(302)*. Led through national and regional cooperation, the strategy supports older people to remain active, connected and independent, while strengthening healthy ageing across communities and reducing territorial inequities.

Ireland
"The Community Call" brought together local authorities, health services, voluntary organizations and community groups to identify older people at risk and connect them with food, medicines, social contact and practical support. By strengthening trusted local networks and early outreach, the initiative helped to reduce isolation, improve access to essential services and support healthy ageing in the community *(303,304)*. The initiative established 31 dedicated local authority helplines, with local authorities in turn creating highly localized, subcounty operational layers to efficiently deploy grass-roots aid at local level.

Republic of Moldova
The Age-friendly Community Initiative supports local communities in rural areas, including villages and communes, in developing age-friendly environments that improve access to health and social services, foster social participation and reduce isolation among older people *(305)*. The approach encourages older people to participate in identifying local priorities and shaping community development plans and services. Several villages and communes in the Republic of Moldova are members of the WHO Global Network for Age-friendly Cities and Communities, providing opportunities for peer learning and the exchange of good practices. By strengthening local governance and community-led action, the initiative helps older people to remain active, socially connected and independent.

Greater Manchester (United Kingdom)
The *Greater Manchester Age-Friendly Strategy 2024–2034* adopts a whole-system approach to healthy ageing across transport, housing, employment, health, digital inclusion and neighbourhoods *(306)*. Led by the Greater Manchester Combined Authority through the Ageing Hub, the strategy places older people at the centre of decision-making and uses local evidence to target inequities between communities *(307)*. By embedding healthy ageing across regional planning and public policy, it aims to improve healthy life expectancy and support people to age well in their own communities.

6 Moving forward: health equity by design for a strong Europe




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Summary

Health ministries and governments have a key role for driving health equity locally and nationally by translating equity commitments into measurable improvements in people's lives through systematically using equity-focused approaches to budgeting, priority-setting, service design, partnerships, policy development and implementation.

HESRi2 data reveal that the same five foundations shape health throughout life: income, employment, living conditions, health services, and human and social capital. Strengthening these foundations improves health, expands opportunity and prevents disadvantage from becoming entrenched. Health ministries cannot achieve this alone, but they are uniquely positioned to be the first port of call. By generating evidence, championing prevention and UHC, identifying populations at greatest risk and convening partners across government, they can help to align policies across sectors to improve health, prosperity and resilience.

The order of the following subsections is purely sequential and does not denote their importance.

Budgeting and spending for health equity

Progress in health equity does not depend solely on expanding public budgets, but on deploying existing resources more strategically. This involves:

- shifting from historical input-based budgets to data-driven, needs-adjusted, output-based formulae that prioritize people in vulnerable situations;
- rebalancing capital allocations towards people, primary care multidisciplinary teams and early intervention, rather than specialized physical infrastructure (for example through the Early Intervention Investment Framework) *(308)*; and
- mobilizing pooled budgets across ministries to co-finance shared equity priorities, such as housing and health, or health and employment.

Innovative financing for health equity

Shifting from passive relief to active capability-building can form part of a wider approach to unlocking institutional and private capital *(308)*, with targeted actions to enable this.

- Turn government budgets into long-term local investments for health equity by using public-sector procurement, training, employment and capital investment to retain economic value locally and expand access to jobs, skills and secure livelihoods *(210)*.
- Partner with social impact investors and responsible businesses to (i) mobilize long-term capital for addressing the social and economic determinants of health; (ii) leverage environmental, social and governance (ESG) commitments to drive responsible business practices and create positive social impacts; and (iii) co-finance preventive and community-based interventions, using outcomes-based financing models to sustain long-term action on health inequities *(78)*. Examples include the Global Health Equity Network's Zero Health Gaps Pledge and the Health Foundation's Long-term Investors in People's Health programme *(309,310)* and the Better Future's Fund *(311)*.
- Create regional health equity investment partnerships that combine public funding with social impact-investment capital to scale proven interventions targeting the root causes of inequities.

Prioritization and resource allocation for health equity

Prioritizing and allocating resources for health equity ensures that public and private investments are directed towards the populations and determinants that contribute most to avoidable health gaps, social well-being and sustainable economic development.

- Systematically use data to identify the types of care that drive OOP payments, unmet needs and financial hardship and the people most at risk. Reduce OOP payments, especially for people with low incomes, starting by exempting people with low incomes from all co-payments and using income-based annual caps on all co-payments to ensure affordable access to care regardless of gender and socioeconomic status.
- Expand ESG criteria to explicitly include health equity.
- Apply equity impact assessments to routine public policy and investment decisions, including those related to loosening regulations and cutting policies and services.
- Collaborate with the analytical units in central and development banks to provide them with high-quality and comprehensive equity data and trend analysis as inputs to their routine forecasting and modelling of a country's economic, social and development outlook.

Balancing passive and active policies for health equity

Using active policies increases the opportunities and pathways to improve health and lives, while passive safety nets protect people when they need them the most. Balancing these approaches offers sustainable routes out of inequity at any stage in life, while protecting human, social and economic capital in times of crisis.

This can be achieved by progressively shifting to active policies that build capabilities, skills and effective routes into long-term security for those at risk or already falling behind. Using non-stigmatizing passive transfers to prevent acute poverty and poor health across the life-course can also play a role when needed. Active policy actions can include the following areas.

- **Income, employment and mental health**: include income and mental health support with ALMPs, skills development, apprenticeships and supported employment.
- **Health and housing:** move beyond reactive screening and temporary shelter by integrating social prescribing, community support networks and Housing First models.
- **Children and families:** supplement child benefits with early childhood development programmes, parenting support and family resource centres.

Better data for health equity

Securing better data is not a technical add-on but a core component of the infrastructure needed for fairer and more effective policy-making. High-quality, disaggregated data enable governments to identify inequities, target resources where they are most needed and monitor whether policies are reducing or widening health gaps.

- Invest in routine collection and reporting of disaggregated data by age, sex, socioeconomic status, ethnicity (where appropriate), disability and place of residence across health and non-health sectors.
- Strengthen national and subnational analytical capacity by establishing dedicated equity data functions, improving workforce skills in data analysis and interpretation, and promoting the regular use of equity evidence in policy-making.
- Integrate equity indicators into national monitoring, planning and budgeting systems so that progress in reducing health inequities is routinely measured, used in modelling and forecasting and reported alongside economic and development outcomes *(207)*.
- Improve data sharing and interoperability across sectors, enabling health, education, employment, housing, social-protection and environmental data to be linked and analysed together to identify the drivers of inequity *(77)*.

Accountability for health equity

Routinely embedding equity outcomes into the policy cycle of existing and new policies ensures that equity gains are built in from the start and avoids the need to "buy back" lost health and human capital. This is unjust, avoidable, costly and inefficient.

- Establish a dedicated health equity monitoring function at the local, national and regional levels to track inequities, identify emerging risks and trigger timely policy action, drawing on examples such as Iceland's Welfare Watch, UNICEF Social Monitor, WHO's Health Equity Status Report initiative and the EU proposed Social Imbalances Procedure *(2,77,312,313)*.
- Use public-value mechanisms – such as social and economic duties and ESG – that move beyond voluntary corporate social responsibility and create incentives and requirements, and support the public sector and businesses to contribute to health, well-being and equity outcomes alongside their core purpose.
- Design equity into reforms and the sequencing of digital, technological, climate and social innovations to enable and support those who are being left behind to adapt and benefit equally from the changes. Use anticipatory governance approaches, such as equity-sensitive risk assessment and policy stress-testing, alongside benefit incidence analyses and equity impact assessments.

Policy synergies for health equity

No single intervention can shift health and social inequities but the actions of many stakeholders can. When governments keep two hands on the wheel by coordinating action on the key determinants and equitable health-care delivery, significant progress can be made. This requires leveraging synergies and complementarities across sectors and with other institutions and stakeholders, to align interests and coordinate policies that close gaps.

- Apply a basket of interventions for populations experiencing multiple vulnerabilities. Mutually reinforcing policies are the most effective way to address interconnected barriers and to create sustainable pathways towards greater health, independence and security.
- Use collaborative governance approaches, such as shared targets, joint policy assessments and reviews, health equity compacts[2] and place-based partnerships, to align incentives, resources and action across sectors and stakeholders; for example, housing and health partnerships, child well-being programmes, age-friendly cities and health-promoting schools approaches, good work–good health compacts, and women's health alliances.

Participation, partnership and co-production approaches

Policies and services often have blind spots concerning the realities of the lives of women, men, girls and boys who are being left behind. This results in policies with limited impact to reduce health and social inequities. Engaging the left out and left behind through meaningful participatory approaches makes policies and services more relevant and impactful and the results more equitable and sustainable. The process of participation improves skills, confidence, agency, social connections and well-being, making it a health and equity intervention in its own right *(4,16,147,314,315)*.

- Establish permanent lived-experience and community advisory bodies, such as elder councils, youth advisory boards and future generations bodies, to ensure that lived experience is embedded in formal decision-making.
- Use participatory budgeting, citizens' assemblies, juries and facilitated dialogues to give everyone in left-behind communities a voice and influence in policy choices (and the allocation of public resources) that affects their lives and opportunities, particularly in underserved areas.
- Invest in trusted civil-society intermediaries, peer researchers and community-led evidence gathering to reach people who are often excluded, identify needs that routine data may miss and assess whether policies and services are accessible and reducing inequities.

[2] A health equity compact is a shared commitment among governments, institutions and communities to take coordinated action on the determinants of health, reduce inequities and leave no one behind.

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Annex. Methodology

The report draws on multiple complementary sources of evidence. Its principal analytical foundation is the underlying harmonized database of 132 indicators, based on internationally comparable vital statistics and harmonized survey data, including the Health Behaviour in School-aged Children study, European Union Statistics on Income and Living Conditions, European Social Survey, European Health Interview Survey, the WHO STEPwise approach to Surveillance and United Nations Children's Fund Multiple Indicator Cluster Surveys. The complete list of indicators, equity stratifiers, data sources and country coverage is provided in Annex 6.1 of the accompanying data report to this second iteration of the Health Equity Status Report Initiative *(1)*.

Central to this report is the effect that social, economic and environmental conditions have on health and well-being. The report covers a range of outcomes: mortality (based on life expectancy and infant mortality), morbidity (self-reported long-term activity-limiting illness, depression, obesity and self-reported prevalence of diabetes and tuberculosis), health behaviours (based on smoking, alcohol consumption and physical activity) and well-being (based on self-reported health and life satisfaction).

Thirty-six Member States in the WHO European Region contribute data through European Union-wide surveys, including European Health Interview Survey, European Social Survey and European Union Statistics on Income and Living Conditions, while 45 provide data to the Health Behaviour in School-aged Children study. To extend geographical coverage of indicators further, particularly across countries in the eastern part of the WHO European Region that do not participate in these surveys, additional sources were used, including the United Nations Children's Fund Multiple Indicator Cluster Surveys and the WHO STEPwise approach to Surveillance. Consequently, the number of countries included varies by indicator according to data availability. This report uses a subset of indicators chosen for their policy relevance.

Indicators are available for individual Member States in the WHO European Health Equity Atlas *(2)*. They are presented in the following groups in this report: the WHO European Region, United Nations statistical subregions (see Table A1), and grouped according to the Human Development Index. These groupings facilitate comparisons but should not be interpreted as reflecting similarities in health systems, welfare models or other health policy characteristics.

Table A1. United Nations statistical subregions and their populations

Subregion and country	Country code	Subregion population (millions)[a]	Distribution of population within each subregion[a] (%)
Central Asia		**82.3**	**100**
Kazakhstan	KAZ		25
Kyrgyzstan	KGZ		9
Tajikistan	TJK		13
Turkmenistan	TKM		9
Uzbekistan	UZB		44
Eastern Europe		**280.9**	**100**
Belarus	BLR		3
Bulgaria	BGR		2
Czechia	CZE		4
Hungary	HUN		3
Poland	POL		13
Republic of Moldova	MDA		1
Romania	ROU		7

Russian Federation	RUS		51
Slovakia	SVK		2
Ukraine	UKR		13
Northern Europe		**108.9**	**100**
Denmark	DNK		5
Estonia	EST		1
Finland	FIN		5
Iceland	ISL		0.4
Ireland	IRL		5
Latvia	LVA		2
Lithuania	LTU		3
Norway	NOR		5
Sweden	SWE		10
United Kingdom	GBR		64
Southern Europe		**150.4**	**100**
Albania	ALB		2
Andorra	AND		0.1
Bosnia and Herzegovina	BIH		2
Croatia	HRV		3
Greece	GRC		7
Italy	ITA		39
Malta	MLT		0.4
Montenegro	MNE		0.4
North Macedonia	MKD		1
Portugal	PRT		7
San Marino	SMR		0.02
Serbia	SRB		4
Slovenia	SVN		1
Spain	ESP		32
Western Asia		**113.8**	**100**
Armenia	ARM		3
Azerbaijan	AZE		9
Cyprus	CYP		1
Georgia	GEO		3
Israel	ISR		9
Türkiye	TUR		75
Western Europe		**200.8**	**100**
Austria	AUT		5
Belgium	BEL		6
France	FRA		34
Germany	DEU		42
Luxembourg	LUX		0.3
Monaco	MCO		0.02
Netherlands (Kingdom of the)	NLD		9
Switzerland	CHE		4

[a] 2024 World Bank population estimates of the subregion and the percentage of the subregional population within each country. WHO uses International Organization for Standardization (ISO) 3166-1 alpha-3 country codes *(3)*.

Source: World Bank World Development Indicators *(4)*.

Analysis

Socioeconomic position was assessed, where possible using two stratifiers: income and educational level. Where individual or household income data were available, populations were grouped into five equally sized groups (quintiles (Q)), with the least affluent (Q1), moderately affluent (Q3) and most affluent (Q5) commonly referred to in the report. Education was grouped, using the International Standard Classification of Education as low (pre-primary to lower-secondary), medium (upper-secondary to post-secondary non-tertiary) and high (tertiary education). For some indicators, other stratifiers were used (see the HESRi2 data report for details).

Wherever possible, indicators are reported separately for women and men. This is based on available recoding of sex in the datasets used. It does not necessarily reflect gender identities. For this reason, inequities described in this report should not be taken to explain the influence of gender norms, roles, relationships and power. The absence of a gender-relevant or disaggregated indicators should not be interpreted as evidence that such inequities do not exist.

Analyses presented in this report are based on methods described in the HESRi2 data report (e.g. changes over time).

Several considerations are important when interpreting the analyses presented in the report.

- **No single indicator captures the full picture of health equity.** HESRi2 draws on multiple indicators across the essential conditions.
- **Trends are an indicator of change within a country** and not intended for comparison between countries.
- **Where no increase or decrease is reported in the trend for a country**, this indicates that the statistical test did not reveal a consistent trend. This can either reflect insufficient data or lack of a consistent direction over time.

Box A1. Derivation of the headline estimate to establish the number of people affected by health inequities

The estimate that 187 million girls, boys, women and men across the WHO European Region are prevented from living healthy, prosperous lives by avoidable inequities was based simply on 20% of the estimated population of the Region in 2024.

Estimates within each life stage were reached similarly, using the estimated population in the appropriate age group. Estimates of the number of least affluent people in ill-health were obtained by multiplying the proportion of the least affluent estimated to be in ill-health by the estimated size of the least affluent population in each age group.

Return-on-investment and macroeconomic modelling

Young people

The analyses use country fixed-effects linear regression models to estimate the impact of lagged limiting illness, and a first-difference regression model to estimate how changes in depression between 2014 and 2022 influence rates of young people not in employment, education or training and youth unemployment. The older-age analyses use logistic regression models to simulate a best-practice pension policy scenario, assuming universal pension coverage and expenditure at least equivalent to the European average, to estimate potential impacts on health and social isolation.

Working-age people

For working-age adults, the potential income and fiscal benefits of reducing health inequities were estimated using microsimulation techniques combined with the European Union tax–benefit microsimulation model to project changes in employment, household income, taxes paid and social benefits if individuals with lower educational attainment achieved the health status of those with higher educational attainment

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The WHO Regional Office for Europe
The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

Member States
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Finland
France
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Germany
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Ireland
Israel
Italy
Kazakhstan
Kyrgyzstan
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Lithuania
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Malta
Monaco
Montenegro
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North Macedonia
Norway
Poland
Portugal
Republic of Moldova
Romania
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