SUBJECTIVE HEALTH AND ITS DETERMINANTS IN THE WORKING-AGE POPULATION IN CZECHIA

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Abstract
This study evaluates subjective health and identifies its key demographic, socioeconomic, and lifestyle determinants within the Czech working-age population (16–64 years) using weighted data from the 2022 EU-SILC survey (N = 8,141). Binary logistic regression models reveal that lower education, economic inactivity, material deprivation, and subjective social deficits significantly increase the odds of poor self-rated health and activity limitations. Gender patterns vary across health dimensions, while poor health among non-drinkers is likely driven by a combination of health selection and sociocultural factors, rather than direct behavioural protective effects.

Keywords: SRH, GALI, demographic factors, social and economic capital, lifestyle, working-age population, Czechia
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INTRODUCTION

Health is a complex, multidimensional concept with physical, psychological, and social dimensions (*WHO*, 1946). It incorporates not only the physiological functioning of organs and the ability to cope with adverse influences, but also emotional well-being, the fulfilment of social roles, and the capacity to establish interpersonal relationships. Rather than merely serving as a foundation for survival, health is an essential resource for everyday life. Furthermore, *Dosedlová et al*. (2016) describe health not as a static state, but as a continuous process shaped and influenced by bio-psycho-social systems. Therefore, health cannot be reduced to the simple binary where people are either healthy or ill. Instead, for analytical purposes, this phenomenon is typically categorised into three interconnected domains: subjective, objective, and functional health.

Subjective health refers to an individual's perception of their well-being and overall quality of life. Objective health, also referred to as biological health, is evaluated by healthcare professionals based on clinical, physiological, or psychiatric examination. It includes diagnoses and other objectively measurable indicators of health that reflect an individual's internal biological characteristics. *Hübelová et al.* (2023) define it as the presence or absence of pathological conditions. Functional health relates to the ability to perform routine daily activities and whether

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physical functions impose limitations. It considers mobility, strength, coordination, and other functional aspects of health. Functional health represents a separate category, yet it overlaps with the other two domains, as it can be objectively assessed by a physician and subjectively evaluated by the individual (*Tubeuf et al.*, 2008). For example, an individual with a permanent physical impairment (such as using a wheelchair) may possess a high degree of subjective health if they have adapted to their condition and do not perceive significant restrictions in their desired daily activities.

This study focuses on subjective health, which represents one of the indicators of an individual's overall health status. Subjective health is based on the self-assessment and personal perception of one's own health condition. It encompasses various dimensions of health such as physical, functional, social, and emotional. This indicator reflects the quality of life, the ability to manage daily activities, and overall vitality. Additionally, subjective health assessment may also indicate the quality of the healthcare in each society. If a large proportion of the population rates their health as poor, this could indicate that the level of healthcare is unsatisfactory (*Rychtaříková et al.*, 2008). Subjective health is a complex indicator influenced by a multitude of factors. Many authors consider it a reliable and irreplaceable indicator of actual health status (*Wu et al.*, 2013). In survey research, subjective health is mostly measured with two types of questions: '*How do you feel overall?*' and '*How would you rate your health in general?*'. Some studies include a supplementary comparative question, '*How would you rate your health compared to others of your age?*', which allows for comparison with peers. Responses are typically collected on a five-point Likert scale: *very good, good, fair (satisfactory), poor, very poor.* Currently, this methodology has become the standard approach in international health surveys. However, some studies point out that the results of comparing subjective health assessments among people from different cultures may vary.

The main objective of this paper is to evaluate subjective health status and its determinants within the Czech working-age population. In line with Eurostat methodology (2026), this population is conventionally defined as individuals aged 15–64 years, representing the key life stage associated with employment capabilities and economic activity. Specifically, this study addresses the following research question: *What are the key demographic, socioeconomic, and lifestyle determinants influencing self-rated health and global activity limitations in Czechia?*

Health determinants and health inequalities

Health is a desirable state and a universal goal, yet not everyone can achieve or sustain equally good health throughout their life. Health inequalities, which are systematic differences between various social and economic groups, remain a central focus of demographic and sociological research. These inequalities reveal disadvantaged population segments and geographical areas with limited access to quality healthcare, providing a basis for targeted health policies and programmes aimed at achieving health equity (*WHO*, 2024).

The factors that influence health status, both positively and negatively, are known as health determinants. They influence not only the quality and length of life but also the subjective perception of well-being. There are direct determinants, involving genetics, the environment, healthcare quality, and individual lifestyle, and indirect, distant determinants, such as political and economic systems, demographic structures, and social inequalities that shape the direct determinants (*Kachlík*, 2016).

In this study, determinants are categorised into four interconnected groups: demographic factors, economic capital, social capital, and lifestyle. Demographic factors include age and sex. These determinants are among the most frequently used predictors in health research, yet they are often merely control variables, rather than the primary focus of analysis (*Franz et al.*, 2017; *Vafaei et al.*, 2021). Research consistently shows significant gender-based differences in health perception. While many studies, such as *Park et al.* (2015), suggest that men generally report better subjective health than women, this is often attributed to higher morbidity rates and a higher prevalence of non-fatal chronic conditions among women. Conversely, women tend to be more health-conscious, possess higher health literacy, and report their health

status with greater accuracy (*Idler*, 2001). However, recent studies suggest that this relationship is heavily moderated by social and behavioural contexts. For instance, *Vafaei et al.* (2021) found that in certain populations, women may report better health than men when adjusted for gender roles and social support.

Economic capital is represented by income level, labour market status, and educational attainment (*Šubrt et al.*, 2010). Economic security is a fundamental determinant of health. Higher income levels generally correlate with better health outcomes due to reduced exposure to environmental risks and improved access to high-quality healthcare. While international research often identifies a linear relationship where higher income leads to better self-rated health (*Karlsson et al.*, 2010), this association is not always consistent. For instance, *Vafaei et al.* (2021) suggest that individuals in Canada in middle-income groups may report better health than high-income earners due to lower levels of occupational stress.

Educational attainment plays an equally critical role, as it shapes socioeconomic status and future career trajectories. Higher education is associated with better health literacy, more stable employment, and a greater emphasis on preventive measures. In Czechia, education has been identified as a key predictor of mortality and health-related quality of life. Individuals with lower education levels exhibit significantly higher mortality rates and poorer health perceptions (*Rychtaříková et al.*, 2008). Generally, respondents with higher levels of educational attainment, specifically those who have completed secondary and tertiary education, report significantly better self-rated health (*Raghupathi*, 2020).

Social capital, as the quality and quantity of social ties and networks, is an essential resource for maintaining good health. In this analysis, it is operationalised through marital status, social isolation, and the social environment (*Sociologická encyklopedie*, 2020). Historically, marital status has been recognised as a significant predictor of mortality and morbidity, as married individuals (particularly men) tend to report better physical and mental health than people who are single, divorced, or widowed (*Hamplová*, 2014; *Rychtaříková*, 2013). However, modern research highlights the importance of the *quality* of these relationships rather than mere marital status. While social isolation is a known risk factor for psychological distress and premature mortality, living alone does not automatically equate to low social capital. Recent studies, such as *Pasanen et al.* (2021), for the Finnish population, have found that individuals with high-quality social networks can maintain excellent subjective health even outside of traditional partnership structures.

Lifestyle, including behavioural factors such as alcohol consumption, smoking, physical activity, dietary habits, and BMI, plays a significant role in health outcomes (*WHO* 2010). The WHO estimates that lifestyle factors contribute to over 60% of health determinants (*Farhud*, 2015). The impact of alcohol on subjective health is often culturally mediated. While excessive consumption is a major global health risk (*WHO*, 2022), some studies have observed the 'paradox' of moderate drinkers reporting better subjective health than abstainers, though this may be influenced by social context rather than physiological benefits. Although smoking is unequivocally linked to severe health impairments (*WHO*, 2023), its effect on *subjective* perception can be contradictory. Some researchers suggest a 'compensation mechanism' exists, where smokers use tobacco to manage stress, leading to temporarily positive results for self-rated health (*Park et al.*, 2015). Healthy dietary habits and maintaining a healthy weight are essential for preventing chronic civilisation diseases, significantly influencing long-term health trajectories (*Heffer et al.*, 2021; *Vafaei et al.*, 2021).

Regular physical activity is another critical predictor, as it enhances cardiovascular health and psychological well-being through neurobiological mechanisms. Research consistently shows that individuals with regular exercise habits report significantly higher levels of subjective health (*Tanaka et al.*, 2020; *Park et al.*, 2015).

DATA AND METHODOLOGY

The primary data source is the 2022 European Union Statistics on Income and Living Conditions (EU-SILC) for Czechia. While core demographic and socioeconomic variables were obtained from the main questionnaire, subjective health and well-being indicators were derived from the 2022 ad-hoc

module on *Health and Quality of Life*. Following the EU-SILC design, these detailed questionnaires are administered only to individuals aged 16 and older (*Eurostat*, 2022). Therefore, the analytical sample was restricted to the 16–64 working-age group, comprising an unweighted $N = 9{,}878$ respondents, representing a weighted population of 6,350,353 individuals in Czechia.

The analysis examines two dependent variables dichotomised for binary logistic regression. Self-Rated Health (SRH), originally measured on a five-point Likert scale from very good to very poor, was transformed into a binary outcome comparing *good* (very good, good) versus *poor* (fair, poor, and very poor) health statuses. In the specific context of Czech health surveys, the *fair* (přijatelné) response category often attracts individuals who are already experiencing a clinically meaningful decline in functional capacity but are reluctant to report their health explicitly as poor (*Vrabcová*, 2014). Grouping *fair* with *poor* health establishes a balanced distribution for robust logistic modelling (approximately 20% poor vs 80% good health; Table 1 and effectively isolates individuals with optimal health from those experiencing any degree of poor health. The second dependent variable, Global Activity Limitation Indicator (GALI), is based on the respondent's perception of health-related restrictions. Respondents answered the following standardised question: '*For at least the past six months, have you been limited because of a health problem in activities people usually do?*' (*Eurostat*, 2022). The original three categories' responses (*strongly limited, limited but not strongly, not limited*) were merged into a binary indicator comparing individuals *with limitations* (approximately 25%) versus those *without limitations* (approximately 75%; Table 2).

Table 1 Dichotomised SRH in the working-age population, EU-SILC, Czechia, 2022

Original category	Frequency (N)	Percentage (%)	Analysed category	Frequency (N)	Percentage (%)
Very good	3,155	34.25	Good	7,791	80.85
Good	4,636	46.60			
Fair	1,589	14.62	Poor	2,087	19.15
Poor	432	3.90			
Very poor	66	0.63			
Total	9,878	100.00		9,878	100.00

Note: *N* represents unweighted sample sizes and *w*% indicates percentages weighted using personal cross-sectional weights (pkoef).
Source: CZSO, EU-SILC 2022 (*N* = 9,878; weighted pop. = 6,350,353), author's calculations.

Table 2 Dichotomised GALI in the working-age population, EU-SILC, 2022

Original category	Frequency (N)	Percentage (%)	Analysed category	Frequency (N)	Percentage (%)
Yes, limited	2,158	20.14	With limitations	2,596	24.40
Yes, strongly limited	438	4.27			
No, not limited	7,282	75.60	Without limitations	7,282	75.60
Total	9,878	100.00		9,878	100.00

Note: *N* represents unweighted sample sizes and *w*% indicates percentages weighted using personal cross-sectional weights (pkoef).
Source: CZSO, EU-SILC 2022 (*N* = 9,878; weighted pop. = 6,350,353), author's calculations.

Explanatory variables are categorised into demographic factors, economic capital, social capital, and lifestyle characteristics. Demographic factors include *sex* and *ten-year age groups*. Economic capital is represented by *the highest level of education attained* (ISCED classification), *labour market status*,

and *income quartiles*. It is important to note that the category of economically inactive individuals represents a highly heterogeneous group. In the context of the working-age population, this group comprises diverse sub-populations, including students, homemakers, and individuals who are out of the labour market due to severe, long-term health problems or disability.

Social capital encompasses *marital status, parenthood, feelings of loneliness, social exclusion*, and *frequency of contact with family and friends*. Finally, lifestyle factors such as *Body Mass Index* (BMI), *dietary habits, smoking status, alcohol consumption*, and *physical activity* were included.

Although educational attainment and marital status are often categorised as standard sociodemographic variables, they were theoretically reallocated for the purpose of this conceptual framework. Educational attainment is integrated into the economic capital category because it serves as the foundational driver of socioeconomic status, future career trajectories, and stable employment. By directly shaping economic security and health literacy, education represents a critical predictor of mortality and subjective health both generally (*Raghupathi*, 2020) and even within the Czech population (*Rychtaříková et al.*, 2008). Marital status is included as a part of social capital, as it represents an institutionalised form of bonding and critical emotional and material household level support. Research demonstrates a protective health effect associated with marriage. Compared to their unmarried, divorced, or widowed counterparts, married individuals, especially men, often exhibit lower morbidity and more favourable physical and mental health outcomes (*Hamplová*, 2014; *Rychtaříková*, 2013). Table 3 presents the distribution of all explanatory variables. Bivariate Chi-square tests confirmed significant associations between all explanatory variables and both health outcomes ($p < 0.05$).

Table 3 Descriptive characteristics of the studied population by SRH and GALI

Variable	Category	Frequency (N)	SRH		GALI	
			Good (%)	Poor (%)	Without limitations (%)	With limitations (%)
Sex	Men	4,825	81.71	18.29	76.80	23.20
	Women	5,053	79.97	20.03	74.36	25.64
Age groups	16–24	1,256	93.65	6.35	89.52	10.48
	25–34	1,560	92.21	7.79	86.91	13.09
	35–44	2,106	86.94	13.06	81.08	18.92
	45–54	2,493	78.56	21.44	71.34	28.66
	55–64	2,463	56.31	43.69	53.54	46.46
Educational attainment	Primary and lower secondary (ISCED 0–2)	1,058	79.18	20.82	74.60	25.40
	Upper secondary without the school-leaving exam (ISCED 3 C)	3,038	70.38	29.62	66.88	33.12
	Upper secondary with the school-leaving exam (ISCED 3 A)	3,566	83.95	16.05	78.49	21.51
	Tertiary (ISCED 5–8)	2,201	90.21	9.79	82.77	17.23
	Not stated	15	21.27	78.73	15.87	84.13
Labour market status	Economically active	7,323	83.89	16.11	78.15	21.85
	Economically inactive	255	64.07	35.93	56.39	43.61
	Other inactive	1,391	56.83	43.17	54.37	45.63
	Students	909	95.79	4.21	91.68	8.32

Table 3 (continued)

Variable	Category	Frequency (N)	SRH		GALI	
			Good (%)	Poor (%)	Without limitations (%)	With limitations (%)
Income quartile	1st quartile	2,313	77.16	22.84	73.66	26.34
	2nd quartile	2,629	74.77	25.23	69.89	30.11
	3rd quartile	2,533	82.39	17.61	76.94	23.06
	4th quartile	2,403	89.07	10.93	81.89	18.11
Marital status	Single	3,408	87.73	12.27	82.96	17.04
	Married	4,986	80.03	19.97	73.72	26.28
	Divorced	1,294	66.00	34.00	62.85	37.15
	Widowed	190	54.02	45.98	55.13	44.87
Parenthood	Yes	4,525	82.85	17.15	77.59	22.41
	No	5,353	78.93	21.07	73.68	26.32
Feelings of loneliness	Yes	1,598	68.11	31.89	62.84	37.16
	No	7,056	83.54	16.46	77.97	22.03
	Not stated	1,224	80.74	19.26	77.32	22.68
Feelings of social exclusion	Agree	327	60.10	39.90	54.83	45.17
	Neither agree nor disagree	515	62.29	37.71	60.18	39.82
	Disagree	7,808	83.30	16.70	77.21	22.79
	Not stated	1,228	78.40	21.60	77.15	22.85
Frequency of contact with relatives	At least once a week	4,750	82.24	17.76	76.10	23.90
	Several times a month	4,044	80.99	19.01	76.56	23.44
	Less often or never	638	68.24	31.76	63.31	36.69
	Not stated	446	83.70	16.30	79.73	20.27
Frequency of contact with friends	At least once a week	4,310	85.63	14.37	80.74	19.26
	Several times a month	4,512	79.22	20.78	73.49	26.51
	Less often or never	570	56.35	43.65	50.83	49.17
	Not stated	486	79.47	20.53	75.58	24.42
Body Mass Index	Underweight	229	85.43	14.57	78.64	21.36
	Normal weight	4,032	86.42	13.58	82.33	17.67
	Overweight	3,926	80.38	19.62	74.91	25.09
	Obesity	1,691	67.22	32.78	59.76	40.24
Fruit consumption	Daily	4,889	83.11	16.89	76.92	23.08
	Several times a week	4,000	79.50	20.50	75.03	24.97
	Less often or never	596	67.54	32.46	63.85	36.15
	Not stated	393	86.44	13.56	82.13	17.87

Table 3 (continued)

Variable	Category	Frequency (N)	SRH		GALI	
			Good (%)	Poor (%)	Without limitations (%)	With limitations (%)
Vegetable consumption	Daily	4,873	83.28	16.72	77.31	22.69
	Several times a week	470	79.03	20.97	74.35	25.65
	Less often or never	4,143	66.09	33.91	62.42	37.58
	Not stated	392	86.41	13.59	82.09	17.91
Smoking	Daily	2,200	74.59	25.41	71.12	28.88
	Occasionally	347	84.64	15.36	75.39	24.61
	Never or former smoker	6,934	82.27	17.73	76.55	23.45
	Not stated	397	86.55	13.45	82.99	17.91
Alcohol consumption	Daily	1,837	79.80	20.20	73.44	26.56
	Weekly or monthly	5,863	83.02	16.98	78.04	21.96
	Less often or never	1,771	73.29	26.71	67.99	32.01
	Not stated	407	86.65	13.35	82.60	17.40
Physical activity	Daily	1,478	87.93	12.07	79.57	20.43
	Several times a week	3,477	89.03	19.97	83.74	16.26
	Less often or never	4,531	71.41	28.59	67.14	32.86
	Not stated	392	86.93	13.07	82.28	17.72

Note: *N* represents unweighted sample sizes and *w*% indicates row percentages weighted using personal cross-sectional weights (pkoef), calculated horizontally to 100%. Not stated categories represent item non-response due to the survey design.
Source: CZSO, EU-SILC 2022 (N = 9,878; weighted pop. = 6,350,353), author's calculations.

A higher proportion of missing values was observed for the variables 'feelings of loneliness' and 'feelings of social exclusion' (approximately 12.5 %). The non-response for this item is directly caused by the methodological design of the EU-SILC survey, which strictly prohibits proxy interviews for subjective questionnaire modules to avoid external bias.

For the logistic regression analysis, missing values across all variables were handled using the listwise deletion method. The final analytical sample comprised N = 8,141 respondents (weighted N = 5,215,062). Within this sample, the SRH model included 6,472 good and 1,669 poor health cases, while the GALI model comprised 6,017 cases without limitations and 2,124 cases with limitations.

To account for the complex EU-SILC survey design, all statistical procedures, including descriptive statistics, bivariate adjustments (Table 1, 2, 3), and regression modelling (Table 4) utilised survey-specific SAS (v9.4) procedures (PROC SURVEYFREQ, PROC SURVEYLOGISTIC). These procedures incorporated three design components to ensure unbiased parameter estimates and correct standard errors: personal cross-sectional weights to inflate sample results to the target population, stratification by NUTS 3 regions to reflect geographical sampling, and household identification numbers as clusters to adjust for intra-household observational dependence. Prior to final modelling, potential multicollinearity was assessed using the Variance Inflation Factor (VIF), with all values remaining well below the critical threshold of 5.

The binary logistic regression models estimate the odds of reporting poor health (SRH) and living with limitations (GALI). Reference categories (Table 4) were selected a priori to represent either

the most prevalent group or the normative sociological baseline. Results are presented as Odds Ratios (*OR*) accompanied by 95% Confidence Intervals (*CI*), and statistical significance is determined by the Wald Chi-Square test (* $p < 0.05$, $p < 0.01$, and *** $p < 0.001$). Model fit was evaluated using the Akaike Information Criterion (AIC) and the ROC AUC (*c-statistic*). The full SRH model achieved an AUC of 0.814 (*AIC* = 3,846,628), indicating excellent discrimination between individuals with good and poor health. The GALI model demonstrated very good predictive capacity with an AUC of 0.758 (*AIC* = 4,917,783). The large absolute AIC values directly reflect the expected mathematical application of population-inflated cross-sectional weights, as the survey procedures scale the log-likelihood calculations to the weighted population size.

RESULTS

This section presents the empirical findings from the binary logistic regression models evaluating the determinants of subjective health status in the Czech working-age population. Two separate models were estimated: Model 1 focuses on the factors contributing to poor self-rated health (SRH), while Model 2 identifies the determinants of living with global activity limitations (GALI). The estimated Odds Ratios (*OR*) along with their 95% Confidence Intervals (*CI*) are systematically summarised in Table 4.

Table 4 Odds Ratios for poor SRH and for living with GALI in the working-age population, Czechia, 2022

Explanatory variable	Category	Model 1: Poor health (SHR) OR (95% CI)	Model 2: With limitations (GALI) OR (95% CI)
Sex	Men	1.00 (ref.)	1.00 (ref.)
	Women	0.77*** (0.65–0.90)	0.92 (0.80–1.07)
Age groups	16–24	1.00 (ref.)	1.00 (ref.)
	25–34	1.09 (0.63–1.90)	1.21 (0.78–1.88)
	35–44	2.15** (1.25–3.68)	1.85** (1.19–2.86)
	45–54	3.93*** (2.29–6.73)	3.12*** (2.02–4.82)
	55–64	8.71*** (5.03–15.07)	5.00*** (3.21–7.78)
Educational attainment	Primary and lower secondary (ISCED 0–2)	2.24** (1.58–3.17)	1.61** (1.18–2.18)
	Upper secondary without the school-leaving exam (ISCED 3 C)	1.83*** (1.46–2.29)	1.27* (1.05–1.54)
	Upper secondary with the school-leaving exam (ISCED 3 A)	1.41*** (1.15–1.75)	1.08 (0.91–1.30)
	Tertiary (ISCED 5–8)	1.00 (ref.)	1.00 (ref.)
Labour market status	Employed	1.00 (ref.)	1.00 (ref.)
	Unemployed	1.22 (0.81–1.85)	1.88** (1.28–2.75)
	Other inactive	2.17*** (1.74–2.69)	1.90*** (1.55–2.33)
	Students	0.33** (0.16–0.66)	0.56* (0.32–0.96)
Income quartile	1st quartile	2.21*** (1.62–3.00)	1.40* (1.08–1.83)
	2nd quartile	1.53*** (1.21–1.94)	1.31** (1.07–1.60)
	3rd quartile	1.36** (1.11–1.68)	1.14 (0.96–1.36)
	4th quartile	1.00 (ref.)	1.00 (ref.)

Table 4 (continued)

Explanatory variable	Category	Model 1: Poor health (SHR) OR (95% CI)	Model 2: With limitations (GALI) OR (95% CI)
Marital status	Married	1.00 (ref.)	1.00 (ref.)
	Single	1.20 (0.97–1.49)	0.98 (0.81–1.18)
	Divorced	1.50*** (1.23–1.84)	1.15 (0.96–1.37)
	Widowed	1.41 (0.95–2.11)	0.89 (0.61–1.32)
Parenthood	No	1.00 (ref.)	1.00 (ref.)
	Yes	0.86 (0.72–1.02)	0.76*** (0.65–0.88)
Feelings of loneliness	No	1.00 (ref.)	1.00 (ref.)
	Yes	1.58*** (1.32–1.89)	1.52*** (1.30–1.78)
Feelings of social exclusion	Agree	1.00 (ref.)	1.00 (ref.)
	Neither agree nor disagree	1.13 (0.76–1.68)	0.93 (0.64–1.35)
	Disagree	0.60** (0.43–0.84)	0.66* (0.48–0.91)
Frequency of contact with relatives	At least once a week	1.00 (ref.)	1.00 (ref.)
	Several times a month	1.06 (0.90–1.25)	0.94* (0.81–1.08)
	Less often or never	1.48* (1.09–2.01)	1.51** (1.16–1.97)
Frequency of contact with friends	At least once a week	1.00 (ref.)	1.00 (ref.)
	Several times a month	1.14 (0.97–1.35)	1.19* (1.03–1.38)
	Less often or never	2.10*** (1.56–2.83)	2.07*** (1.60–2.69)
Body Mass Index	Normal weight	1.00 (ref.)	1.00 (ref.)
	Underweight	1.47 (0.85–2.56)	1.61* (1.04–2.50)
	Overweight	1.11 (0.94–1.31)	1.17* (1.01–1.35)
	Obesity	2.09*** (1.72–2.53)	2.21*** (1.86–2.63)
Fruit consumption	Daily	1.00 (ref.)	1.00 (ref.)
	Several times a week	1.06 (0.82–1.37)	0.89 (0.72–1.10)
	Less often or never	1.15 (0.77–1.70)	0.97 (0.68–1.40)
Vegetable consumption	Daily	1.00 (ref.)	1.00 (ref.)
	Several times a week	0.89 (0.69–1.15)	1.07 (0.86–1.32)
	Less often or never	0.87 (0.57–1.31)	1.12 (0.77–1.64)
Smoking	Never or former smoker	1.00 (ref.)	1.00 (ref.)
	Daily	1.16 (0.98–1.38)	1.03 (0.88–1.20)
	Occasionally	0.85 (0.56–1.28)	1.21 (0.88–1.67)
Alcohol consumption	Abstinence	1.00 (ref.)	1.00 (ref.)
	Daily	0.65*** (0.51–0.83)	0.72** (0.58–0.90)
	Weekly or monthly	0.67*** (0.55–0.81)	0.68*** (0.57–0.80)
Physical activity	Several times a week	1.00 (ref.)	1.00 (ref.)
	Daily	0.87 (0.69–1.11)	1.16 (0.91–1.35)
	Less often or never	1.47*** (1.23–1.76)	1.32*** (1.13–1.53)

Note: *ref.* = reference category; * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$
Source: CZSO, EU-SILC 2022 ($N = 8{,}141$), author's calculations.

Regarding demographic characteristics, sex emerged as a significant predictor only for SRH. Holding all other variables constant, women exhibited significantly lower odds of reporting poor health compared to men (*OR* = 0.77; 95% *CI*: 0.65–0.90), whereas no statistically significant gender differences were observed for functional limitations (GALI). As expected, age demonstrated a strong, progressive gradient for both health outcomes. While the differences between the 16–24 and 25–34 age groups were not statistically significant, older groups showed a substantial increase in poor health. Respondents aged 55–64 displayed the highest risks, with more than eight times higher odds of poor SRH (*OR* = 8.71; 95% *CI*: 5.03–15.07) and five times higher odds of experiencing activity limitations (*OR* = 5.00; 95% *CI*: 3.21–7.78) compared to the youngest reference group.

Economic capital indicators revealed distinct socioeconomic gradients across both models. In terms of education, compared to the tertiary-educated reference group, individuals with primary and lower secondary education exhibited the highest odds of both poor SRH (*OR* = 2.24; 95% *CI*: 1.58–3.17) and GALI limitations (*OR* = 1.61; 95% *CI*: 1.18–2.18). A clear gradient was maintained for those with upper secondary education without the school-leaving exam, who also faced significantly elevated odds of poor health outcomes (SRH: *OR* = 1.83; 95% *CI*: 1.46–2.29; GALI: *OR* = 1.27; 95% *CI*: 1.05–1.54). For individuals with upper secondary education with the school-leaving exam, the risk remained significantly higher only for poor SRH (*OR* = 1.41; 95% *CI*: 1.15–1.75), whereas the association with GALI limitations did not reach statistical significance. Labour market status also played a critical role. Compared to employed individuals, the 'other inactive' group reported the highest risks for both poor SRH (*OR* = 2.17; 95% *CI*: 1.74–2.69) and limitations (*OR* = 1.90; 95% *CI*: 1.55–2.33). Unemployed individuals did not differ significantly from the employed regarding SRH but their odds of limitations were 88% higher (*OR* = 1.88; 95% *CI*: 1.28–2.75). Conversely, students enjoyed a substantial protective effect, showing much lower odds of both poor SRH (*OR* = 0.33; 95% *CI*: 0.16–0.66) and GALI limitations (*OR* = 0.56; 95% *CI*: 0.32–0.96). Finally, an income gradient was clearly visible, as individuals in the lowest income quartile had more than twice the odds of poor health (*OR* = 2.21; 95% *CI*: 1.62–3.00) and 40% higher odds of limitations (*OR* = 1.40; 95% *CI*: 1.08–1.83) compared to the highest income quartile.

Regarding demographic and family structures, the analysis revealed specific associations with health outcomes. Within marital status, only divorced individuals significantly differed from the married baseline, exhibiting 50% higher odds of poor SRH (*OR* = 1.50; 95% *CI*: 1.23–1.84). Parenthood displayed a significant association exclusively in the GALI model, where parents had lower odds of living with restrictions compared to non-parents (*OR* = 0.76; 95% *CI*: 0.65–0.88).

Subjective social indicators were strongly linked to health outcomes. Respondents experiencing loneliness had elevated odds of both poor SRH (*OR* = 1.58; 95% *CI*: 1.32–1.89) and limitations (*OR* = 1.52; 95% *CI*: 1.30–1.78). Similarly, those who disagreed with feeling socially excluded showed a significantly lower risk of poor health (SRH: *OR* = 0.60; 95% *CI*: 0.43–0.84; GALI: *OR* = 0.66; 95% *CI*: 0.48–0.91) compared to those who felt excluded. Regarding social interactions, individuals who met with relatives only several times a month, instead of weekly, had higher odds of poor health outcomes (SRH: *OR* = 1.48; GALI: *OR* = 1.51). A similar, more pronounced pattern emerged for peer networks: meeting friends only several times a month more than doubled the odds of both poor SRH (*OR* = 2.10; 95% *CI*: 1.56–2.83) and activity limitations (*OR* = 2.07; 95% *CI*: 1.60–2.69) compared to weekly contact.

Body Mass Index (BMI) showed that obesity more than doubled the odds of poor SRH (*OR* = 2.09; 95% *CI*: 1.72–2.53) and GALI limitations (*OR* = 2.21; 95% *CI*: 1.86–2.63) relative to normal weight. Being underweight was also associated with a higher risk of limitations (*OR* = 1.61; 95% *CI*: 1.04–2.50). Dietary habits (fruit and vegetable consumption) and smoking status did not yield statistically significant results in either model. Physical activity showed mixed results. Compared to the 'never' baseline, individuals engaging in physical exercise several times a week had higher odds of poor health outcomes (SRH: *OR* = 1.47; GALI: *OR* = 1.32). Finally, alcohol consumption revealed

a consistent pattern. Compared to abstainers, both daily drinkers (SRH: *OR* = 0.69; 95% *CI*: 0.51–0.83; GALI: *OR* = 0.72; 95% *CI*: 0.58–0.90) and weekly/monthly drinkers (SRH: *OR* = 0.67; 95% *CI*: 0.55–0.81; GALI: *OR* = 0.68; 95% *CI*: 0.57–0.80) exhibited significantly lower odds of reporting poor subjective health or activity limitations.

DISCUSSION

The findings of this study demonstrate that the determinants of activity limitations (GALI) largely mirror the structural trends observed in self-rated health (SRH) within the Czech working-age population. A compelling finding is that working-aged women in Czechia exhibit significantly lower odds of reporting poor health compared to men, while no significant gender differences emerged regarding functional limitations. This contrasts with well-established general population trends, where women typically report poorer subjective health than men despite their longer life expectancy, a phenomenon widely known as the gender health paradox (*Idler*, 2001). This deviation is likely due to the specific focus on the working-age population (ages 16–64). It is possible that the trend of poorer health perception among women primarily emerges in older age groups. In contrast, the age variable behaved in strict accordance with theoretical expectations, revealing a robust and progressive decline in both subjective health and functional capacity. This steep gradient clearly reflects the dual impact of biological ageing and the cumulative exposure to socioeconomic and occupational health risks throughout life and aligns seamlessly with international evidence (*Franz et al.*, 2017).

Economic capital proved to be a dominant structural predictor. The protective effect of education is clearly visible in both models, which can be attributed to differences in health literacy. Highly educated individuals generally possess a superior capacity to comprehend preventive care, adhere to medical recommendations, adopt protective lifestyle habits, and secure healthier work environments (*Dosedlová et al.*, 2016). While the elevated risks among the unemployed and inactive populations align with global research (*Kwon et al.*, 2020; *Vafaei et al.*, 2021), these findings should be interpreted in the light of the health selection effect (*Hoffmann et al.*, 2018). The 'other inactive' category represents a highly heterogeneous group comprising homemakers, caretakers, and individuals who are out of the labour market owing to severe or long-term health conditions. This suggests that the observed risks are heavily driven by health selection, where individuals with chronic illnesses or functional limitations face a higher likelihood of exiting the labour force. In these instances, poor health may operate as a primary driver of labour market exclusion rather than merely its consequence. In sharp contrast, students, analysed as a distinct category, enjoyed a substantial protective effect (*OR* = 0.3 for SRH; *OR* = 0.6 for GALI), highlighting the health advantages of younger populations who are still shielded from occupational stressors and cumulative labour market disadvantages. Finally, the persistent income gradient, where the lowest quartile faces more than double the odds of poor SRH, underscores that material deprivation remains a fundamental barrier to health maintenance.

Social capital emerged as a robust psychosocial protector against health decline. The protective role of parenthood against activity limitations (*OR* = 0.8) is consistent with Czech demographic literature emphasising the stabilising effect of family frameworks and the associated feelings of responsibility and purpose (*Hamplová*, 2014). Conversely, subjective social deficits severely undermine health. The strong association between feelings of loneliness and poor health outcomes matches evidence from other European contexts, such as Finland, where loneliness has been identified as a major source of chronic psychosocial stress that directly degrades subjective well-being and accelerates functional decline (*Pasanen et al.*, 2021). This may underscore the vital role of peer networks and active socialisation within the working-age population. Both models indicate that there is a particularly strong association between infrequent interactions with friends, several times a month compared to weekly, and elevated health risks (*OR* = 2.1 for both models). From a psychosocial perspective, regular contact with peers may involve higher levels of physical, emotional, and social activation, which could be crucial for sustaining an active lifestyle and mitigating activity limita-

tions. Engaging with friends might also provide unique emotional support and a sense of belonging, which can effectively buffer daily work-related or personal stressors, thereby protecting subjective well-being.

Regarding behavioural determinants, individual lifestyle patterns exhibited a strong association with both health outcomes. The severe health toll of obesity, which more than doubles the risk of poor SRH and activity limitations, remains a major determinant of subjective health status. Regarding physical activity, both models confirm that regular exercise is vital, operating through well-known physiological and psychological pathways. Physical activity is known to stimulate neurotransmitters such as serotonin and norepinephrine, which may explain its strong positive association with subjective vitality and functional resilience (*WHO*, 2022). The results demonstrate that a total lack of physical activity significantly deteriorates health outcomes. Physically inactive individuals face a 47% higher odds of poor SRH and 32% higher GALI restrictions compared to those who exercise regularly.

The lower likelihood of poor health outcomes observed among regular alcohol consumers compared to abstainers demands careful interpretation. In the specific cultural context of Czechia, regular or moderate alcohol consumption appears to be embedded in social rituals. It may serve as an indicator of higher social integration or, conversely, function as a widespread coping mechanism for stress, which might temporarily buffer subjective health deficits. However, these findings may be shaped by the 'sick quitter effect' (*Bloomfield et al.*, 2003). Individuals experiencing severe health decline or chronic conditions frequently transition to complete abstinence due to medication regimens or medical advice. Consequently, the seemingly elevated risk among abstainers could be driven by pre-existing illnesses within this reference group rather than a genuine health-promoting property of alcohol intake. Additionally, it is important to acknowledge contemporary shifting social norms regarding alcohol consumption, particularly among the younger cohorts of the working-age population, such as Generation Z. Recent literature documents a global trend of growing voluntary abstinence and declining alcohol consumption among youth, heavily driven by increased health consciousness, fitness optimization, and a focus on mental well-being (*Caluzzi et al.*, 2022; *Törrönen et al.*, 2019). In theory, the inclusion of these young, fundamentally healthy voluntary abstainers should improve the average health metrics of the non-drinking category. However, the fact that non-drinkers in Czechia still exhibit significantly higher odds of poor SRH and GALI limitations indicates that the 'sick quitter effect' and the negative impacts of social isolation among older working-age cohorts remain the dominant forces, effectively masking these emerging youth lifestyle trends in population-level data.

Limitations of the study

Several limitations must be considered when interpreting the findings of this study. First, the analysis relies strictly on cross-sectional data from the EU-SILC survey, which inherently precludes the establishment of temporal order or causal relationships between the studied determinants and health outcomes. Consequently, the observed associations may be subject to reverse causality, particularly regarding health selection effects in the labour market (where individuals with pre-existing conditions exit the workforce) and the 'sick quitter effect' in alcohol consumption patterns. Second, all measures of health status, social interactions, and lifestyle factors are based on self-reported questionnaire data, which may introduce self-report bias, social desirability bias, or systematic heterogeneity in reporting behaviour across different socioeconomic groups. Third, missing values for subjective variables, most notably the feelings of loneliness and social exclusion, which suffered from approximately 12.5% item non-response due to the prohibition of proxy interviews, were handled using the listwise deletion method. Although methodologically necessary to maintain model consistency, this approach reduced the analytical sample and could introduce bias if the missing data pattern deviates from being completely at random. Finally, due to the standardised design of the EU-SILC ad-hoc module, more detailed clinical data, history of chronic diseases, or precise dietary and lifestyle histories could not be comprehensively controlled for.

CONCLUSION

The analysis of health determinants among the Czech working-age population reveals that health outcomes and behaviours are deeply embedded in specific cultural norms, socioeconomic structures, and social contexts. The findings indicate that lifestyle factors, such as alcohol consumption, cannot be interpreted purely from a health perspective but must be considered in the context of Czech social rituals and potential methodological adjustments like the 'sick quitter' effect. Furthermore, the study highlights the critical structural and relational dimensions of health, demonstrating the pronounced impact of educational attainment, labour market status, and the substantial protective role of peer networks and parenthood in sustaining subjective well-being and mitigating daily activity limitations.

Currently, most professional and political attention is directed towards examining health in the ageing population. However, investigating the health status of individuals in their working-age years (16–64) is equally crucial, as this period represents a key life phase, when the behavioural patterns that fundamentally influence health in later adulthood and old age are formed. A deeper understanding of health determinants within this age group can serve as a foundation for targeted preventive measures and the promotion of a healthy lifestyle. Analysing the subjective health of the working-age population provides valuable insights into the links between lifestyle, socioeconomic factors, and health status, which can contribute to the development of preventive policies, support healthier ageing, and lead to an overall improvement in public health.

To further understand these dynamics, the next phase of my research will apply a comparative European perspective to identify how different political and historical contexts, institutional frameworks, healthcare systems, and social and cultural patterns influence health trajectories in the working-age population across Europe.

List of abbreviations:

BMI = Body Mass Index
ČSÚ = Czech Statistical Office
EU-SILC = European Union Statistics on Income and Living Conditions
ISCED = International Standard Classification of Education
OR = Odds Ratio
SRH = Self-Rated Health
GALI = Global Activity Limitation Indicator
WHO = World Health Organization

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