Young people - health

Statistics Explained

Data extracted in July 2025.
Planned article update: July 2026

Highlights

In 2024 in the EU, 9 in 10 young people (aged 16-19) considered themselves to be in very good or good health.

Long-standing illness is more frequent among young women: in the EU, in 2024, 14.5% of men and 18.2% of women aged 16-29 years old reported suffering from a long-standing illness or health problems.

In 2024, the prevalence of disability (activity limitations) among young people in the bottom income quintile was almost double that of young people in the top income quintile (10.4% versus 5.3%).

Health is a key aspect of quality of life – and of high interest for both EU residents and policymakers. According to the Treaty on the Functioning of the European Union , (Article 168) public health should be considered in all EU policies. Eurostat data offers insight into a variety of angles related to young people's: physical activity, mental health, diet & nutrition, substance use, overweight rates, access to healthcare, health education & awareness and others.

This article presents a range of health indicators, focusing on young people in the EU. The analysis examines how factors such as age, sex and level of income, influence:

- health status
- causes of death

among people aged 16-29 years (15-29 years in some cases).

Health status

The World Health Organisation (WHO) defines health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. This definition implies different ways of measuring health, such as collecting objective data from health care providers or subjective data on physical functioning, emotional well-being, pain or discomfort, and overall perception of health from respondents participating in surveys. This section focuses on three key indicators describing health status:

- self-perceived health
- long-standing illnesses or health problems and
- disability (activity limitations).

Self-perceived health – high among young people, but income remains a key disparity

Self-perceived health gives an overall assessment by the respondent of their health in general. It is by definition subjective and is expected to include different dimensions of health such as psychological and physical symptoms.

Young people are in better health and consider themselves to be healthier than the population as a whole. The percentage of young people who perceive themselves to be in good or very good health has been relatively stable over time, with a slight decrease from 92.0% in 2010 to 90.1% in 2024. This is significantly higher than the same share in the total population over 16 years of age (68.4%).

Self-perceived health status varies between EU countries (see Figure 1). The lowest shares of young people aged 16-29 years who declared themselves to be in good or very good health in 2024 were registered in Sweden, Finland and Denmark (76.3%, 79.3% and 79.8%, respectively). By contrast, in Romania this percentage was as high as 98.2%, with similarly high shares in Greece (97.7%) and Croatia (96.2%).
In 16 EU countries the share of 16-29-year-olds considering themselves in good or very good health was above 90%.

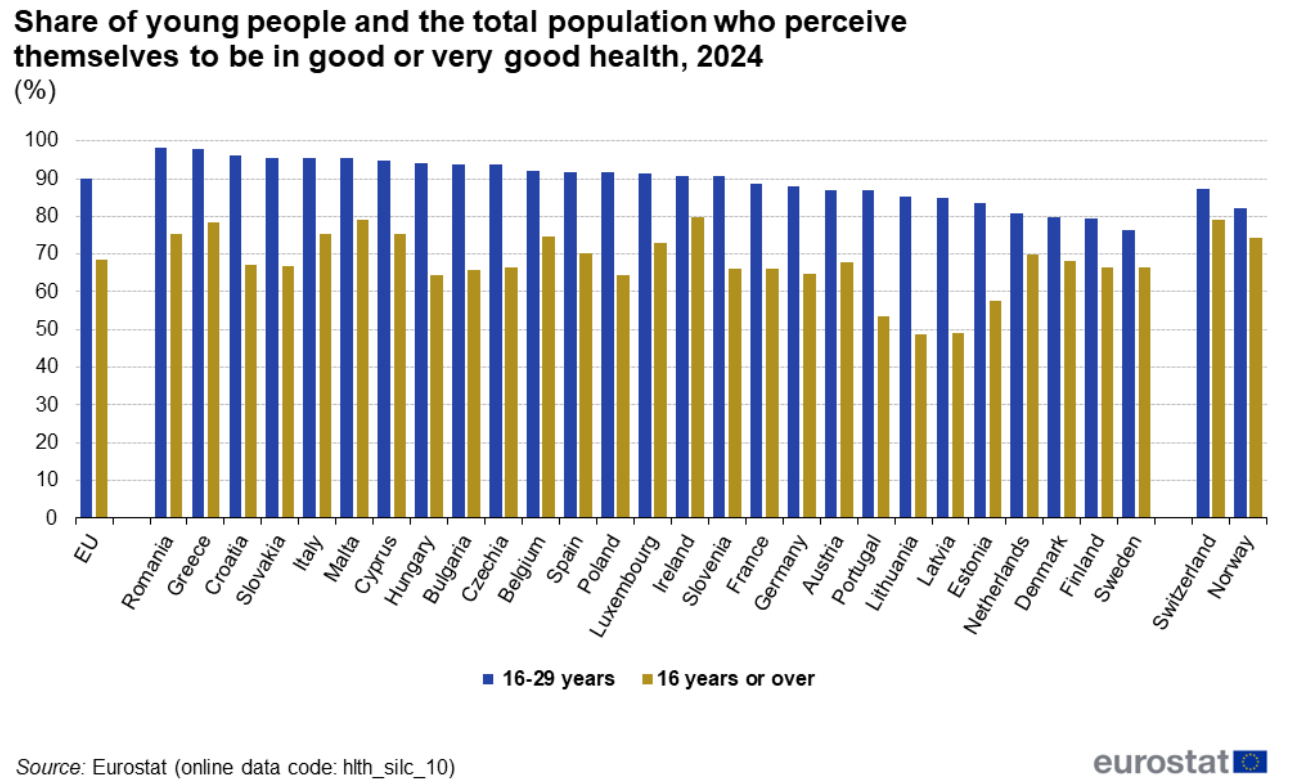


Figure 1: Share of young people and the total population who perceive themselves to be in good or very good health, 2024 Source: Eurostat (hlth_silc_01)

The largest differences in the shares of young people and the total population who perceived their health as very good or good were recorded in Lithuania (a difference of 36.3 percentage points (pp)) and Latvia (35.9 pp difference).

These differences across EU countries in self-perceived health may relate to general health standards in EU countries, and to social and cultural differences, for example how people evaluate their personal health or how they disclose their health problems in surveys.

Looking at the relationship between self-perceived health status and an individual's income situation (Figure 2), a clear pattern can be observed in almost all the EU countries: higher income is associated with better perceived health.

In the EU, 86.7% of young people aged 16-29 years old in the first income quintile perceived their health as good or very good in 2024 compared with 94.0% in the fifth income quintile. An income gap of the self-perceived health status was observed in all but one of the EU countries (Lithuania). In Lithuania, the share of those in the first

(lowest) income quintile reporting good or very good health was 1.6 pp higher than for those in the fifth income quintile. In all other EU countries, the share of people reporting good or very good health increased with the income levels. The largest difference in the share of young people reporting very good or good health between the highest and lowest income quintiles was recorded in the Netherlands (22.9 pp difference), followed by Finland (16.9 pp) and Ireland (10.6 pp). By contrast, the lowest differences between the first and the fifth income quintiles were observed in Slovakia (0.3 pp), Cyprus (0.5 pp), Malta and Greece (both at 0.8 pp difference).

Understanding income quintiles

Income quintiles are a way to categorize households based on their income. When we talk about equivalised disposable income , we're looking at a household's total income after taxes and deductions, adjusted for the number of people living there. This adjustment considers the household members' ages to ensure a fair comparison.

Here is how we break it down:

1. Total household income – imagine the money a household has left for spending or saving after paying taxes and other deductions.

2. Equivalised household members – each member of the household gets a certain weight based on their age. For example:

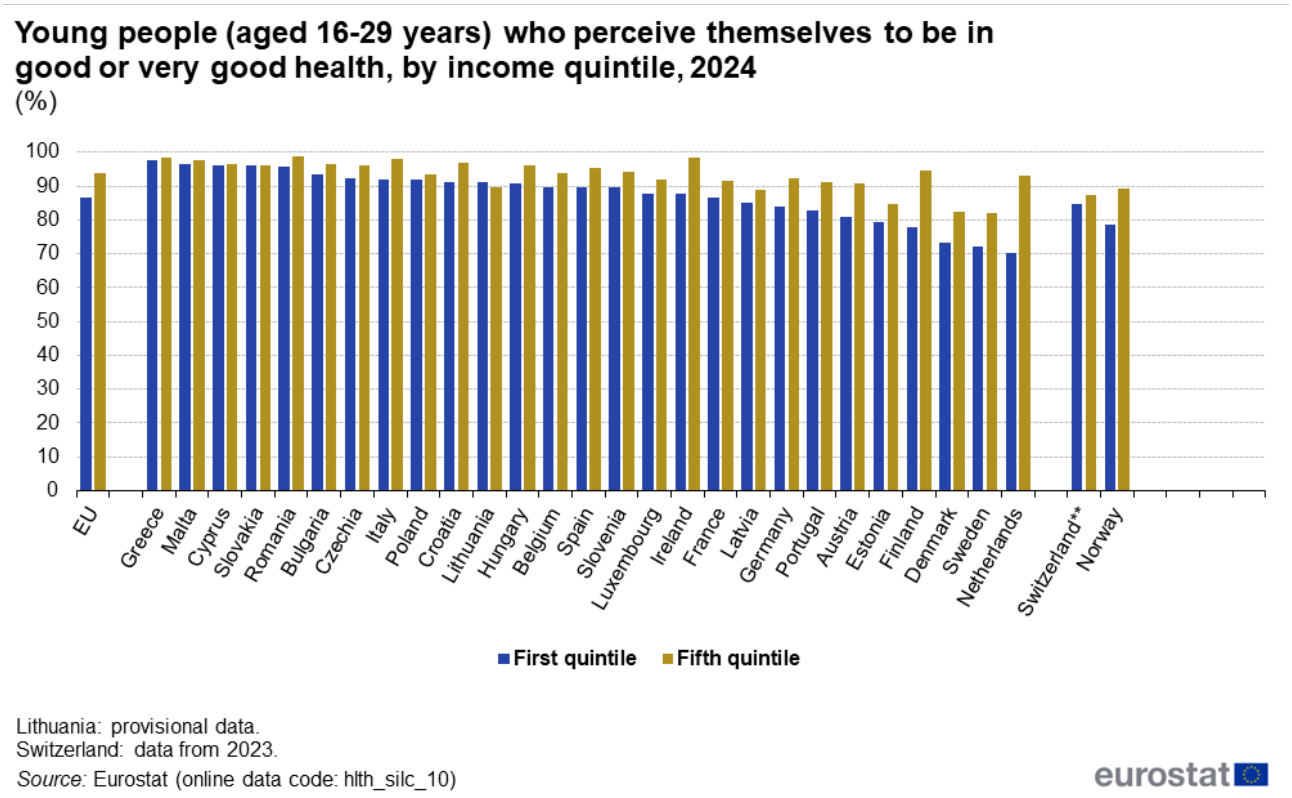
- The first adult counts as 1.0
- Anyone aged 14 years and over counts as 0.5
- Children under 14 years count as 0.3

Using these weights, we calculate a household's 'equivalised' income.

Next, we sort all households by their equivalised income, from lowest to highest. Then, we divide them into 5 parts, or quintiles, each containing 20% of the population.

- 1st quintile – the lowest 20% of the population by income.
- 2nd to 4th quintiles – middle groups.
- 5th quintile – the top 20%, or the wealthiest group.

This approach helps us understand and compare income distribution across different households in a specific area.



Lithuania: provisional data.
Switzerland: data from 2023.
Source: Eurostat (online data code: hlth_silc_10)

eurostat

Figure 2: Young people aged 16-29 years who perceive themselves to be in good or very good health, by income quintile, 2024 Source: Eurostat (hlth_silc_10)

Long-term/chronic illness – not just an adult issue

According to the WHO, long-standing health problems or chronic illnesses – such as heart disease, stroke, cancer, chronic respiratory diseases and diabetes – are by far the leading cause of mortality and disability worldwide.

Chronic health issues impact a meaningful share of youth in the EU, with implications for well-being and daily life. In 2024, 16.3% of people aged 16-29 years reported that they suffered from a long-standing health problem. The lowest prevalence of long-standing health problems among this age group were observed in Romania, Greece, Bulgaria and Italy (all under 4.0%). The highest rates of young people having long-standing health problems were registered in Finland (39.0%), Sweden (24.6%) and Estonia (23.2%). These differences between EU countries could be related to cultural differences in self-perception and in practices for diagnosis, management and treatment of long-standing health problems.

Figure 3 compares the prevalence of self-declared long-standing illnesses between young women and men 14.5% of men aged 16-29 years in the EU declared to be suffering from a long-standing illness or health problem in 2024; this was 3.7 pp lower than the corresponding share recorded among young women of the same age group (18.2%).

This pattern – a higher share of young women than young men reporting suffering from a long-standing illness or health problem was repeated in most (22) EU countries. The disparity is starkest in Finland, where young women's re-
ports of long-term health issues exceed those of men by 10.9 pp, followed by Denmark (7.1 pp) and Sweden (6.8 pp).

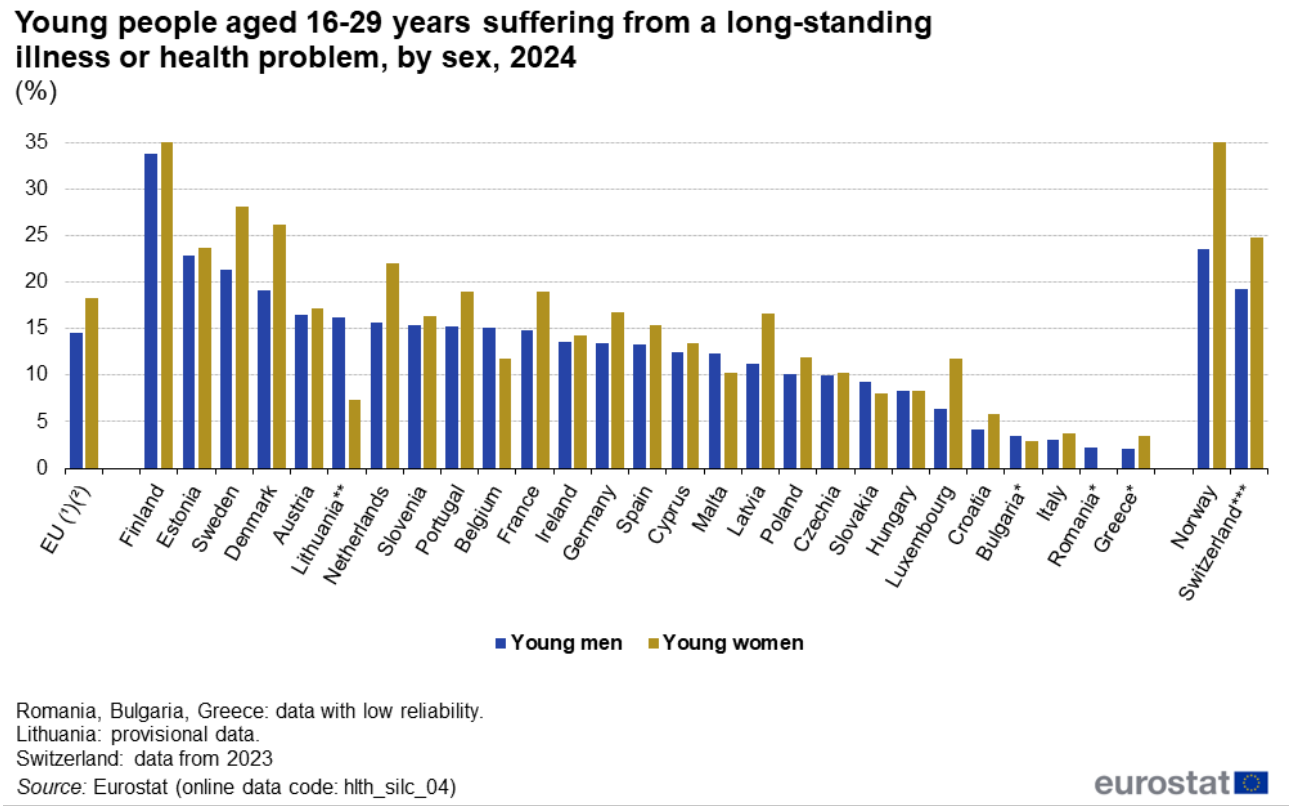


Figure 3: Young people aged 16-29 years suffering from a long-standing illness or health problem, by sex, 2024 Source: Eurostat (hlth_silc_04)

Disability – everyday limitations

People with long-standing health problems can experience difficulties in accomplishing everyday activities, which affects their quality of life. Data on the degree of limitation in usual activities due to health problems are used as a proxy measure for disability.

In 2024, 8.0% of people aged 16-29 years living in the EU reported a disability (long-standing limitations in usual activities) – slightly up from 7.4% 15 years ago and exactly the same share as 10 years ago in 2015. Figure 4 shows that for both men and women the proportions of those with some or severe disability were relatively stable in the past 15 years and are considerably higher in the total population compared to young people. We can see that the gender gap is more significant for the total population than for the 16-29 age group.

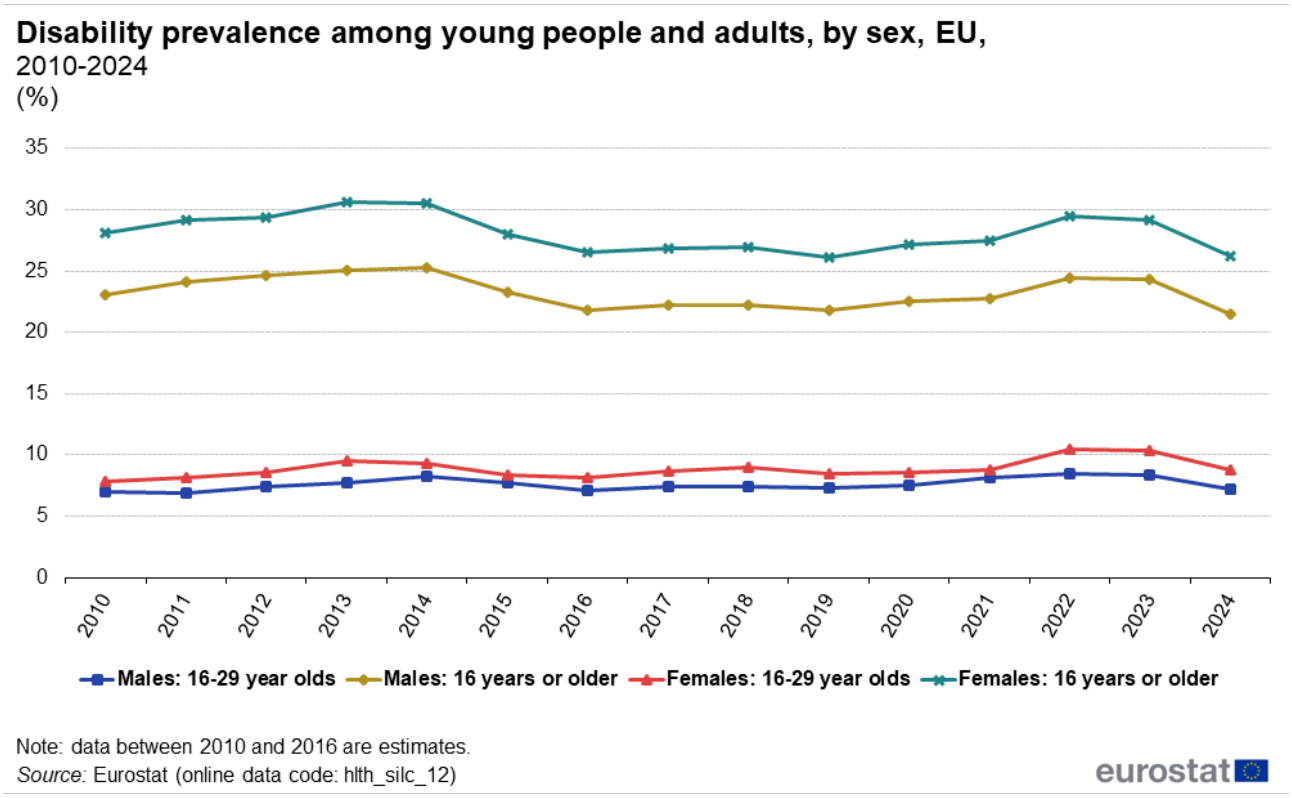


Figure 4: Disability prevalence among young people and adults, by sex, EU, 2010-2024 Source: Eurostat (hlth_silc_12)

Lower income level was associated with higher rates of disability in almost all EU countries (see Figure 5). At EU level in 2024, the prevalence of (moderate or severe) disability among those in the first income quintile was almost double compared to those in the fifth (10.4% compared to 5.3%). This income gap varied considerably across EU countries: the largest difference between the first and the fifth quintiles was registered in Finland where the share of young people in the first income quintile with a disability was 20.5 pp higher than the corresponding share for young people in the fifth income quintile, followed by Sweden (11.9 pp difference) and Austria (7.8 pp difference).

In Slovakia, Czechia, Belgium and Malta the share of young people in the first income quintile with a disability was lower than the corresponding share for young people in the fifth income quintile, with a maximum a difference of 1.6 pp.

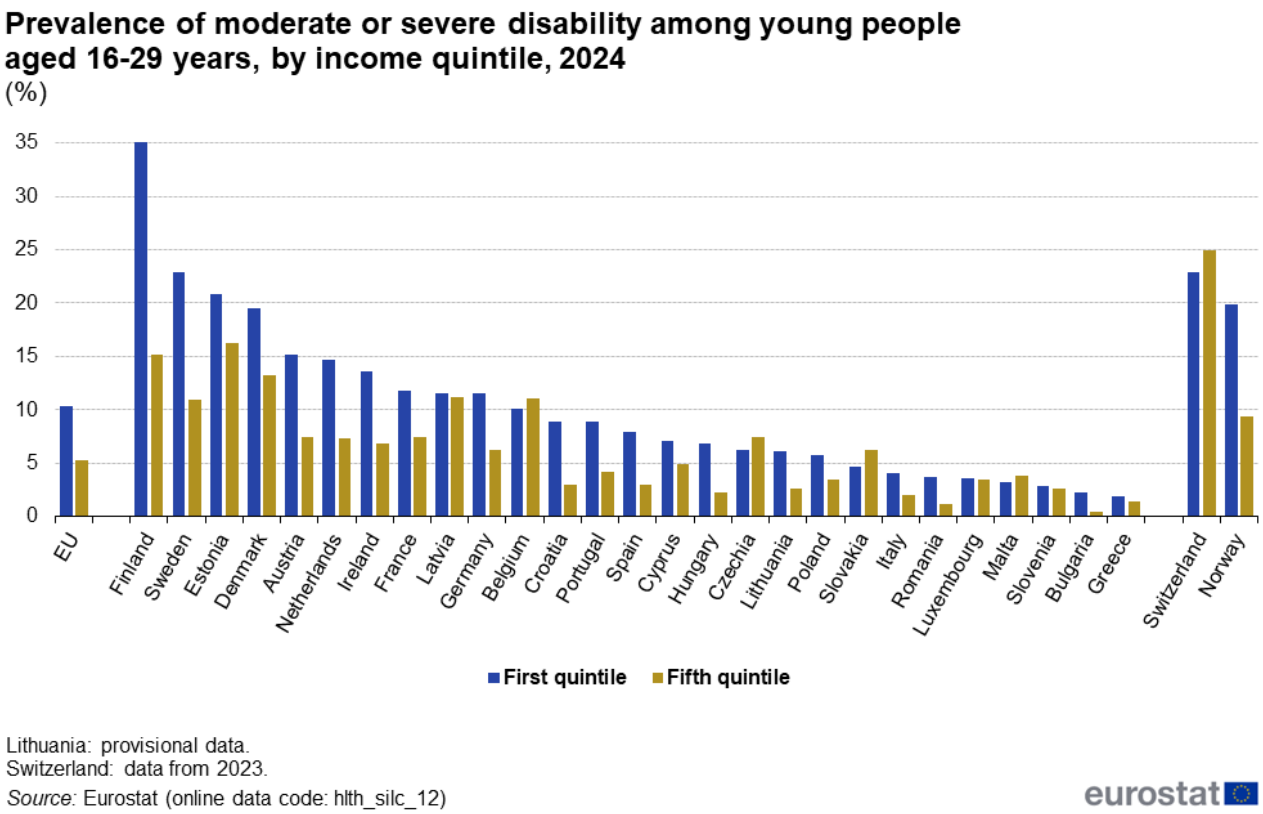


Figure 5: Prevalence of moderate or severe disability among young people aged 16-29 years, by income quintile, 2024 Source: Eurostat (hlth_silc_12)

Causes of death

External factors are the main cause of death for young people

Causes of death vary substantially according to the age group. More than half (56.0%) of the deaths in the total population were caused by circulatory diseases and cancer (neoplasms) in 2022. For young people (aged 15-29 years) external causes are more prevalent: almost half (47.8%) of deaths were related to accidents and intentional self-harm. COVID-19 was responsible for slightly more than 5.9% of deaths in the total population in 2022, while among young people the proportion was down to 1.8% (see Figure 6).

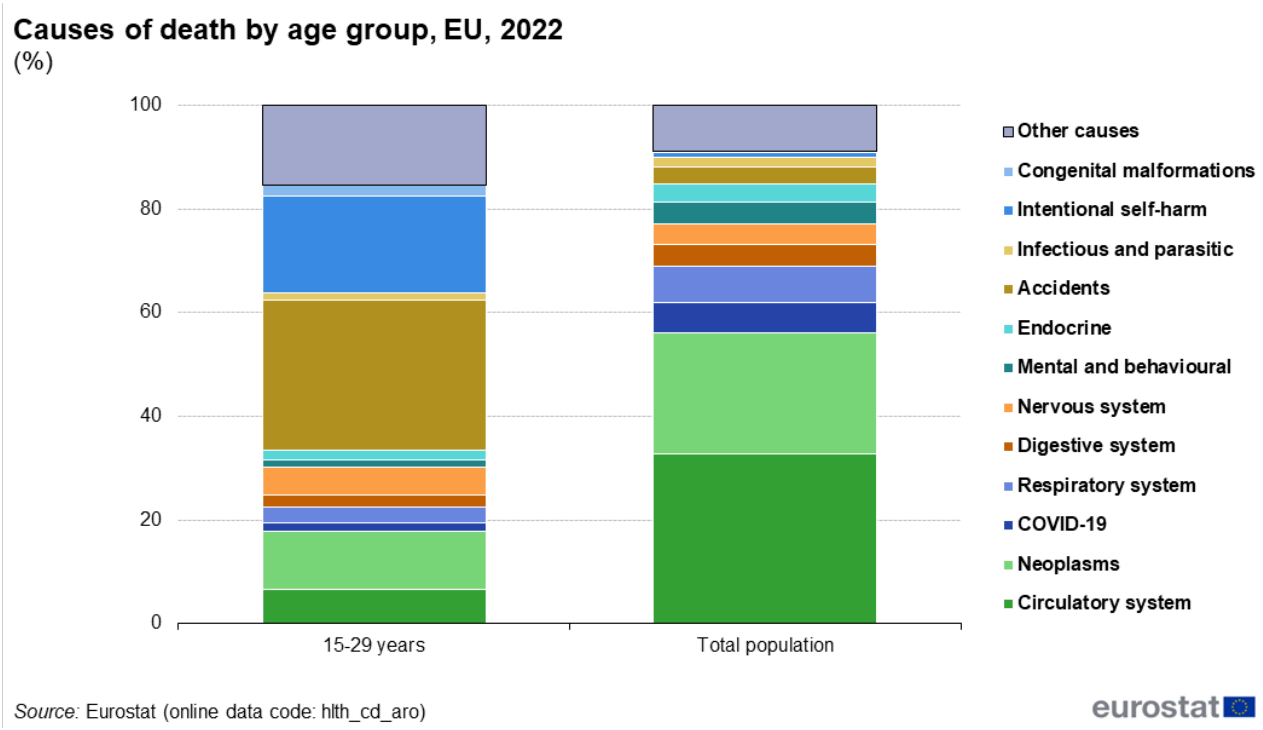


Figure 6: Causes of death by age group, EU, 2022 Source: Eurostat (hlth_cd_aro)

Intentional self-harm implies purposely self-inflicted poisoning or injury and (attempted) suicide.

Suicide is the act of deliberately killing oneself. Risk factors for suicide include mental disorder (such as depression, personality disorder, alcohol dependence or schizophrenia), and some physical illnesses, such as neurological disorders, cancer, and HIV infection.

Source: World Health Organization - International Classification of Diseases Related Health Problems, Tenth Revision (ICD-10)

In the age group of 15-29 years, more than 1 in 6 deaths were registered as intentional self-harm in the EU in 2022, while for the total population the weight of self-harm among other causes of death was 1 in 100. It was the second most prominent cause of death for young people, following accidents.

In absolute terms, 5 017 young people aged 15-29 years died in 2022 in the EU as a result of intentional self-harm. This is a decrease compared to 2012 (when 6 139 young people died of self-harm) (see Figure 7).

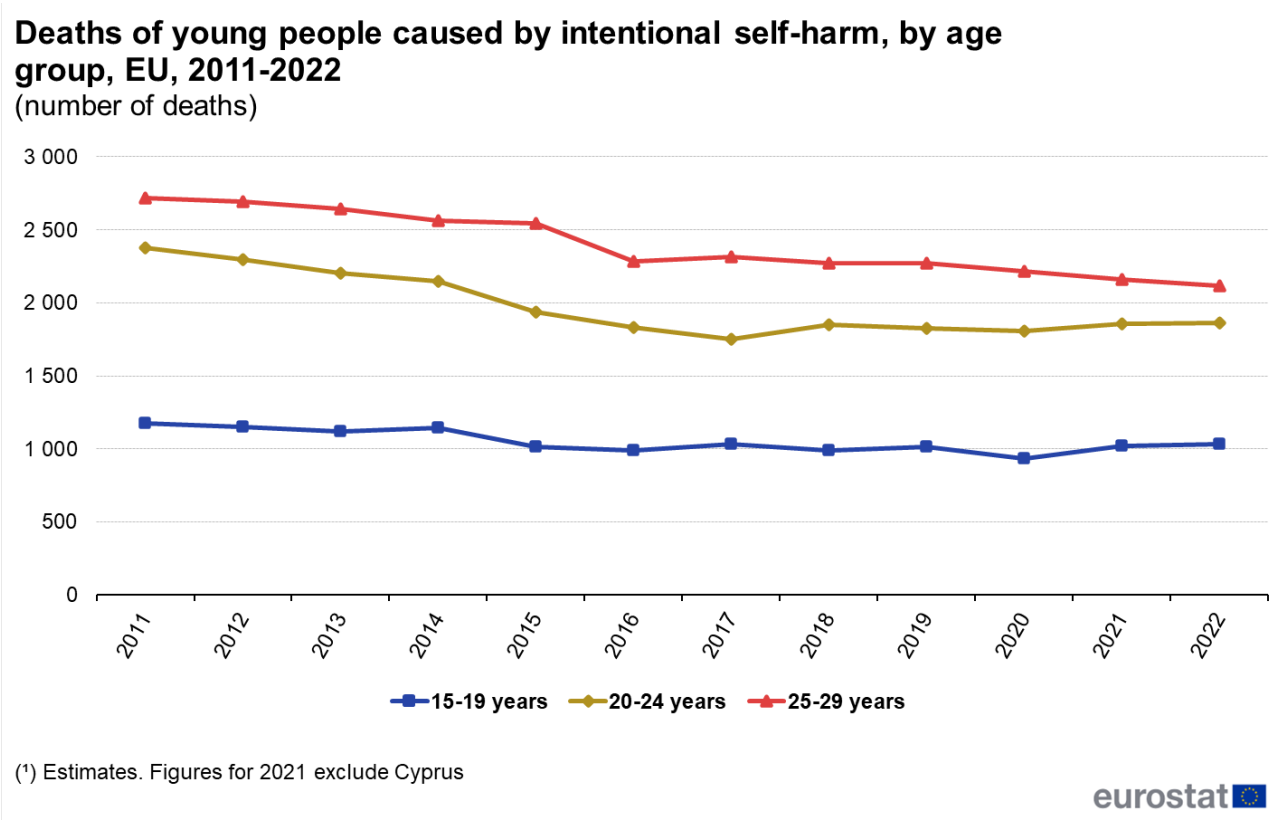


Figure 7: Deaths of young people caused by intentional self-harm, by age group, EU, 2011-2022 Source: Eurostat (hlth_cd_anr) and (hlth_cd_aro)

As shown by Figure 8, most deaths attributed to self-harm among young people were recorded among men aged 25-29 years. Young women were substantially less likely to die from suicide or intentional self-harm, with crude death rates for young men (for 5-year age groups between 15 and 29 years old) being 1.9 to 4.2 times higher than those for young women in the EU.

It should be noted that while there has been for the past 10 years a decreasing tendency in crude death rates associated with intentional self-harm for men, the rate for young women has been stagnant or slightly on the increase.

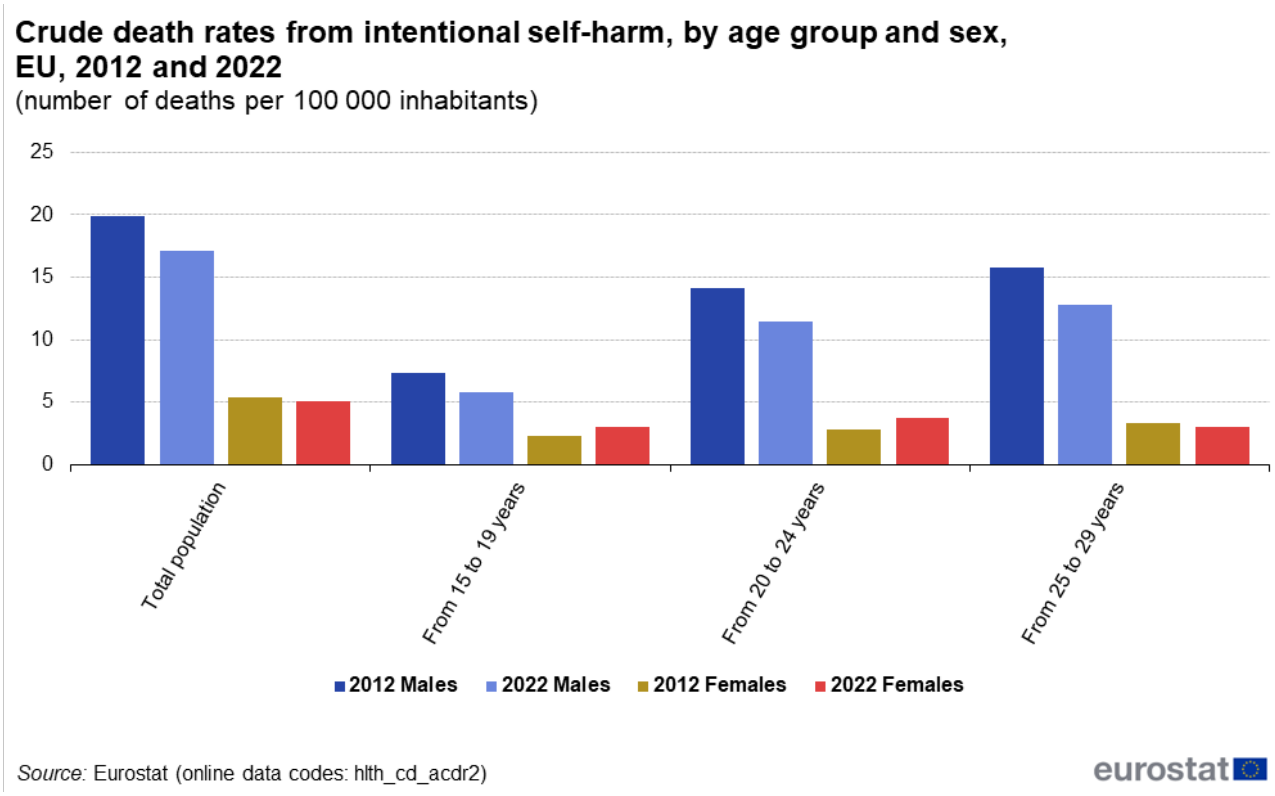


Figure 8: Crude death rates from intentional self-harm, by age, group, and sex, EU, 2012 and 2022 Source: Eurostat (hlth_cd_acdr2)

People in their twenties were more likely to die from intentional self-harm than their younger peers.

The crude death rate associated with intentional self-harm is higher for the total population than for young people – even if the weight of this cause among other causes of death shrinks considerably.

Source data for tables and graphs

- Health: tables and figures

Data sources

A wide range of statistics is gathered to understand health and living conditions across the EU. This includes data on healthcare systems, health-related behaviour, diseases and causes of death and a common set of EU health indicators. Thanks to the open method of coordination for health issues there is EU-wide agreement regarding definitions, data collection and use.

Key sources of this data include health interview surveys and modules, which provide insights into the health status and the health-related behaviours of EU residents. 3 main indicators on health status are collected annually and complementary information, including health determinants, every 3 years within the EU statistics on income and living conditions . Detailed health indicators are collected every 6 years within the European Health Interview Survey (EHIS) .

The limitation with self-reported data is that it introduces subjectivity, being influenced by respondents' personal perceptions and cultural contexts. However, these indicators remain essential for assessing population health, predicting health care needs and measuring socioeconomic disparities.

Statistics on causes of death are among the oldest medical statistics available. They provide information on developments over time and differences in causes of death between countries. Statistics on the causes of death are

based on the medical information provided in the death certificate . These statistics play a key role in the general information system relating to the state of health in the EU. They may be used to determine which preventive and medical-curative measures or which investment in research might increase the life expectancy of the population.

European shortlist of causes of death classifies deaths by 86 causes based on the International Classification of Diseases and Related Health Problems (ICD) .

Context

WHAT IS THE 'HEALTH PROGRAMME'?

The main instrument for implementing the EU's public health strategy is the EU4Health programme , which contributes to funding projects on health promotion, health security and health information.

It was adopted as a response to the COVID-19 pandemic and to reinforce crisis preparedness in the EU. The programme has 4 overarching objectives:

- Improve and foster health;
- Protect people;
- Access to medicinal products, medical devices and crisis-relevant products;
- Strengthen health systems.

Among other topics, a comprehensive, prevention-oriented and multi-stakeholder approach to mental health has been developed after extensive consultation with Member States, stakeholders and citizens, summarised in the 2023 Communication on mental health . If you or somebody you know is struggling with the issues mentioned in this article, you can find a support service in your country on the following page: Get Help - iFightDepression .

Explore further

Other articles

- All articles on Health

Self-perceived health statistics Causes of death statistics

Database

- Population and demography - detailed datasets (demo) , see:

Population (demo_pop)

Mortality (demo_mor)]

- Youth (yth) , see:

Youth health (yth_health)

Thematic section

- Quality of life
- Children and Youth
- Population and Demography overview

Selected datasets

- Population and demography - selected datasets (t_demo) , see:

Population (t_demo_pop)

Mortality (t_demo_mor)

Methodology

- Causes of death (ESMS metadata file – hlth_cdeath_sims)
- European Health Interview Survey (EHIS) (ESMS metadata file — hlth_det_esms)
- Mortality (ESMS metadata file — demo_mor_esms)

Causes of death metadata (hlth_cdeath) Causes of deaths statistics general methodology

External links

- European Commission — Public health
- European Commission Directorate-General for Employment, Social affairs & Inclusion

https://www.who.int/news-room/fact-sheets/detail/suicide

Legislation

- Regulation (EU) No 282/2014 of 11 March 2014 on the establishment of a third programme for the Union's action in the field of health (2014-2020)
  - Summaries of EU legislation — Health for growth: EU health programme (2014-2020)
- Regulation (EU) No 328/2011 of 5 April 2011 implementing Regulation (EC) No 1338/2008 on Community statistics on public health and health and safety at work, as regards statistics on causes of death
- Regulation (EC) No 1338/2008 of 16 December 2008 on Community statistics on public health and health and safety at work
  - Summaries of EU legislation: statistics on public health/health and safety at work