# Gender Equality Index 2020: Digitalisation and the future of work

## Disability and education significantly affect health and access to healthcare

Examination of the Gender Equality Index confirms that good health and healthcare are not enjoyed equally by all women and men. Age, education, migration status, family status and disability all intersect with gender to some extent and impact one of the main indicators of self-perceived health (Figure 23).

Recent evidence suggests that certain groups of LGBTI people may experience poorer health than other groups. For instance, 80 % of lesbian women and 84 % of gay men report good or very good health, on average, compared with only 64 % of trans people and 65 % of intersex people (and 79 % of LGBTI people on average) (FRA, 2020).

People with disabilities are clearly among the most disadvantaged groups. While only 20 % of women with disabilities report having good or very good health (compared with 23 % of men with disabilities), as many as 7 % of women and 6 % of men with disabilities have experienced an unmet need for medical care (compared with 4 % of women and 3 % of men among the total population).

Similarly, 7 % of women and 7 % of men with disabilities reported an unmet need for dental care in the EU on average. While the numbers experiencing unmet need are relatively low, there is significant variation across the Member States.

Women with low education have significantly poorer self-assessed health than men with low education or women with high education. These education-related inequalities increase with age: for the youngest (16–24 year olds), the gap between those with low education and those with high education is only 2 p.p. for women and 3 p.p. for men.

By time of retirement (aged 65–74), however, that difference grows to 24 p.p. between women with low education and those with high education and 19 p.p. between men with high education and those with low education[1].

In 2018, only 41 % of older women (aged 65–75) with low education reported having good or very good health, compared with 64 % of highly educated women. In addition to poorer health, those with low education were more likely to experience difficulties in accessing the health services they needed.

Cost was the main barrier to accessing health and dental services, with a very large share viewing them as too expensive[2]. There is a clear correlation between income and health: the higher the income, the better the health, regardless of age[3]. Women and men with disabilities and women with low education are all more likely than other groups of women and men to be out of the labour market or in precarious work (EIGE, 2018b) and therefore to have a low income.

Indeed, the data show that access to health services – especially dental care – was connected to employment status, as well as level of income: 9.9 % of unemployed men and 9.4 % of unemployed women reported an unmet need for dental care[4], with as many as 80 % of those people giving cost as the reason (81 % of men and 83 % of women who are unemployed and have an unmet need)[5].

In the lowest income quintile, 7 % of women and men reported an unmet need for dental examination, compared with only 2 % of the highest quintile in 2018[6]. Countries where health insurance provides at least some coverage for dental care services have a narrower margin of inequality in access to dental care (Palència et al., 2014).

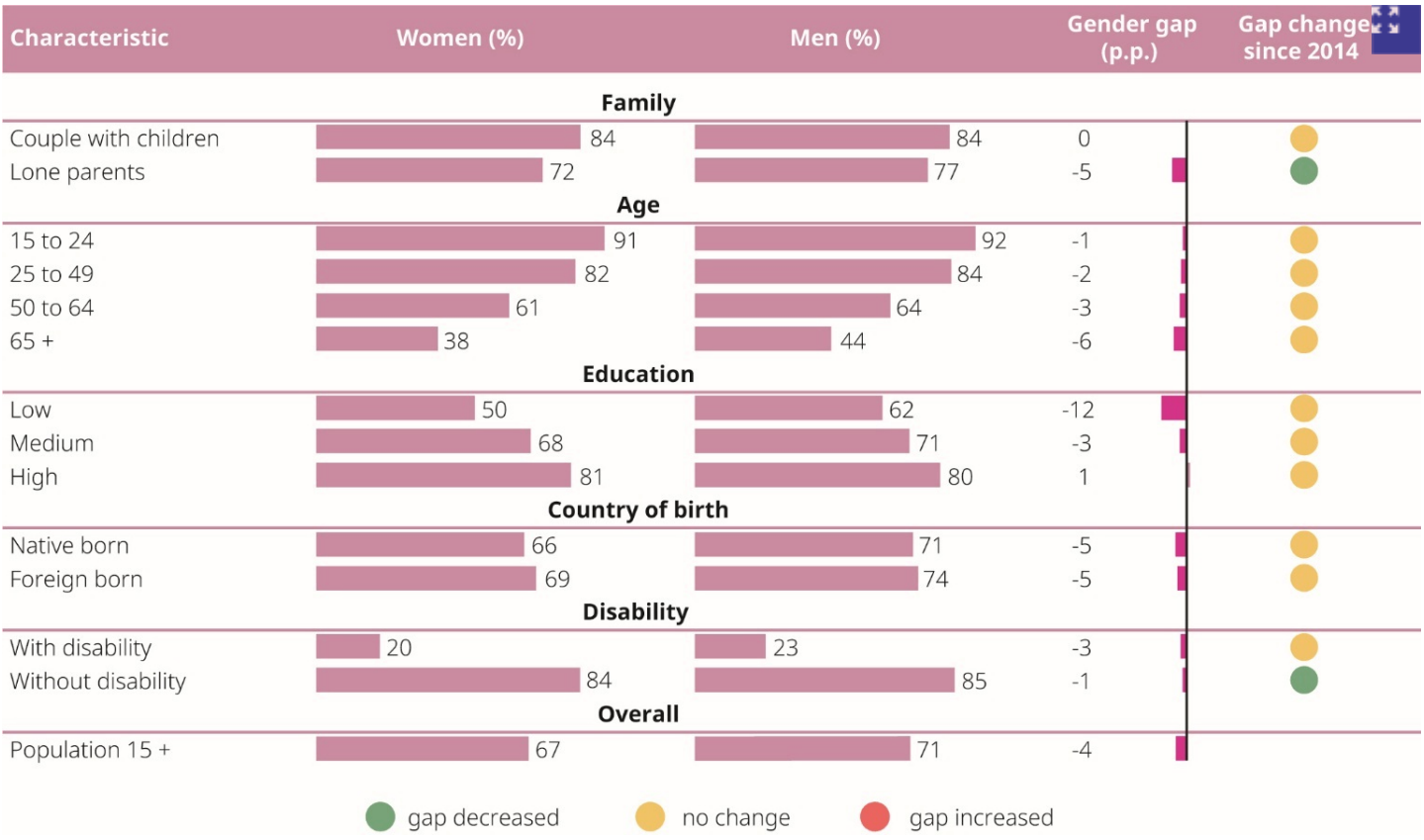


Figure 23. Self-perceived health by sex, family composition, age, education level, country of birth and disability, EU, 2018

The data highlight how different inequalities accumulate: poor health, low educational achievement, inactivity or unemployment, and low income go hand in hand, resulting in a situation where healthcare services are least accessible to those who are most in need. This, in turn, can have further detrimental consequences for health.

Gender differences in ill health are often due to differences in employment status, as employment is one of the main predictors of better health (Lahelma et al., 2001). Poor work and employment conditions – which are often concentrated among populations in vulnerable situations – can widen inequalities in health (Forster et al., 2018).

Overall, health and access to health services are connected to 'social status', which can be measured by level of education, occupation or income level (Forster et al., 2018).

The economic crisis and the strain on the health services created by the COVID-19 pandemic highlight the need to strengthen social and health protections for unemployed people and those with low incomes. Women with low education and women with disabilities fall into these categories particularly often and are thus at greater risk of remaining without proper healthcare, even while being among those most likely to suffer from poor health.

The 2008 recession made access to medical care more difficult, as a result of unemployment and financial hardship (Madureira-Lima et al., 2018).

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## Footnotes

[1] Eurostat hlth_silc_02).

[2] Eurostat hlth_silc_16).

[3] Eurostat hlth_silc_10).

[4] Eurostat hlth_silc_15).

[5] EIGE calculations based on Eurostat hlth_silc_15).

[6] Eurostat hlth_silc_09).

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