IBIMA Publishing
Communications of International Proceedings
https://ibimapublishing.com/p-articles/46ECO/2025/4648625/
Vol. 2025 (25), Article ID 4648625

Assessment of Cross-Country Differences in Life Satisfaction and Quality of Life among Older Adults in Six EU Countries*

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* Presented at the 46th IBIMA International Conference, 26-27 November 2025, Ronda, Spain

Abstract

The aim of this article is to provide a comparative assessment of life satisfaction and key quality-of-life indicators among older adults in six European Union countries: Czechia, Germany, Lithuania, Poland, Spain and Sweden. Using data from the Survey of Health, Ageing and Retirement in Europe (SHARE, Wave 8; 2019–2020), complemented by macroeconomic indicators, the study examines how pension expenditure and the gender pension gap relate to self-rated health, the frequency and extent of social contacts (including social network size), and overall life satisfaction. By combining subjective and objective indicators, the analysis reflects the multidimensional nature of quality of life in later life.

The findings reveal clear discrepancies between objective living conditions and reported life satisfaction. Countries characterised by high pension expenditure and well-developed social services — notably Sweden and Germany — display relatively high levels of life satisfaction despite only moderate outcomes in self-rated health and social contact frequency. By contrast, Poland and Spain, despite comparable levels of self-rated health and similar intensity of social contacts, report lower life satisfaction, suggesting a stronger influence of institutional stability, perceived security and culturally shaped expectations. Lithuania and Czechia — countries with lower income levels and poorer health indicators — nonetheless demonstrate higher life satisfaction than Poland and Spain, indicating that life satisfaction cannot be explained solely by material or structural conditions.

Overall, the study highlights the importance of public policies that account not only for economic and health-related factors but also for institutional stability, the quality of public services, levels of social trust and the alignment of pension systems with citizens' expectations. These findings underline that subjective evaluations of quality of life in older age are shaped by a complex interplay of structural conditions, social relationships and cultural response patterns.

Keywords: quality of life of older adults, life satisfaction, self-rated health, material conditions, social relations.

Cite this Article as: Justyna KUJAWSKA Vol. 2025 (25) " Assessment of Cross-Country Differences in Life Satisfaction and Quality of Life among Older Adults in Six EU Countries " Communications of International Proceedings, Vol. 2025 (25), Article ID 4648625, https://doi.org/10.5171/2025.4648625

Introduction

Population ageing is one of the most significant social and economic challenges facing contemporary Europe. The growing proportion of people aged 65 and over, observed across all European Union Member States, necessitates not only reforms to pension and healthcare systems but also a deeper reflection on the quality of life of older adults. Demographic ageing affects family structures, the labour market, and social and health policy, raising an important question: how do older adults perceive their health, living conditions and their role within society?

Life satisfaction is widely recognised as one of the key indicators of subjective well-being and plays an important role in evaluating the effectiveness of social and health policies. Numerous studies show that subjective perceptions of health are strongly associated with objective health indicators, longevity and levels of social engagement in later life (Diener et al., 2018; Helliwell and Aknin, 2018). Perceived health is shaped not only by biological factors but also by economic, social and cultural conditions, including income, education, the quantity and quality of social relationships and the availability of support networks.

Moreover, cross-country differences in economic security in later life are also shaped by structural inequalities, including the gender pension gap, which remains substantial in many EU Member States and may significantly affect older adults' financial well-being.

Comparative research indicates that older adults' assessments of life satisfaction vary considerably across Europe. In Northern and Western European countries — characterised by comprehensive social protection systems, strong institutional support and high levels of social trust — older adults are more likely to evaluate their quality of life positively. In Southern and Eastern Europe, by contrast, perceived quality of life tends to be lower despite strong family ties. This may reflect more limited access to healthcare, lower income levels, higher living costs and culturally embedded perceptions of ageing (OECD, 2024).

These cross-national variations may also reflect culturally embedded expectations and response patterns, as older adults in different societies assess their quality of life relative to distinct social norms, value systems and perceived standards of ageing.

The aim of this study is to provide a comparative assessment of the quality of life of older adults in selected European Union countries and to identify the factors that may account for differences between them. The analysis draws on data from the Survey of Health, Ageing and Retirement in Europe (SHARE), including self-rated health, life satisfaction and the frequency of social contacts. These subjective indicators are combined with objective measures of living conditions — such as pension expenditure and the gender pension gap — to capture the multidimensional nature of life satisfaction in older age.

Life satisfaction is treated in this study as the primary indicator of the subjective dimension of quality of life in older age.

Literature Review

Population ageing has accelerated markedly since the late twentieth century and has become one of the most significant socio-economic challenges facing contemporary Europe. In 2024, 21.6% of the EU population was aged 65 or over (Eurostat, 2025). As the proportion of older adults increases, so does interest in understanding their needs and the factors that shape their everyday functioning. Perceptions of quality of life play a crucial role in the ageing process, as demonstrated by both cross-sectional and longitudinal research (Diener et al., 2018; Helliwell and Aknin, 2018). The global demographic shift has therefore underscored the importance of examining both the subjective and objective determinants of quality of life in later life.

Quality of life and subjective well-being: conceptual distinctions

Quality of life (QoL) is widely recognised as a multidimensional construct. According to the World Health Organization (WHO), QoL reflects an individual's perception of their position in life, situated within the context of cultural norms, value systems, personal goals, expectations and concerns (WHO, 1998). This conceptualisation encompasses both objective living conditions—such as income, employment, housing and social support—and subjective aspects, including personal expectations, values and life satisfaction (Fernández-Ballesteros, 2010; Bowling, 2005).

A commonly accepted distinction is made between QoL and subjective well-being (SWB). While QoL refers to the domains and conditions of life, SWB captures individuals' evaluative and affective judgements about their lives. It is typically operationalised through measures of life satisfaction as well as positive and negative affect

(Diener et al., 1999). This differentiation is widely applied in ageing research and has informed multiple frameworks analysing quality of life in older age (Higgs et al., 2003; Hyde et al., 2003).

Measurement instruments for quality of life in older age

A wide range of measurement instruments reflects the multidimensional nature of quality of life. Although they differ in theoretical foundations and scope, these tools share a common emphasis on the physical, psychological and social dimensions of functioning.

WHOQOL Instruments

The WHOQOL-100 assesses six domains of quality of life: physical health, psychological well-being, level of independence, social relationships, environment and spirituality/personal beliefs. Its abbreviated version, the WHOQOL-BREF, evaluates four domains. Both instruments capture the complexity of quality of life across multiple life areas and have been extensively validated (Jaracz et al., 2006; Sierakowska, 2017).

CASP Scales

The CASP-19 and CASP-12 instruments were developed specifically to assess quality of life in older age and are grounded in the needs-satisfaction tradition, drawing on Maslow's motivational framework and Doyal and Gough's (1991) theory of human needs. The CASP framework captures four key components central to quality of life in later life:

1. Control,
2. Autonomy,
3. Self-realisation,
4. Pleasure.

CASP-based measures have been incorporated into major European longitudinal studies on ageing, including the Survey of Health, Ageing and Retirement in Europe (SHARE) (Hyde et al., 2003; Higgs et al., 2003; Börsch-Supan et al., 2013).

SF-36 and EQ-5D

The SF-36 evaluates eight domains: physical functioning, role limitations due to physical health, bodily pain, general health, vitality, social functioning, emotional role limitations and mental health. These domains are aggregated into two summary scores: the Physical Component Summary (PCS) and the Mental Component Summary (MCS) (Murray and Evans, 2003).

The EQ-5D (both 3L and 5L versions) assesses mobility, self-care, usual activities, pain/discomfort and anxiety/depression, and includes a visual analogue scale (VAS) that captures respondents' overall health status. Owing to its strong cross-country comparability, it is one of the most widely used instruments for measuring health-related quality of life (HRQoL) (Cieślik and Podbielska, 2015).

Together, these instruments underscore the multidimensionality of quality of life and highlight the importance of incorporating subjective assessments of functioning and well-being, particularly in research on older adults.

Determinants of quality of life and well-being in later life

Health consistently emerges as one of the strongest predictors of subjective well-being. Campbell et al. (1976) demonstrated that respondents perceived health as the most important contributor to happiness. Subjective health assessments correlate more strongly with well-being than objective clinical indicators (Larson, 1978; Okun and George, 1984). Numerous empirical studies confirm the positive association between health and subjective well-being (Deaton, 2008; Graham, 2008; Binder and Coad, 2011; Cubí-Mollá et al., 2014), while higher levels of well-being are associated with increased longevity (Diener and Chan, 2011). Contemporary research further emphasises that health systems should support not only the treatment of disease but also psychological resilience and positive functioning (Steptoe et al., 2015).

Socio-economic status is another influential determinant of well-being across the life course. Income shows a strong correlation with life satisfaction and happiness (Easterlin, 1974; Diener et al., 1985; Pinquart and Sörensen, 2000). However, higher income does not guarantee sustained increases in well-being—a finding central to the Easterlin paradox. Inglehart et al. (2008) argue that improvements in economic security, such as job stability without excessive working hours, may contribute more to life satisfaction than income increases alone.

Social interactions are also crucial for life satisfaction in older age. Interpersonal relationships influence not only well-being but also physical health (Helliwell et al., 2009). The development of social relationships increases

personal resources and opportunities to achieve meaningful goals, thereby enhancing subjective well-being (Lucas and Dyrenforth, 2006). Integrated analytical frameworks highlight the combined influence of income, health and social connectedness on well-being (Lamu and Olsen, 2016).

Gender differences in well-being arise from distinct life experiences, exposure to stressors and social role expectations (Nasser and Fakhroo, 2021). Another important line of research concerns the relationship between age and happiness. While earlier studies suggested a U-shaped pattern across the life course (Blanchflower and Oswald, 2008), more recent analyses reveal considerable variation across countries. Bartram (2024) finds that in many European countries life satisfaction declines with age, challenging the universality of the U-curve.

Taken together, these theoretical insights illustrate that quality of life and subjective well-being in later life are shaped by a complex interplay of health status, socio-economic resources, social connectedness, gender and life-course dynamics. The empirical analysis that follows draws on SHARE data to examine cross-country differences in self-rated health, social contact frequency and life satisfaction among older adults in six European Union countries, supplemented by macro-level indicators such as pension expenditure and the gender pension gap.

Method

The statistical information used in this study comes from the SHARE-ERIC project — the Survey of Health, Ageing and Retirement in Europe (Börsch-Supan et al., 2013). SHARE is a longitudinal survey conducted approximately every two years and collects data on the socio-economic situation, lifestyle and health of individuals aged 50 and over living predominantly in European countries.

The dataset used in this analysis focuses on respondents aged 60 and over residing in six European Union countries: Czechia, Germany, Lithuania, Poland, Spain and Sweden. These countries represent Western and Northern Europe, Southern Europe and the post-socialist regions of Central and Eastern Europe. The statistical information derives from Wave 8 of SHARE, conducted in 2019–2020, immediately prior to the onset of the Covid-19 pandemic (Bergmann and Börsch-Supan, 2021). Respondents were divided into four age groups: 60–69, 70–79, 80–89 and 90+ (the latter being the smallest group).

Subjective well-being was measured using life satisfaction, assessed on a scale from 1 to 10, where 1 denotes complete dissatisfaction and 10 denotes complete satisfaction with life. Self-rated health was measured on a five-point scale ranging from 1 (very good health) to 5 (very bad health).

Social contacts were assessed using three indicators derived from SHARE. “Average contact” refers to the mean reported frequency of contact with individuals in the respondent’s social network, measured on a categorical scale ranging from very frequent to rare contact. In addition, the proportion of individuals reporting daily and at least weekly contact was calculated. A measure of social network size was also included, defined as the number of people the respondent identified as important.

To provide a more comprehensive picture of the living conditions of older adults in Europe, supplementary Eurostat indicators were incorporated:

– population structure by age group,

– pension expenditure per pensioner,

– gender pension gap by age group.

After data cleaning and restricting observations to the six analysed countries, the analytical sample ranged from 13,445 older adults for the self-rated health analysis to 66,710 respondents for the life satisfaction analysis.

All calculations were performed using RStudio.

Having outlined the dataset and the construction of the key indicators, the next section presents the empirical results.

Results

This section presents the main empirical findings, focusing on cross-country differences and age-related patterns in demographic structure, economic conditions, health assessments, social activity and life satisfaction.

The following subsection outlines the key characteristics of the analysed countries, beginning with population structure (Table 1) and economic and income-related conditions (Table 2)**.**

Table 1. Population structure by age groups in 2006, 2015 and 2024 in selected EU countries

Age groups	0-14			15-64			65 and over		
Country/year	2006	2015	2024	2006	2015	2024	2006	2015	2024
Czechia	14,6	15,2	15,9	71,1	67,0	63,6	14,2	17,9	20,5
Germany	14,1	13,2	13,9	66,6	65,8	63,6	19,3	21,0	22,4
Lithuania	16,6	14,5	14,5	67,1	67,0	65,1	16,3	18,6	20,4
Poland	16,2	15,0	15,1	70,5	69,5	64,4	13,3	15,4	20,5
Spain	14,5	15,1	13,2	68,9	66,3	66,4	16,6	18,5	20,5
Sweden	17,3	17,3	17,1	65,4	63,1	62,3	17,3	19,6	20,6
EU	15,8	15,3	14,6	67,3	65,6	63,8	16,9	19,1	21,6

Source:Own calculation based on Eurostat data

The table 1. presents the age structure over the past 20 years, divided into three age groups. At that time, Czechia had the highest share of the working-age population and the lowest share of the post-working-age population. At the same time, it recorded a relatively low proportion of the pre-working-age population.

Currently, among the analysed countries, Spain and Lithuania have the most favourable age structure — a high proportion of working-age individuals and the lowest share of those aged 65+. The least favourable structure is observed in Sweden, although Sweden simultaneously has the largest share of young people, which is likely to positively affect the labour market in the future.

Table 2. Comparison of average monthly pension expenditures (nominal and in PPS) and the gender pension gap in 2015, 2020 and 2023 in selected countries.

Country/ year	Average monthly pension expenditure						Gender pension gap		
	euro			Purchasing power standards			[%]		
	2015	2020	2023	2015	2020	2023	2015	2020	2023
Czechia	409	561	843	659	810	1001	12,7	12,7	11,4
Germany	1205	1425	1595	1129	1320	1463	42,5	29,1	26,9
Lithuania	242	365	498	408	553	640	13,3	15,0	13,7
Poland	459	516	699	843	925	1070	19,5	19,2	16,9
Spain	1230	1399	1654	1285	1413	1816	33,7	31,1	27,8
Sweden	1701	1736	1890	1242	1297	1546	28,5	29,1	27,4
EU	1123	1539	1444	1123	1539	1444	33,0	27,7	25,2

Source: Own calculation based on Eurostat data

The table 2. presents average monthly pension expenditures (a macroeconomic perspective) expressed in euros and adjusted for purchasing power, as well as the gender pension gap between the average pensions of women and men. A nine-year period between 2015 and 2023 is considered. The year 2020 is also included, as respondents participating in Wave 8 of the SHARE project provided their answers during that period.

In nominal terms, in 2015 the highest pension expenditure per pensioner was recorded in Sweden, while the lowest was observed in Lithuania, where the expenditure was seven times lower than in Sweden. From 2020 onwards, pension expenditures increased in the Central and Eastern European countries. In 2023, Lithuania, Poland and Czechia continued to record the lowest pension expenditures, although the difference between Lithuania and Sweden had narrowed to 3.7 times.

Pension expenditures appear more favourable after adjusting for purchasing power. Although Lithuania, Czechia and Poland still show the lowest levels, the gaps between Spain and these countries are considerably smaller. In 2023, pensioners in Spain were, on average, able to purchase 2.8 times more goods than those in Lithuania, 80% more than pensioners in Czechia, 70% more than those in Poland, and 24% more than pensioners in Germany.

Turning to the second part of the table — the gender pension gap between the average pensions of women and men — it can be observed that the gap has narrowed over the examined years. The largest gender pension gap

was recorded in Germany, Spain and Sweden. In Germany, it decreased by as much as 15.6 percentage points. The lowest gender pension gap was observed in Czechia and Lithuania. Its magnitude reflects differences in women's labour market participation in these countries.

In Germany, the prevailing model is one in which men work full time and provide the primary income for the household, while women are more likely to engage in domestic care, raise children or work part-time. In Spain, a traditional family model also persists, but the gender pension gap is additionally shaped by shorter contribution periods linked to childcare and eldercare responsibilities, women's overrepresentation in lower-paid occupations (such as caregivers, nurses and teachers), and by high structural unemployment rates affecting women.

In Sweden, despite very high female labour market participation and a well-developed welfare system, women receive lower pensions due to the concentration in lower-paid occupations, voluntary part-time work, and longer life expectancy. In the Central and Eastern European countries, women tend to have longer contribution periods, return to work more quickly after childbirth, face a shortage of part-time occupations, and share financial responsibilities for household maintenance and loan repayment. As a result, the gender pension gap in these countries is smaller.

The economic context described above provides an important interpretative background for the international comparisons presented in the following sections: health (Table 3), social activity (Table 4) and life satisfaction (Figure 1).

Table 3. Self-rated health in selected countries

country	age groups	number of responses	% rating health as			mean	standard deviation
			very good/good	fair	bad/very bad		
Czechia	60–69	983	26,1	53,2	20,8	2,97	0,85
	70–79	1268	14,9	56,7	28,4	3,18	0,81
	80–89	516	7,6	50,8	41,7	3,44	0,82
	90+	48	4,2	31,2	64,6	3,83	0,91
Germany	60–69	1221	23,7	41,8	34,5	3,11	0,98
	70–79	1121	18,3	40,5	41,2	3,29	0,97
	80–89	588	10,8	35,4	53,9	3,54	0,91
	90+	76	2,6	28,9	68,4	3,84	0,75
Lithuania	60–69	467	6,9	40,7	52,5	3,51	0,77
	70–79	395	3,3	29,9	66,8	3,75	0,72
	80–89	240	2,1	18,3	79,6	4,02	0,71
	90+	35	2,9	8,6	88,5	4,03	0,62
Poland	60–69	1100	11,6	44,8	43,6	3,44	0,9
	70–79	790	5,1	34,1	60,9	3,75	0,84
	80–89	327	3,7	20,5	75,8	4,04	0,83
	90+	72	2,8	23,6	73,6	4,19	0,9
Spain	60–69	659	26,1	41,1	32,7	3,05	0,93
	70–79	742	13,4	35,4	51,2	3,43	0,91
	80–89	431	6,1	26,7	67,2	3,79	0,9
	90+	67	3	16,4	80,6	4,01	0,79
Sweden	60–69	655	47,9	31,5	20,6	2,56	1,11
	70–79	1018	38	36,1	26	2,8	1,07
	80–89	528	23	36,9	40,2	3,2	1,02
	90+	98	17,4	27,6	55,1	3,48	1,03

Source Own calculation based on SHARE Wave 8 data

The table 3. combines the categories of self-rated health classified as "very good" and "good", as well as "bad" and "very bad". Older age groups assess their health as worse compared with younger groups, meaning that health status declines with age (reflected in higher average values). The vast majority of respondents rate their health as "good" or "fair".

Swedish respondents report the most positive health assessments, and a higher percentage of women than men evaluate their health as "very good". A substantial share of respondents also choose the category "good", particularly in the 60–79 age group. In contrast, among respondents aged 80 and over, assessments of "bad"

become more frequent, and women aged 90 and above most often rate their health as “very bad”. Sweden also shows the greatest variability in health assessments across all age groups.

The lowest combined percentages of “very good” and “good” health assessments are observed in Lithuania and Poland, with a marked decline beginning already at age 70. In these countries, negative (bad and very bad) health assessments predominate. Among respondents aged 80 and above, women rate their health more negatively than men.

In the oldest age group in Spain, women also assess their health significantly worse than men.

To evaluate social relations, the frequency of social contacts was examined. Table 4 presents summary information for the countries included in the study.

Table 4. Basic information concerning the social contacts of older adults

Country	Average Contact Frequency	Daily Contact (%)	Social Network Size
Czechia	2,18	51,1	2-4
Germany	2,37	56,3	2-5
Lithuania	1,50	57,2	1-3
Poland	2,10	51,7	2-4
Spain	1,30	42,1	1-3
Sweden	2,44	50,9	2-4

Source: Own calculation based on SHARE Wave 8 data

The variable measuring the frequency of social contacts is an ordinal variable taking the following values: 1 – daily contact, 2 – several times per week, 3 – once per week. Thus, the lower the mean value, the more frequent the contact. In this context, Spain performs best, followed by Lithuania and then Poland — older adults in these countries typically maintain contact several times per week. Swedish respondents reported the lowest frequency of contact, usually once or several times per week. Although Spain records the highest overall contact frequency, it also shows the lowest percentage of respondents reporting daily contact — 42.1%. This suggests that contacts tend to occur several times per week rather than every day. Regarding the number of people with whom older adults stay in contact (and whom they trust), the most common range is 2–4 people, while in Lithuania and Spain it is 1–3 people.

With respect to receiving various types of assistance, almost all respondents reported receiving some form of help from individuals outside their household. Among older adults aged 60–90, only a small percentage require support with personal activities or household tasks, with the latter being more common. After age 90, the proportion of individuals requiring help with personal care and domestic tasks increases sharply. In most of the analysed countries, more than 50% of respondents in this age group report needing such assistance. It should be noted, however, that the number of respondents aged 90 and over in the sample is very small.

When evaluating life satisfaction, it is evident that, on average, respondents in Spain reported the lowest levels of life satisfaction, while those in Sweden reported the highest. A general tendency can be observed across all countries: life satisfaction decreases with age. The oldest respondents report the lowest levels of satisfaction, which may be associated with poorer health, disability and the need for support from others, particularly in household tasks such as cleaning, cooking and shopping.

In five of the analysed countries, women reported higher life satisfaction than men. The exception is Spain, where the mean life satisfaction score for men was 7.39 compared with 7.13 for women on a 1–10 scale (10 = highest satisfaction). The smallest gender difference was noted in Czechia (0.08 points), while the largest occurred in Lithuania (0.46 points). In Sweden, the average life satisfaction of women was 8.77 and of men 8.45, whereas in Poland women reported an average of 7.47 and men 7.06. This observation aligns with the findings of Nasser and Fakhroo (2021), who indicate that men and women perceive life satisfaction differently. A synthetic overview of life satisfaction results is presented in Figure 1.

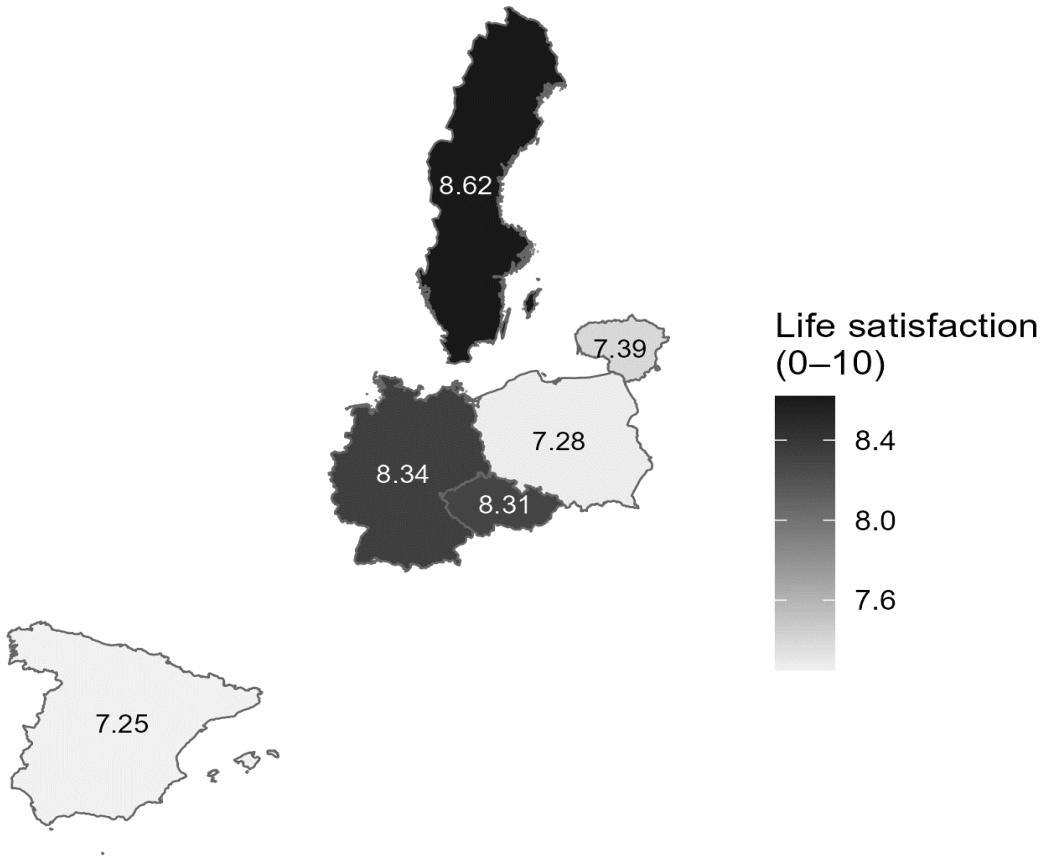
To assess the influence of sample selection (i.e., the differing number of respondents across variables — the smallest sample for self-rated health and the largest for life satisfaction), a sensitivity analysis was conducted. Mean levels of life satisfaction (0–10) were compared across three samples:

(1) all respondents with available information on life satisfaction,

(2) all respondents with available self-rated health, and

(3) a combined sample including only individuals for whom both variables were available.

The mean levels of life satisfaction in the full and the combined samples differed by no more than 0.01 points, indicating that restricting the sample to individuals with complete data does not distort the distribution of life satisfaction. Slightly larger differences observed in the 90+ age group are a result of the very small sample size, and caution is therefore needed when interpreting these values.



Source: Own calculation based on SHARE Wave 8 data

Figure 1. Average Life Satisfaction in Six European Countries

Conclusion

A comparative analysis of six countries (Czechia, Germany, Lithuania, Poland, Spain and Sweden) shows that life satisfaction among individuals aged 60+ does not directly follow objective indicators of living conditions, such as self-rated health, pension expenditure, the gender pension gap or the frequency of social contacts. Although the results highlight the importance of institutional and social factors, self-rated health remains a central component of quality of life in later life and consistently shapes how older adults evaluate their overall situation.

Poland, despite relatively average results in health, pension expenditure and contact frequency, exhibits lower life satisfaction than Czechia and Lithuania. In Lithuania, despite the worst health indicators and the lowest pension expenditure, the declared level of life satisfaction is higher than in Poland, which may reflect lower expectations, stronger family-centred social structures and culturally specific response patterns. Czechia presents a relatively favourable profile — moderate health burden, a low gender pension gap and frequent social contacts — which translates into high levels of life satisfaction.

A contrasting pattern is observed in Spain, where, despite high pension expenditure and the most intensive social contacts among the analysed countries, life satisfaction is the lowest. This suggests a substantial role of institutional and macro-social factors, such as economic instability, inequalities or unmet expectations regarding the social protection system. Germany, in turn, achieves high life satisfaction despite moderate contact frequency and a relatively large gender pension gap. This may indicate that institutional stability, high-quality public services

and trust in the social security system play a compensatory role, mitigating the impact of unfavourable structural factors.

Sweden, which scores the highest in life satisfaction, combines the best health outcomes and the highest pension expenditure with strong institutional capital. Despite relatively infrequent social contacts and a substantial gender pension gap, long-term stability in social care systems and high levels of public trust contribute to more positive assessments of quality of life. In this context, life satisfaction should be understood as a key evaluative component of quality of life, reflecting older adults' broader subjective assessment of their living conditions.

The divergence between objective living conditions and subjective life satisfaction indicates that effective policies for older adults must extend beyond traditional financial and healthcare instruments. Neither the level of pension expenditure nor the frequency of social contacts alone constitutes a sufficient determinant of high quality of life. Instead, institutional stability, the quality of public services, levels of social trust and the alignment between citizens' expectations and their actual living conditions play a far more significant role.

Countries with relatively weaker structural indicators (e.g. Lithuania and Czechia) may nevertheless achieve higher perceived quality of life due to strong social bonds and lower expectation thresholds, whereas countries with high expenditure levels (e.g. Spain) may experience lower life satisfaction because of pronounced socio-economic tensions. The results for Germany and Sweden highlight the importance of long-term stability in social protection systems and high levels of institutional trust, which can enhance life satisfaction even when structural indicators — such as a large gender pension gap or limited social interaction — are less favourable. These findings align with broader European patterns, where Northern and Western European countries tend to report higher quality of life than Southern and Eastern European states.

Overall, the findings show that older Europeans differ substantially in how they evaluate their life satisfaction and overall quality of life, with the highest levels observed in countries characterised by stable social protection systems and high levels of social trust.

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Appendix: Description of Variables Used in the Study

Variable	Description	Scale / Coding
Life Satisfaction	Overall assessment of satisfaction with life	1 = very dissatisfied … 10 = very satisfied
Self-Rated Health	Perceived health status	1 = very good, 2 = good, 3 = fair, 4 = bad, 5 = very bad
Average Contact Frequency	Average frequency of social contact with members of the respondent's social network	Scale from "very frequent" to "rare" (continuous index provided by SHARE)
Daily Contact	Whether the respondent maintains daily social contact	0 = no, 1 = yes
Weekly Contact	Whether the respondent maintains at least weekly social contact	0 = no, 1 = yes
Social Network Size	Number of important persons identified by the respondent	Count variable
Pension Expenditure per Pensioner	Total pension expenditure per pensioner	EUR per pensioner per month
Gender Pension Gap	Difference between average male and female pensions	Percentage (%)
Population Structure by Age	Share of population by age groups	Percentage (%)