COVID-19 and persons with disabilities

Statistics on
health, care, isolation and networking

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Methodological note

1. Definition of persons with disabilities

In the present study, we use mainly the EU-SILC survey (EU Survey for Income and Living Conditions). It is important to discuss the definition of disability used in the framework of this survey.

The EU-SILC survey[1] reports activity limitations and is used as proxy of disability. The concept is operationalized by using the Global Activity Limitation Indicator (GALI) for observing limitation in activities people usually do because of one or more health problems.[2] The EHIS survey (European Health Interview Survey) uses a similar method.

The data on disability refer to self-evaluation by the respondents of the extent of which they are limited in activities people usually do, because of health problems, for at least the last 6 months. The answer distinguishes: strongly limited, limited and not limited. In the following, we use the general term disability in order to cover both "strongly limited" and "limited".

GALI is one of several ways of measuring disability. Eurostat notes that "GALI is closer to the EU policy target (participation restriction) and provides several other advantages" (for ex. it enables measuring disability with a single item instrument).[3] Also, GALI has an acceptable reliability.

For comparison, we may note that the UN Convention states that "persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others".

A possible improvement of the GALI question might be its extension, in order to take into account, the interaction with barriers. The questionnaire could be adapted as follows. If a person says that he has been "limited because of a health problem in activities people usually do", a question might ask:

Do you consider that a "reasonable accommodation" may eradicate/decrease: 1. All limitations; 2. Most limitations; 3. Certain limitations; 4. Some limitations; 5. None; 6. Don't know. Guidelines concerning the question ought to explain that reasonable accommodation might include technical aids, assistive technologies, eradication of architectural barriers, accessible communications and technologies, etc.

In specific surveys, focussing notably on employment and education, the reference to 'reasonable accommodation' might take more concrete forms. These might include recognised tools improving the accessibility of the workplace and/or the education

[1] Eurostat: "*Methodological Guidelines and Description of EU-SILC Target Variables 2018 operation (Version July 2019)*"; DocSILC065 (2018 operation). Eurostat Directorate F: Social Statistics Unit F-4: Quality of life; EUROPEAN COMMISSION.

[2] Health variables of EU-SILC in: https://ec.europa.eu/eurostat/cache/metadata/en/hlth_silc_01_esms.htm.

[3] European Commission – Eurostat: "Item 4.3: Global Activity Limitation Indicator (GALI) as a core variable"; Directorate F: Social statistics, DSS/2015/Sept/04.3. Meeting of the European directors of social statistics. Luxembourg, 15-17 September 2015.

system. Similarly, surveys on mobility might focus on architectural barriers and transport design.

The answer relies on a self-assessment. Self-assessment and personal judgement are often used by several surveys (for example concerning health status, affordability of health care services, functioning of governments, satisfaction with public services, etc.). The goal is not to have a scientific measure but rather an indicator for future research and action. This information could be combined with questions related to the nature of functional limitations.

Despite these observations, we may argue that the EU-SILC definition lies between the two major conceptual models of disability: the medical model which views disability as a feature of the person, directly caused by disease (disability requires medical care) and the social model of disability, which sees disability as a socially created problem and not at all an attribute of an individual (disability demands a political response to correct an unaccommodating physical or social environment).[4]

In the EU 27, in 2018, about 24.5 % of persons aged 16 and over declared a disability (activity limitation) (EU-SILC UDB 2018).

2. Household data and personal data

In a survey, a certain number of variables (income, education, employment, health, etc.) are measured at the personal level. The survey unit is the individual and all household members are interviewed. But other variables are measured at the household level, for example dwelling type, tenure status, etc. In this case, information will be collected from a single, appropriately designated respondent in each sample household. The household respondent is the person from whom household-level information is obtained.[5]

The information concerning health care or home care is collected usually at household level. Information concerning health, disability, education, employment, etc. is collected at the personal level. In the latter case, data enable us to compare persons with and without disabilities.

Data collected at the household level do not enable us to compare straightforward persons with and without disabilities. For example, the EU-SILC 2016 ad hoc module included a question on the “Use of health care services” (HC160), by the household.[6] The aim of this question is to collect information on whether members (any member, including former members) of the household used any healthcare services, during the last 12 months. This does not enable us to compare persons with and without disabilities.

In order to proxy persons with and without disabilities, we will focus on household respondents with and without disabilities. This is only an approximation. For this reason, we assess the validity of this instrument with alternative measures.

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4 WHO (2002) “Towards a Common Language for Functioning, Disability and Health: ICF”; World Health Organization, Geneva.

5 For further information, concerning the EU-SILC survey, the reader may consult op. cit. Eurostat: “Methodological Guidelines and Description of EU-SILC Target Variables 2018 operation (Version July 2019)”.

6 See full analysis below.

One alternative measure is to focus only on respondents living alone (one-person household). In this case, we can compare persons with and without disabilities. But this restricts dramatically the number of observations and one-person households are not a representative sample of the population. However, this group is interesting because, generally, it cumulates several disadvantages.

3. Persons in institutions

We use mainly the micro-data of the EU-SILC and EHIS surveys. Both cover persons living in private households. Persons living in collective households (institutions) are generally excluded from the target population. The reader ought to keep this in mind, notably when we discuss the needs and the use of services (health and care) by persons with disabilities.

However, we present an estimation of persons in institutions in order to enable the reader to have an overview of the number of persons with disabilities living in institutions.

4. Weighting

All estimations are weighted. The methodology is described in the EU-SILC Target Variables manual (op. cit.).

1 Health of persons with disabilities

Introduction

Before to analyse the use of health care services, it is useful to study the health status and the chronic conditions and diseases reported by persons with disabilities. This will enable us to assess the importance of needs and the nature of these needs.

Then, we analyse personal care needs. This will help us to analyse at a later stage the importance of care needs and the provision of professional home care.

Finally, we discuss the relation between health and the COVID-19 pandemic. The goal is to assess whether persons with disabilities share some characteristics which are considered to be factors associated with severe cases or deaths due to COVID-19.

The identification of these characteristics and underlying conditions aim to identify persons at risk, in order to inform health workers, policy makers and to promote the elaboration of targeted prevention policies.

1.1 General health of persons with disabilities

1.1.1 Self-perceived health

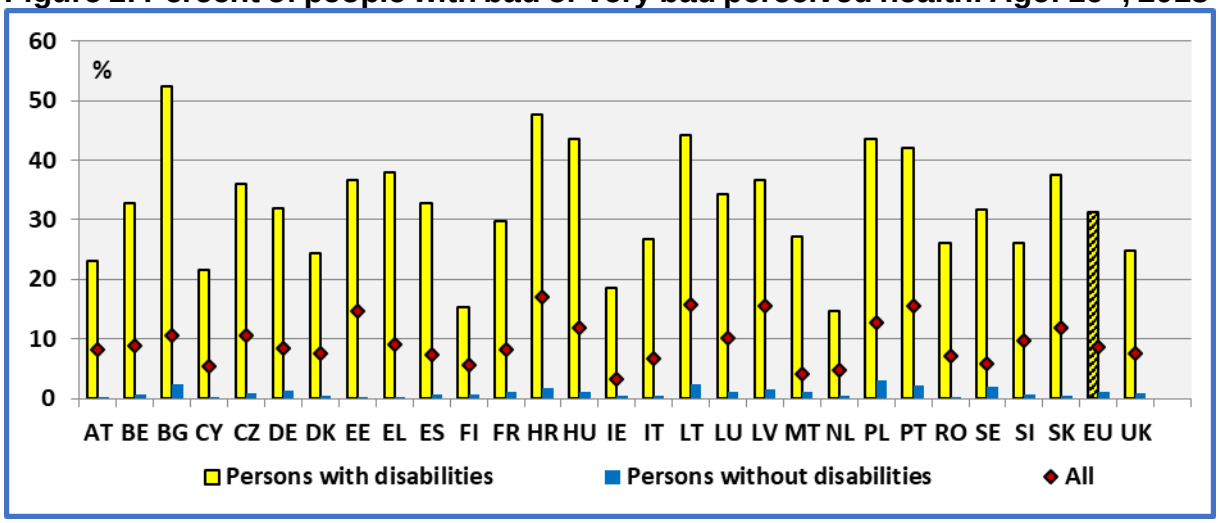
General health of the population is an important indicator for EU policy makers. This indicator focusses on the share of people with good or very good perceived health (% of population aged 16 or over). It is included, as a main indicator, in the Social Scoreboard for the European Pillar of Social Rights and is part of the EU Sustainable Development Goals (SDG) indicator set. It is used to monitor progress towards SDG 3 on good health and well-being.

Eurostat notes that the indicator is a subjective measure on how people judge their health in general on a scale from "very good" to "very bad". It is expressed as the share of the population aged 16 or over perceiving itself to be in "good" or "very good" health. The data stem from the EU Statistics on Income and Living Conditions (EU SILC). Indicators of perceived general health have been found to be a good predictor of people’s future health care use and mortality.

In the EU 27, in 2018, about 31.4 % of persons with disabilities, aged 16 and over, declare to be in bad or very bad health compared to 1.1 % of persons without disabilities. In fact, about 83.0 % of persons with disabilities declare suffer from a chronic (long-standing) illness or condition, compared to 17.2 % of persons without disabilities.

Health deteriorates with age, but this deterioration is more rapid for persons with disabilities, at least at younger ages.

Figure 1: Percent of people with bad or very bad perceived health. Age: 16+, 2018



Data source: EU-SILC UDB 2018 Release 2020, Version 1.

The Survey of Health, Ageing and Retirement in Europe (SHARE),[7] organised between June and August 2020, covering persons aged 50 and more, invited the interviewees to "compare their health with that before the outbreak of Corona". In the EU 25 countries covered, about 2.9 % declared an improvement, 9.1 % declared a worsening and 88.0 % about the same.

About 4.3 % of persons with an excellent health before the COVID-19 declared a worsening of their health but this rate was 28.2 % for those with a poor health (before).

1.1.2 Health conditions and diseases of persons with disabilities

The European Health Interview Survey (EHIS wave 2) includes a question asking: "during the past 12 months, have you had any of the following diseases or conditions?"

A. Asthma (allergic asthma included)
B. Chronic bronchitis, chronic obstructive pulmonary disease, emphysema
C. Myocardial infarction (heart attack) or chronic consequences of myocardial infarction
D. Coronary heart disease or angina pectoris
E. High blood pressure (hypertension)
F. Stroke (cerebral haemorrhage, cerebral thrombosis) or chronic consequences of stroke
G. Arthrosis (arthritis excluded)
H. Low back disorder or other chronic back defect
I. Neck disorder or other chronic neck defect
J. Diabetes
K. Allergy, such as rhinitis, hay fever, eye inflammation, dermatitis, food allergy or other allergy (allergic asthma excluded)
L. Cirrhosis of the liver
M. Urinary incontinence, problems in controlling the bladder

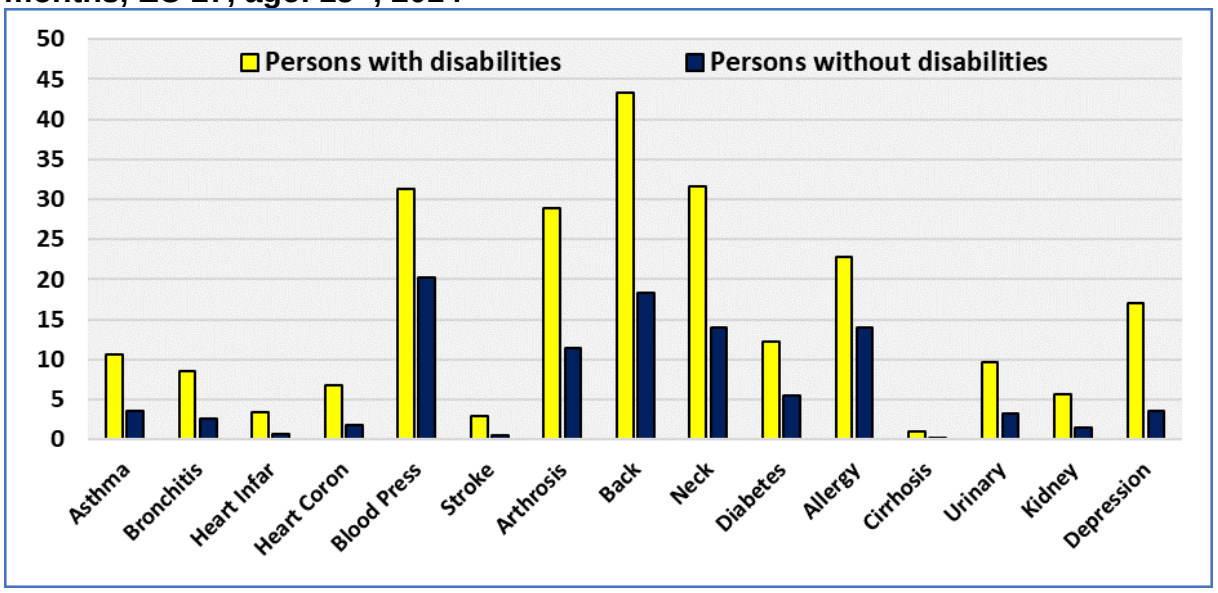
[7] Börsch-Supan, A. (2020). Survey of Health, Ageing and Retirement in Europe (SHARE) Wave 8. COVID-19 Survey 1. Release version: 0.0.1. beta. SHARE-ERIC. Data set. DOI:10.6103/SHARE.w8cabeta.001. Data collected between June and August 2020. The EU countries covered are: Germany, Sweden, Netherlands, Spain, Italy, France, Denmark, Greece, Belgium, Czech Republic, Poland, Luxembourg, , Hungary, Portugal, Slovenia, Estonia, Croatia, Lithuania, Bulgaria, Cyprus, Finland, Latvia, Malta, Romania and Slovakia.

N. Kidney problems
O. Depression

The respondent answers for each chronic disease. Consequently, the interviewee may report several chronic diseases or conditions.

In the EU 27, about 31.3 % of persons with disabilities report high blood pressure (hypertension), 31.6 % report a neck disorder and 43.4 % report a low back disorder. The corresponding rates for persons without disabilities are 20.2 % (blood pressure), 14.0 % (neck) and 18.3 % (back).

Figure 2: Per cent of persons reporting a disease or condition during the last 12 months, EU 27, age: 15+, 2014



**: A person may report several diseases/conditions. Age-standardised estimates.*

1.1.3 Difficulties in personal care activities

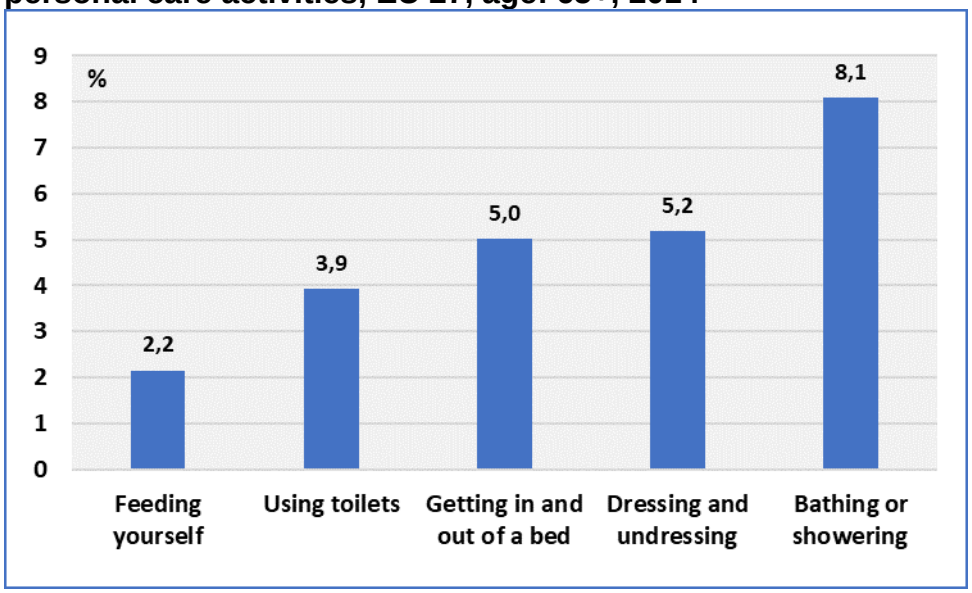
The EHIS W2 survey asks: “Do you usually have difficulty doing any of these activities without help?”. The question is addressed to persons aged 65 and over. The personal care activities included are:

- Feeding yourself
- Getting in and out of a bed or chair
- Dressing and undressing
- Using toilets
- Bathing or showering

Possible answers are 1. No difficulty, 2. Some difficulty, 3. A lot of difficulty and 4. Cannot do at all / Unable to do. We aggregate together answers 3 and 4.

The following figure presents the percentage of older people (aged 65 and over) who declare a lot of difficulty or being unable to do personal care activities. We can see that in the EU 27, among persons aged 65 and over, about 2.2 % have difficulties or are unable to feed themselves. This rate is 8.1 % for bathing or showering activities.

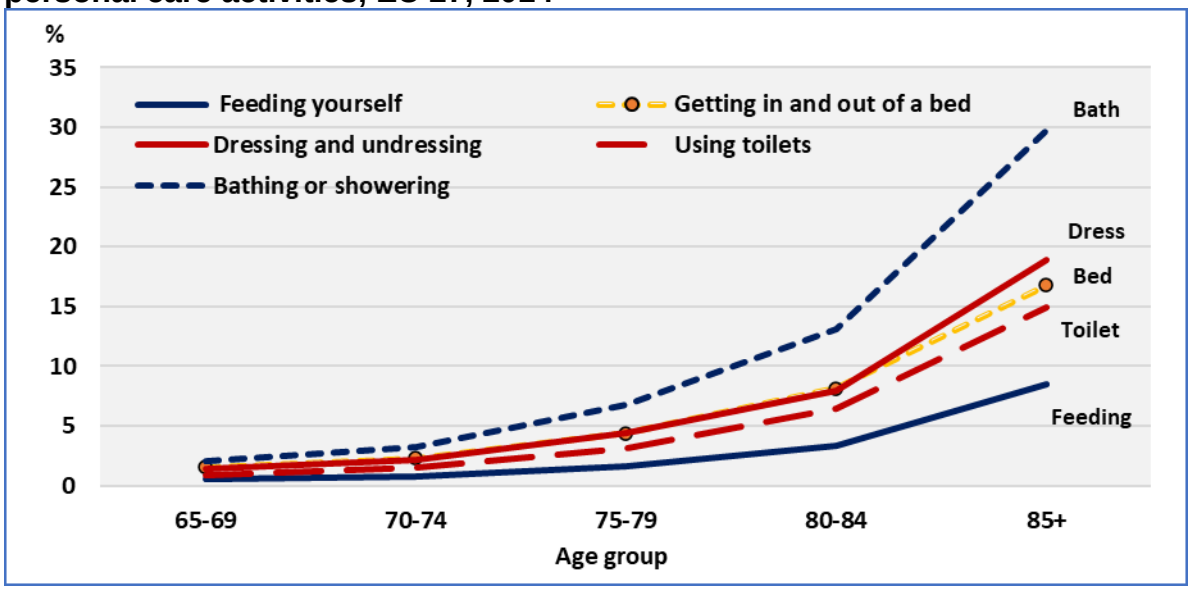
Figure 3: Percent of persons having lot of difficulty or being unable to do personal care activities, EU 27, age: 65+, 2014



**: A person may report difficulties in different activities.*

The percentage of persons aged 65 and over, with difficulties or inability to do personal care activities increases with age. This rate is close to 1 % for persons aged 65-69. But after the age of 80-84, there is a rapid increase. For example, concerning persons aged 85 and over, the percentage who have difficulties or are unable to bath or shower is 30 %.

Figure 4: Percent of persons having lot of difficulty or being unable to do personal care activities, EU 27, 2014



**: A person may report difficulties in different activities.*

1.2 COVID-19, risk factors and disability

1.2.1 Comorbidities and disability

ECDC provides a detailed presentation of COVID-19 epidemiology in the EU/EEA and the UK.[8] The data covers all persons and do not distinguish by disability status. Taking into account the total of severe and fatal cases, the five (5) most important cases (in % of total severe/fatal cases) are: Cardiac disorder, diabetes, cancer, hypertension and chronic lung disease (excluding asthma).

On the other hand, the EHIS survey presents the percentage of persons who suffered, in the last 12 months, the specified disease/condition, in the EU (extended to include Iceland and Norway). We may observe that persons with disabilities report more often than other persons cardiac disorders, diabetes and chronic lung diseases. Persons with disabilities report more often diseases/conditions which are associated with high shares of severe hospitalisations and deaths due to COVID-19.

The following table presents these results.

Table 1: COVID-19 risk groups and diseases/conditions reported by persons aged 15+

Precondition (Diseases/Conditions)	**Distribution of severe hospitalisations & deaths by disease/condition Covers: EU28/EEA Report Week 51, 2020**		**Percent of persons who suffered, in the last 12 months, the specified disease/condition* Covers: EU28+IS+NO (EHIS W2) 2014**		
		Excludes cases declaring None (No disease)	**Total**	**Persons without disabilities**	**Persons with disabilities**
	%	**%**	**%**	**%**	**%**
None	27.1	-	-	-	-
Cardiac disorder	24.2	33.2	**3.8**	1.9	5.5
Diabetes	17.5	24.0	**5.3**	4.7	5.9
Hypertension	5.6	7.7	**16.2**	17.5	15.0
Chronic lung disease	5.5	7.5	**3.1**	2.3	3.9
Kidney-related condition, renal	3.2	4.4	**2.0**	1.4	2.5
Cancer, malignancy	9.7	13.4			
Neuromuscular, neurological	3.1	4.3	***6.5**	*4.6	*8.1
Asthma	1.7	2.4	**4.5**	4.9	4.1
Other	2.2	3.1	**(-)**	(-)	(-)
Total	**100**	**100**	**100***	**100***	**100***
(Number (sample for EHIS survey))	(65 450)	(47 684)	(298 095)	(206 980)	(91 115)

**: A person may report several diseases/conditions. Depression was treated as a neurological disease. The EHIS W2 survey covers persons aged 15+, living in private households.*

[8] ECDC: "*COVID-19 surveillance report"*, Week 51, 2020. Op. cit.

Source: ECDC (COVID-19 surveillance report, Week 51, 2020) and EHIS W2 2013-2015.

In Belgium, Sciensano notes that in a recent meta-analysis (10 articles, 76 993 patients overall), the most prevalent underlying diseases/conditions found among hospitalised COVID-19 patients were hypertension, cardiovascular diseases, diabetes mellitus, smoking, chronic obstructive pulmonary disease (COPD), malignancy, and chronic kidney disease.[9]

In France, comorbidities were reported in the case of 7 678 deaths. This represents 66 % of all deaths indicating COVID-19 during the period March-September 2020 and for which information was available. A cardiac disease was indicated in 34 % of deaths and hypertension for 24 %. Diabetes (16 %), chronic lung disease (13 %) and kidney disease (12 %) were important too.[10]

In the USA, CDC notes that people of any age with the following conditions are at increased risk of severe illness from COVID-19: cancer, chronic kidney disease, COPD (chronic obstructive pulmonary disease), immunocompromised state (weakened immune system), obesity (body mass index [BMI] of 30 or higher), serious heart conditions and type 2 diabetes mellitus.[11] Furthermore, from January 2020 to May 2020, among patients with a chronic illness, about 20 % died compared with almost 2 % of those who were otherwise healthy. Virus patients with a chronic condition were also more likely to be hospitalised.[12]

The above studies converge towards the same conclusions. cardiac disorder, diabetes, hypertension,[13] chronic lung disease and kidney-related condition / renal disease appear to be important risk factors.

The graph above (see Health conditions and diseases of persons with disabilities) indicated that persons with disabilities face a higher risk of comorbidities and that for important health conditions, they are overrepresented in these diseases/conditions. This means that persons with disabilities face a higher risk in relation to COVID-19 compared to persons without disabilities.

Obesity has often been noted. For example, in France, among those who were admitted in reanimation services, between 05 October to 15 December 2020, 45 % suffered from obesity (Body Mass Index - BMI>=30).[14] We may note that the share of

[9] Sciensano (2020), Fact Sheet: COVID-19 disease (SARS-CoV-2 virus); 21 September 2020, Version 6, https://covid-19.sciensano.be/sites/default/files/Covid19/COVID-19_fact_sheet_ENG.pdf.

[10] Santé publique France ; COVID-19 : Point épidémiologique hebdomadaire du 17 septembre 2020; https://www.santepubliquefrance.fr/content/download/281989/document_file/COVID19_PE_20200917.pdf.

[11] CDC: "People with Certain Medical Conditions", Updated 11 September 2020 https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html.

[12] Lindsey Tanner: "*Coronavirus Death Rate is Higher for Those with Chronic Illnesses*" https://www.jems.com/2020/06/16/coronavirus-death-rate-is-higher-for-those-with-chronic-illnesses/.

[13] However, high rates concerning hypertension ought to be treated with care because a high number of persons report this health condition and it is expected to find high rates also among persons reporting COVID-19.

[14] Santé publique France. COVID-19 : Point épidémiologique hebdomadaire du 17 décembre 2020. https://www.santepubliquefrance.fr/maladies-et-traumatismes/maladies-et-infections-respiratoires/infection-a-coronavirus/documents/bulletin-national/covid-19-point-epidemiologique-du-17-decembre-2020.

obese people is 24.1 % among persons with disabilities, aged 20 and over, compared to 13.2 % among persons without disabilities of the same age group.[15]

The Survey of Health, Ageing and Retirement in Europe (SHARE) organised between June and August 2020, covering persons aged 50 and more, indicates that, in the EU 25 countries covered, about 28.7 % of those who were depressed, declared a deterioration since the outbreak of the pandemic.

French data indicate a continuous deterioration of mental health since the rise of COVID-19 pandemic. The prevalence rate almost doubled, between end September and end November 2020. This increase was important among young persons and persons at risk of financial poverty.[16]

The list of underlying conditions is meant to inform health professionals to target groups at high risk and provide them with the best care possible, and to inform health policy makers in order to elaborate actions about illness prevention. The definition of priority groups during a vaccination policy might be one example.

1.2.2 Age

As noted above, older people face a higher risk of experiencing severe hospitalisations or dying from COVID-19. The risk of hospitalisation and death increases sharply with age.[17]

In Belgium, older age has been repeatedly identified as the most important risk factor for severe COVID-19 disease.[18]

In France, on 13 September 2020, among the 116 420 patients hospitalised since 1 March 2020, the average age was 71 years. In the same period, 30 999 deaths due to COVID were reported to the French Public Health (Santé Publique France). The average age of dead persons was 84 years and 90 % were older than 65 years.[19] Similar results were reported later (Report 17 December 2020).

[15] EHIS Wave 2 2013-2015.

[16] Santé publique France. COVID-19 : Point épidémiologique hebdomadaire du 17 décembre 2020. https://www.santepubliquefrance.fr/maladies-et-traumatismes/maladies-et-infections-respiratoires/infection-a-coronavirus/documents/bulletin-national/covid-19-point-epidemiologique-du-17-decembre-2020.

[17] ECDC: "*COVID-19 surveillance report"*, Week 51, 2020; This report provides an overview of the COVID-19 epidemiology in the EU/EEA and the UK using the available data compiled from multiple sources. European Centre for Disease Prevention and Control (ECDC): https://www.ecdc.europa.eu/en/covid-19/surveillance/weekly-surveillance-report.

[18] Sciensano: https://covid-19.sciensano.be/sites/default/files/Covid19/COVID-19_fact_sheet_ENG.pdf.

[19] 1. Santé publique France; COVID-19: Point épidémiologique hebdomadaire du 17 septembre 2020; https://www.santepubliquefrance.fr/content/download/281989/document_file/COVID19_PE_20200917.pdf.
2. Anaïs Thiébaux, 18/09/20: https://sante.journaldesfemmes.fr/fiches-maladies/2622115-victimes-coronavirus-covid-france-age-deces-hospitalisation-reanimation-mortalite-departement-homme-femme-chiffres-jeunes/#coronavirus-maladie-comorbidite-facteur-risque.

A survey by ECDC indicated that countries that had already published recommendations had primarily prioritised (population with higher risk) older people, healthcare workers and those persons with certain comorbidities.[20]

Analysis by age indicates that persons with disabilities represent a high share among older people.

1.2.3 People in institutions

Data concerning people in institutions are scarce. In fact, surveys often cover persons living in private households. Also, published census data do not distinguish the different types of institutions.

A relatively old study, based on fifteen Member States and end 1990 data, arrived at the conclusion that, in the age group 16-64, a maximum of 1 % of the population are disabled living in institutions for dependent people. Also, in the age group, 65 and over, about 6 % to 7 % of the population live in institutions but about 80 % are disabled. So about 5 % of the population aged 65+ are disabled living in institutions (including homes for elderly people).

Since this estimation, EU became 27 and a policy of de-institutionalisation took place, in the recent years.

Eurostat published the results of the 2011 census which took place in the Member States.[21] Eurostat presents the population by housing arrangement and notably persons in 'Collective living quarters'. These are premises which are designed for habitation by large groups of individuals or several households and which are used as the usual residence of at least one person at the time of the census.

We can summarise the results, for EU 28, as follows:

1. Age <15: 0.3 % (EU 28) of the population aged less than 15 live in collective living quarters This includes different institutions including, hospital care and pupil residents.
2. Age 15-64: 1.0 % (0.9 % for EU 27) of the population live in collective living quarters. But this includes military, monasteries, prisons, etc.
3. Age 65+: 3.3 % (EU 28) of the population live in collective living quarters. This includes penal institutions and religious institutions.

Data published by DREES, in 2015, provide the following rates for France.[22] For the age group of persons aged less than 65, about 0.3 % of the population, of the same age group, are disabled people living in institutions. The census gives 1.4 % persons living in collective quarters, but this includes penal institutions, military institutions, student residents, monks, etc. In the age group 65 and over, about 4.7 % of the population, aged 65 and over, are disabled people living in institutions. The census gives 5.8 % of the population living in collective quarters. The ratio (4.7 %/5.8 %) is

[20] European Centre for Disease Prevention and Control. Overview of COVID-19 vaccination strategies and vaccine deployment plans in the EU/EEA and the UK – 2 December 2020. ECDC: Stockholm; 2020.

[21] Eurostat: https://ec.europa.eu/eurostat/databrowser/view/cens_11hou_r2/default/table?lang=en

[22] Etudes et Résultats, Juillet 2017, Direction de la Recherche, des Etudes, de l'Evaluation et des Statistiques (DREES) ; Ministère des solidarités et de la santé, France).

80 %. A similar percentage was advanced by the above noted study for the EU 15, in the late 90s.
Without any further information, we consider that we can take 50% of 0.3 % (age: <15) and 50 % of 1 % (age: 15-64) as disabled.

1. Age <15: 50 % of those living in collective quarters are disabled people. This means that about 0.15 % of the population aged <15 is disabled living in institutions.
2. Age 15-64: 50 % of those living in collective quarters are disabled people. This means that about 0.5 % of the population aged 16-64 are disabled persons living in institutions.
3. Age 65+: 80 % of those living in collective quarters are disabled people. This means that 2.6 % of the population aged 65+ are disabled living in institutions.

Two main problems arise from the above choices. They concern the age group of persons aged 15-64. The first relates to residents in military establishments. Their number might be important in certain Member States. The second relates to young persons in health care establishments. In this case, the share of residents with health problems but temporary disabilities might be important. Both biases will tend to overestimate our results. Consequently, we will adopt two scenarios below for this age group: an average scenario (0.45%) and a low scenario (0.35%).[23]

If we apply the above rates, in the total EU 27 population, about 0.8 % are persons with disabilities living in institutions. If we focus on persons aged 15 and over, about 1 % of the population are disabled people living in institutions.

There are important differences across Member States. This depends mainly on the availability of infrastructures (buildings) and policies concerning de-institutionalisation.

The ageing of the population is expected to increase sharply the absolute number of older people in institutions, if there is no policy change.

Table 2: Persons with disabilities living in institutions

Age	0-14	15-64	65+	Total
Total population (EU 27, 2018)				
Number (1 000)	67 944	289 233	89 032	446 209
Persons with disabilities living in institutions (Average scenario)				
%	0.15	0.45	2.6	0.8
Number (1 000)	102	1 302	2 315	3 718
Persons with disabilities living in institutions (Low scenario)				
%	0.15	0.35	2.6	0.8
Number (1 000)	102	1 012	2 315	3 429

Note: The data exclude day centres.
Source of data: Total population is extracted from Eurostat website.

[23] See DREES, Op. Cit. and 2011 Census in England and Wales (http://www.ons.gov.uk/ons/guide-method/census/2011/census-data/2011-census-prospectus/new-developments-for-2011-census-results/statistical-disclosure-control/index.html) on the ONS website.

The information concerning health and disability of persons with disabilities in institutions relies mainly on national administrative data.

Concerning elderly residents of long-term care facilities and nursing homes, the European Centre for Disease Prevention and Control indicated that a high proportion of long-term care facilities (LTCF) and nursing homes across Europe and the world had been severely affected by COVID-19. They reported a high morbidity and mortality in residents due to SARS-CoV-2 infections. The ECDC noted that in several EU countries, deaths among residents had accounted for over half of all COVID-19-related deaths.[24]

In France, from March 2020 to September 2020, 30 999 deaths due to COVID-19 were reported to the French Public Health: 20 471 deaths took place during a hospitalisation and 10 528 deaths were reported among residents in institutions. In institutions, the big majority (10 443) concerned deaths in EHPA (établissements d'hébergement pour personnes âgées) but a certain number (74) included also persons in HPH (Hébergement pour personnes handicapées).[25]

Persons in institutions include an important number of persons with disabilities. This means that persons with disabilities in institutions constitute a group which needs special attention concerning prevention measures.

1.3 Summary and conclusions

1. General health

Self-perceived general health is a good predictor of people's future health care use and mortality. In the EU 27, about 83.0 % of persons with disabilities declare suffer from a chronic (long-standing) illness or condition, compared to 17.2 % of persons without disabilities. The diseases/conditions most often reported by persons with disabilities are high blood pressure (hypertension), neck disorder and a low back disorder.

Among persons aged 50+, about 9.1 % declared a worsening of their health following the COVID-19 pandemic, between June-August 2020, but the rate was 28.2 % for persons in poor health. Also, persons with mental health problems reported a deterioration.

In the EU 27, about 31.3 % of persons with disabilities, aged 15 and over, report high blood pressure (hypertension), 31.6 % report a neck disorder and 43.4 % report a low back disorder. The corresponding rates for persons without disabilities are 20.2 % (blood pressure), 14.0 % (neck) and 18.3 % (back).

In the EU 27, among persons aged 65 and over, about 2.2 % have difficulties or are unable to feed themselves, 3.9 % to use toilets, 5.0 % get in/out of bed, 5.2 % dressing and 8.1 % to take a bath/shower.

[24] ECDC (2020), Epidemiology of COVID-19; update 15 July 2020. https://www.ecdc.europa.eu/en/covid-19/latest-evidence/epidemiology.

[25] Santé publique France ; COVID-19 : Point épidémiologique hebdomadaire du 17 septembre 2020 ; https://www.santepubliquefrance.fr/content/download/281989/document_file/COVID19_PE_20200917.pdf.

2. COVID-19, risk factors and disability

Severe hospitalisations and death rates are higher for coronavirus patients with chronic illnesses than for others who become infected. Persons with disabilities are overrepresented in the majority of diseases/conditions associated with high rates of severe hospitalisations and deaths due to COVID-19 (cardiac disorder, diabetes, chronic lung diseases and kidney-related condition / renal disease; also, obesity). This means that persons with disabilities face a higher risk in relation to COVID-19 compared to persons without disabilities.

Older people face a higher risk of experiencing severe hospitalisations or dying from COVID-19. The ECDC noted that in several EU countries, deaths among residents in institutions had accounted for over half of all COVID-19-related deaths.

COVID-19 may become a chronic illness and generate long lasting health effects. Persistent health problems were reported following acute COVID-19 disease including respiratory symptoms and conditions, cardiovascular symptoms & disease, mental health, fatigue, liver & kidney dysfunction, etc.[26] These chronic illnesses might lead to activity limitations and disabilities.[27]

Furthermore, an economic deterioration resulting from the pandemic might affect adversely living conditions and health. Poverty and unemployment might affect morbidity and chronic illness notably through direct effects (it might increase stress), income effects(malnutrition and unmet medical needs), education and lifestyle effects (risky behaviours) and social capital (isolation and reduction of external resources). This indirect channel might increase disability prevalence with a lag of about two years.

[26] Public Health England: "*Guidance COVID-19: long-term health effects*"; Published 7 September 2020. https://www.gov.uk/government/publications/covid-19-long-term-health-effects/covid-19-long-term-health-effects.

[27] Lisa Du: "*Prognosis, Virus Survivors Could Suffer Severe Health Effects for Years*"; 12 mai 2020 https://www.bloomberg.com/news/articles/2020-05-12/covid-19-s-health-effects-can-last-long-after-virus-is-gone.

2 Access to health and home care

Social distancing is an important prevention measure but once a person has symptoms of coronavirus, (s)he ought to be able use the relevant health services. Some people with disabilities might be at a higher risk of infection or severe illness because of their underlying medical conditions (CDC). Consequently, we propose to analyse indicators concerning access and use of health care services. We study the following indicators:

2.1 Use of health care services
2.2 Affordability of health care services (for those who use health care services)
2.3 Unmet medical needs
2.4 Professional home care
2.5 The cost of professional home care ((for those who use home care services)
2.6 Unmet needs for professional home care
2.7 Access to health and home care and the COVID-19 pandemic

The analysis involves cross-tabulations with socio-economic characteristics such as age, gender, degree of disability, education level, income, etc.

The relation with mental health is analysed whenever this is possible by the availability of the data.

The relation between needs, use and unmet needs with social distancing and COVID-19 is done whenever this is relevant.

Difficulty to afford health and home care services appears in several cases. Economic constraints and the economic implications of COVID-19 are discussed.

2.1 Use of health care services

Introduction

The EU-SILC 2016 ad hoc module included a question on the “Use of health care services” (HC160), by the household. The aim of this variable is to collect information on whether members (any member, including former members) of the household used any healthcare services, during the last 12 months.

Healthcare services include all services with the primary purpose of improving, maintaining and preventing the deterioration of the health status of persons and mitigating the consequences of ill-health.

In the following discussion, we have to keep in mind that the household respondent reports whether any member of the household used any healthcare services during last 12 months. However, in our analysis, we focus on persons with and without disabilities. This is not possible here as the indicator covers the household.

In order to proxy persons with and without disabilities, we will focus on household respondents with and without disabilities. We might use household respondents living alone (one-person household) but this restricts dramatically the number of observations and one-person households are not a representative sample of the population.

Another possibility is to assign to all household members the value reported by the household respondent, as is done for other household variables (dwelling type, etc.). However, health care is not a service which can be consumed by all household members as is the case of a house. Furthermore, an important part of our analysis focusses on age, unmet needs, etc. and this raises the issue of whether a person can assess the needs of other household members, notably if these needs are fully met, etc. This raises issues which are not covered in the present report.

In order to avoid any bias in our analysis, we present alternative estimation methods and report any significant and systematic differences between these methods.

If we focus on persons living in one-person households, there is no difference between estimations covering household respondents or all persons in the sample. The household respondent is the only household member.

2.1.1 Use of health care services by Member State

In the EU 27, about 89.9 % of household respondents with disabilities report that their household used health care services, during the last 12 months, compared to 80.6 % of respondents without disabilities.[28]

In the following, we will focus on household respondents but if there is an important difference with alternative measures, we will report it.

The data indicate that the percentage of household respondents with disabilities using health care services is higher compared to household respondents without disabilities. But, if the household respondent does not report a disability, we may not exclude that, other persons of the household, do not have a disability.

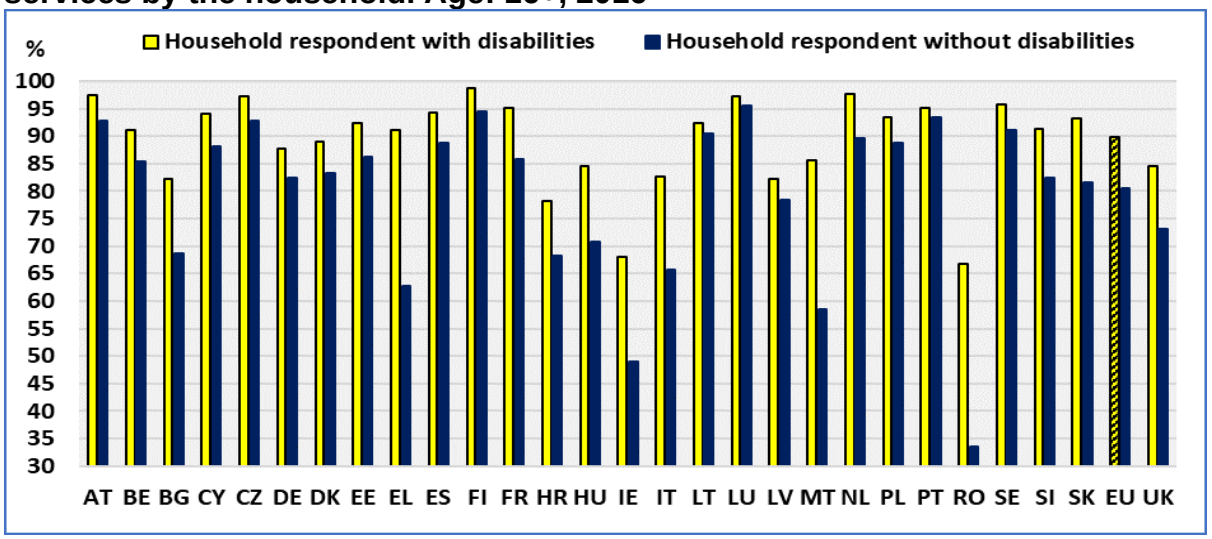
Concerning household respondents with disabilities, Romania, Ireland and Croatia report the lowest rates, while Austria, Netherland and Finland present the highest.

The relative difference[29] between persons with and without disabilities is high in Romania, Malta and Greece.

[28] For comparison, if we take all persons in the sample, where all household members receive the same value declared by the household respondent, we have the following results: in the EU 27, about 90.4 % of household respondents with disabilities report that their household used health care services, compared to 81.6 % of respondents without disabilities. The estimations are presented in the Annex – Statistical tables.

[29] Relative difference=100 x (% Household respondents with disabilities - % Household respondents without disabilities / % Household respondent without disabilities).

Figure 5: Percent of household respondents reporting use of health care services by the household. Age: 16+, 2016



Data source: EU-SILC UDB 2016– version 20 March 2018.

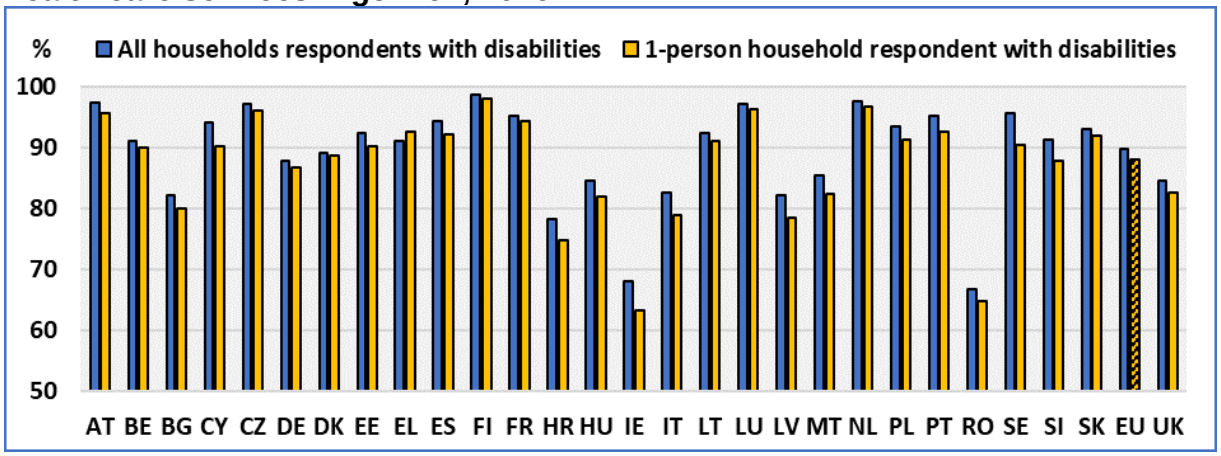
As noted, in the previous figure, the household respondent reports the use of health care services by all household members. In the following, we focus only on one-person households. This will help us to assess the value of the different indicators used to compare persons with and without disabilities.

Concerning persons living in one-person household, about 87.9 % of persons with disabilities use health care services, compared to 72.1 % of persons without disabilities, in the EU. This higher rate may be explained by the fact that persons with disabilities declare more often bad or very bad health. Consequently, they might use more often health care services.

Whether we retain all household respondents or one-person household respondents, the results are strongly correlated. As expected, persons with disabilities uses more often health care services.

In the following, each time we face a small sample for our analysis, we will use the answers of all household respondents with disabilities as a proxy for persons with disabilities.

Figure 6: Percent of household respondents with disabilities reporting use of health care services. Age: 16+, 2016



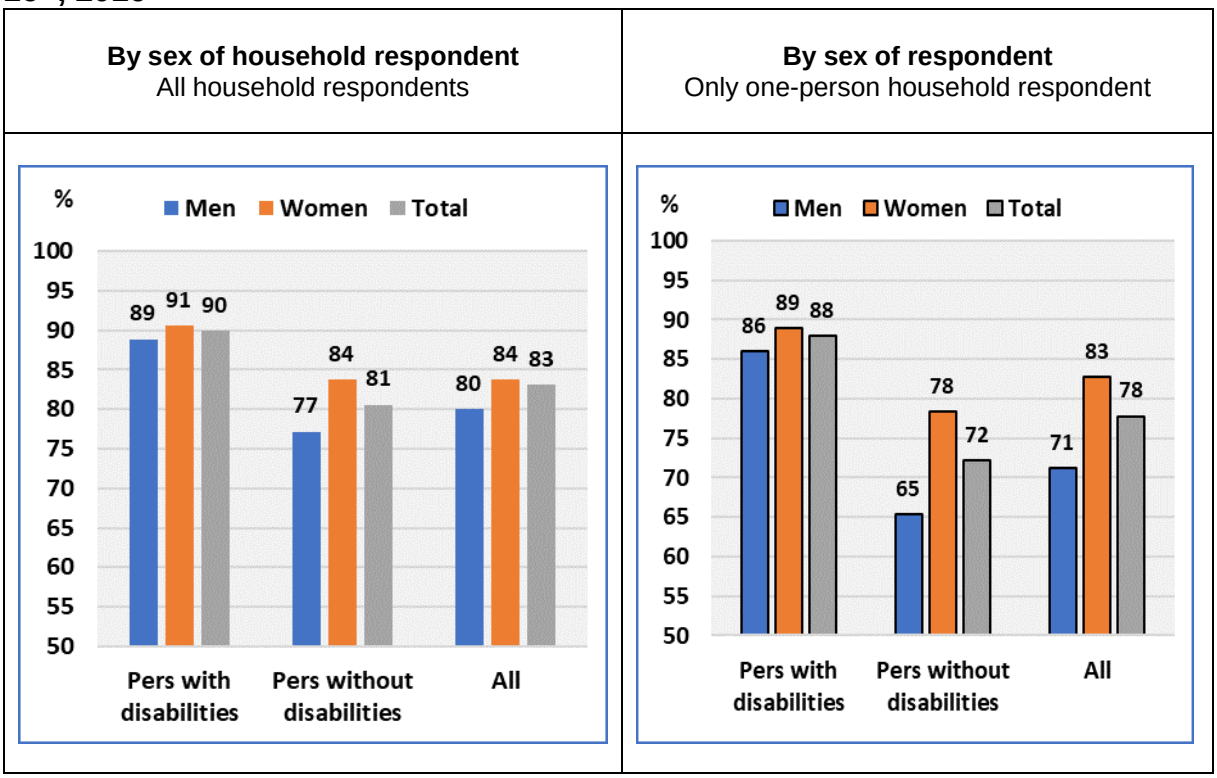
Note: The correlation coefficient is R^2=0.98.
Data source: EU-SILC UDB 2016– version 20 March 2018.

2.1.2 Characteristics by gender

The household respondent reports whether any member of the household used any healthcare services during last 12 months. Consequently, it covers all member of the household. The comparison by gender is not possible, except for one-person households. For this reason, we compare below, all household respondents and one-person household respondent.

Concerning all household respondents, in the following figure, we observe a difference between disabled men (89 %) and disabled women (91 %). For comparison, if we take all persons with disabilities in the sample, the rates are 90 % for men and 91 % for women. But the higher rate of women household respondents might be due to the different age structure between men and women. There are more older women in the sample, given that life expectancy of women is longer compared to men. As we indicate below, the use of health care services is increasing with age.
Concerning one-person household, we find again that the percentage of women with disabilities is higher compared to men.

Figure 7: Percent of persons reporting use of health care services. EU 27, Age: 16+, 2016



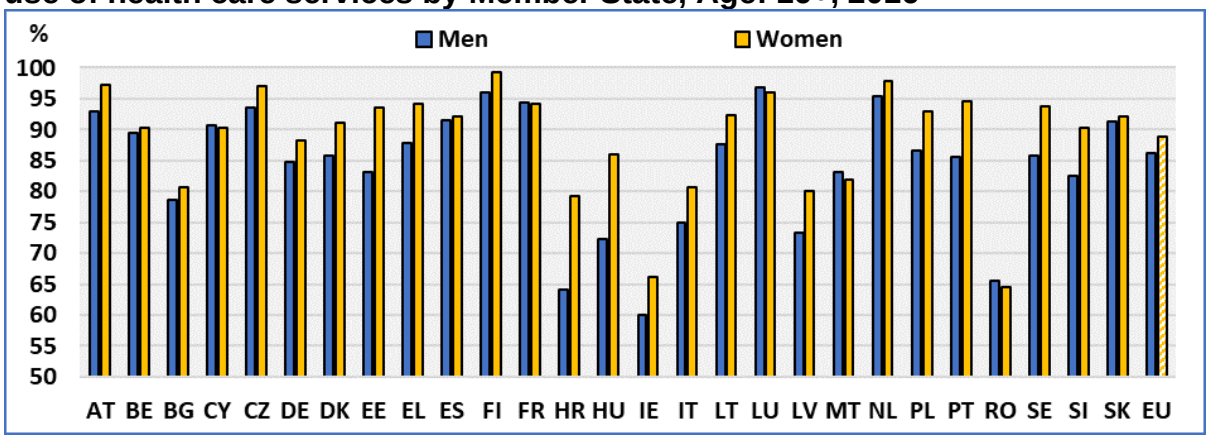
Data source: EU-SILC UDB 2016– version 20 March 2018.

As indicated above, the question refers to the use of health care services by any household member. Consequently, the results presented above, by gender, provide only an approximation of the situation at the EU level.

In order to avoid the above bias, we will analyse gender differences by focussing on one person household. In this case, we know that the health care user is the respondent himself and not any other household member. However, we have to note that one-person households are not representative of the whole population. Still, they provide information on a group of persons which faces several disadvantages compared to other persons.

We focus on persons with disabilities. The following figure indicates that in the big majority of Member States, the percentage of women with disabilities is higher compared to men. But this might be due to an ageing structure effect as indicated before. As we indicate below, the use of health care services is increasing with age.

Figure 8: Percent of persons with disabilities (one-person households) reporting use of health care services by Member State, Age: 16+, 2016



Note: The samples in Malta, Luxembourg and Malta are relatively small.
Data source: EU-SILC UDB 2016– version 20 March 2018.

2.1.3 Characteristics by age group

In our data, the age refers to the household respondent while the answer covers the use of services by all household members. For this reason, we focus only on one-person households. This will help us to compare persons with and without disabilities.

As expected, the use of health care services increases with age. But this increase is relatively lower for persons with disabilities. However, for this latter category, the level is significantly higher at all ages.

2.1.4 Characteristics by degree of disability

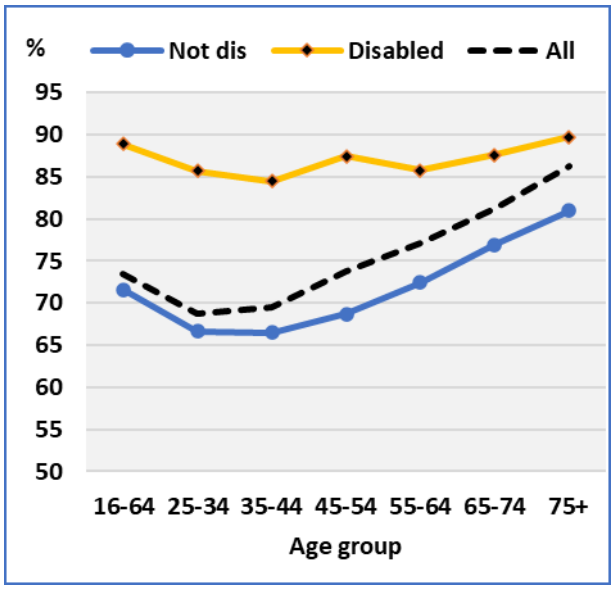
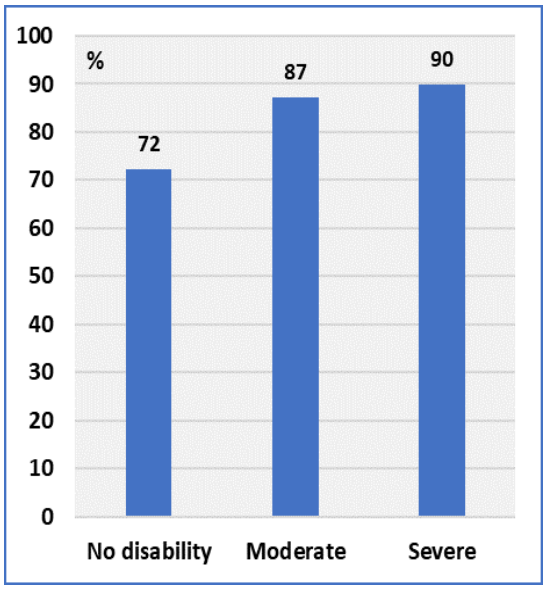
Again, we focus only on one person households. The use of health care services increases with the degree of disability. In the following figure, the data cover only one-person households. The rates are 72 % for household respondents without disabilities, 87 % for persons with moderate disabilities and 90 % for persons without disabilities

For comparison, if we take all household respondents, we obtain 81 % for household respondents without disabilities, 89 % for persons with moderate disabilities and 91 % for persons with severe disabilities.[30]

We have to keep in mind that if a person lives alone, this might be an indication that he is in good health. This might explain the low rate among persons without disabilities living alone.

[30] The respective rates if we take all persons in the sample are: 82 %, 90 % and 92 %. In this case, the value provided by the household respondent is attributed to all household members.

Figure 9: Percent of persons reporting use of health care services. EU 27, 2016
The data cover only one-person households.

By degree of disability	By severity of disability
	

Data source: EU-SILC UDB 2016– version 20 March 2018.

2.1.5 Characteristics by income level

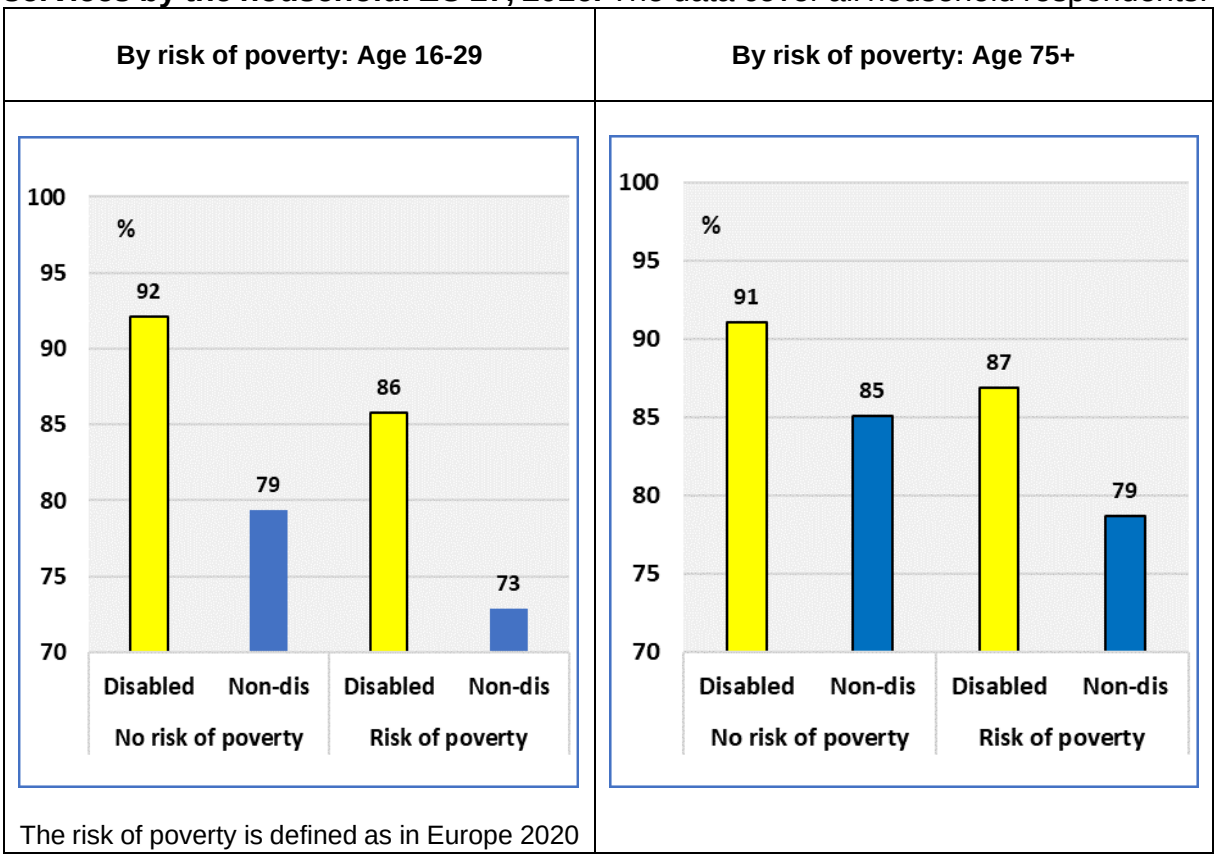
Household income plays an important role. Households with relatively high incomes report more often the use of health care services.

In order to separate the different factors affecting the use of services, we present below graphs by disability, age group and risk of financial poverty. According to Europe 2020, a person is at risk of poverty if he has an equivalised disposable income (after social transfer) below the at-risk-of-poverty threshold, which is set at 60 % of the national median equivalised disposable income after social transfers.

Persons at risk of poverty present lower rates compared to persons which are not at risk of financial poverty, controlling for age and disability.

This is the mirror image of what we will present below. The rate of unmet needs for medical examination increases as household disposable income decreases. This holds both for young and older people. The affordability of health care services will be analysed below.

Figure 10: Percent of household respondents reporting use of health care services by the household. EU 27, 2016. The data cover all household respondents.



Note: A person is at risk of poverty if he has an equivalised disposable income (after social transfer) below the at-risk-of-poverty threshold, which is set at 60 % of the national median equivalised disposable income after social transfers.
Data source: EU-SILC UDB 2016– version 20 March 2018.

2.1.6 Use of health care services and COVID-19

The SHARE COVID-19 survey asks[31] if the interviewee had a medical appointment scheduled, which the doctor or medical facility decided to postpone due to Corona. In the EU, 24.9 % of persons aged 50 and over, declared such a postponement. This rate is 33.9 % for persons declaring a poor health. The rate by age group follows an inverted "U" shape.

The SHARE COVID-19 survey, indicates that, in the EU, about 11.6 % of persons aged 50 and over, forwent medical treatment since the outbreak of COVID-19 because they were afraid to become infected by the corona virus. This rate was 8.8 % for those declaring being in excellent health and 15.2 % for those declaring poor health.

Finally, the survey asked if the interviewee made the demand for an appointment for a medical treatment since the outbreak of Corona and did not get one. In the EU, about 5.4 % of persons aged 50 and over, declared that they were denied an appointment.

A saturation of hospitals and the postponement of cases non-related to COVID-19 may have an indirect detrimental impact on the health of persons with disabilities.

[31] SHARE COVID-19 survey (2020). Op. cit. The data cover 25 EU Member States. Data collected between June and August 2020.

In fact, the rate of persons with disabilities who use health care services is higher compared to persons without disabilities. This is partly due to a higher comorbidity by persons with disabilities. This means that a postponement of medical care might have serious negative impact on the health of persons with disabilities.

The most recent studies show that there is a disruption in healthcare services (including non-communicable diseases diagnosis and treatments).[32] Diabetes, chronic obstructive pulmonary disease, and hypertension were the most impacted conditions due to reduction in access to care.[33] This might deteriorate health and lead to activity limitations increasing consequently the number of persons with disabilities.

WHO notes[34] that the COVID-19 pandemic has had a major impact on the capacity of health systems to continue the delivery of essential health services. It adds that, it is critical to maintain preventive and curative services, especially for the most vulnerable populations, such as children, older persons, people living with chronic conditions, minorities and people living with disabilities.

2.2 Affordability of health care services

Introduction

We have analysed above the "Use of health care services" (HC160), by the household. Health care services cost includes consultations, treatment and prescribed medication

For those who use health care services, the EU-SILC 2016 ad hoc module puts a question on the "Affordability of health care services" (HC180). Eurostat notes that the objective is to assess the respondent feeling about the level of difficulty experienced by the household in covering the total health care services costs for all the household members.

Possible answers are: 1. With great difficulty, 2. With difficulty, 3. With some difficulty, 4. Fairly easily, 5. Easily and 6. Very easily. We have grouped the six categories into three: 1: Difficult (1+2), 2: Fair (3+4), 3: Easy (5+6).

Again, we have to note that the question covers any household member. Consequently, by focusing on household respondents with and without disabilities, we use a proxy for our target group. Furthermore, we check its validity by comparing it with results covering one-person households (with and without disabilities).

2.2.1 Characteristics by Member State

In the following figure, we present the percentage of household respondents declaring difficulty to afford the cost of health care services. In this case, we include all household respondents, whatever the size of the household. As noted, the answer covers all household members.

[32] UN News: "COVID-19 impact on treatment for chronic illness revealed", 4 September 2020; Health. In https://news.un.org/en/story/2020/09/1071732.

[33] Yogini V. Chudasama, Clare L. Gillies, Francesco Zaccardi, Briana Coles, Melanie J. Davies, Samuel Seidu and Kamlesh Khuntia (2020) "*Impact of COVID-19 on routine care for chronic diseases: A global survey of views from healthcare professionals*"; Diabetes & Metabolic Syndrome: Clinical Research & Reviews 14, 965-967. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7308780/pdf/main.pdf.

[34] https://www.who.int/emergencies/diseases/novel-coronavirus-2019/related-health-issues.

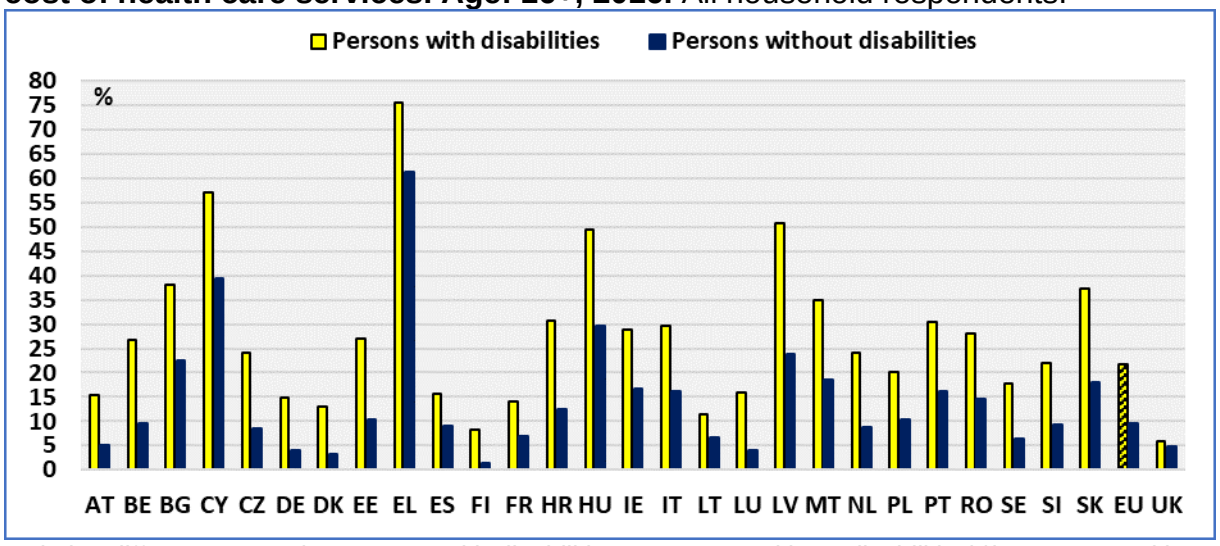
In the EU 27, about 21.8 % of household respondents with disabilities declare a difficulty (with difficulty or with great difficulty), compared to 9.7 % of persons without disabilities. The absolute difference between household respondents with and without disabilities amounts to 12.1 percentage points. This represents a 125.0 % relative disadvantage.

For comparison, if we take all persons in the sample, we obtain the following results: in the EU 27, about 21.3 % of household respondents with disabilities declare a difficulty (with difficulty or with great difficulty), compared to 11.2 % of persons without disabilities. The absolute difference between household respondents with and without disabilities amounts to 10.1 percentage points. These estimations are close to those covering only household respondents. However, there are significant differences for a certain number of countries. The results are presented in the statistical annex.

Concerning household respondents with disabilities, we find the lower rates in the UK, Finland and Lithuania. The highest rates can be found in Latvia, Cyprus and Greece. In Cyprus and Greece, the rates are extremely high, both for household respondents with and without disabilities. Both countries were under economic adjustment programmes.

The relative disadvantage of persons with disabilities in comparison to persons with disabilities is generally low but relatively high in a certain number of Member States (see figure below). Whatever the estimation method, the results are strongly correlated.

Figure 11: Percent of household respondents declaring difficulty to afford the cost of health care services. Age: 16+, 2016. All household respondents.



Relative difference: 100(% Persons with disabilities – Persons without disabilities)/(% Persons without disabilities). The estimations concerning household respondents cover only household respondents in the sample. "All persons in the sample" cover all persons, where all members of a given household are assigned the value provided by the household respondent.*
Data source: EU-SILC UDB 2016– version 20 March 2018.

Persons living alone

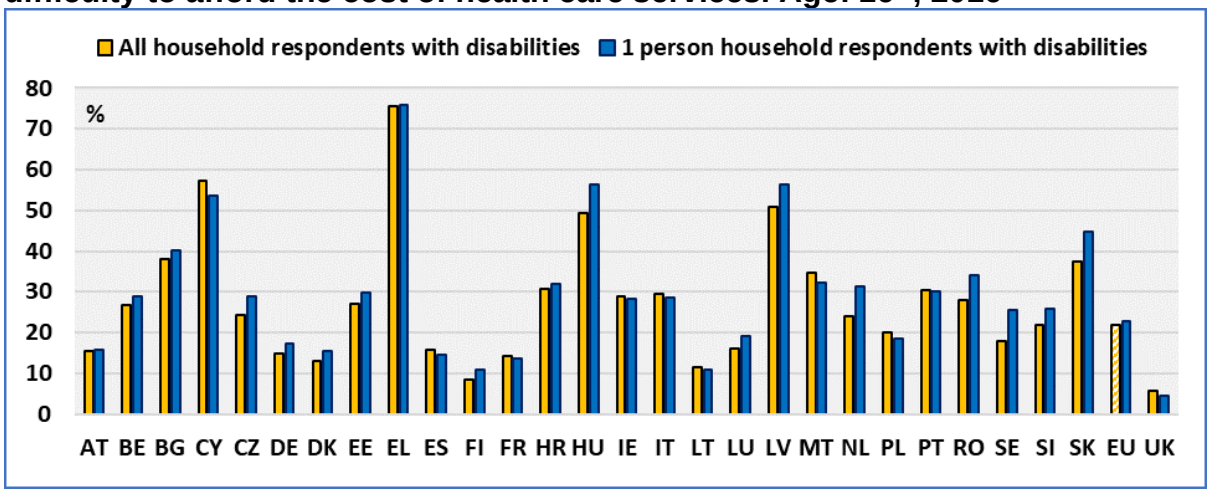
For comparison, in the EU 27, about 22.7 % of persons with disabilities (one-person household respondent) declare difficulty (or with great difficulty) to afford the cost of health care services. This rate is 8.8 % for persons without disabilities. The estimates are very close to those covering all household respondents. The data focus on those

who use health care services. We have to keep in mind that among those who did not use health care services, a certain number might include persons who did not use because they could not afford the cost.

Whether the disabled household respondent answers for the whole family (several persons household) or for only himself (one-person household), the rates are strongly correlated (R^2=0.96). Consequently, the national rates are a good proxy for persons with disabilities.

The national estimates for all household respondents are statistically more robust compared to one-person household respondents. However, their interpretation is more difficult.

Figure 12: Percent of household respondents with disabilities declaring difficulty to afford the cost of health care services. Age: 16+, 2016



Data source: EU-SILC UDB 2016– version 20 March 2018.

2.2.2 Characteristics by gender

The rate of disabled women (only one-person households) declaring difficulty to afford the cost of health care services is 24.4 %. The equivalent rate for men is 19.0 %.

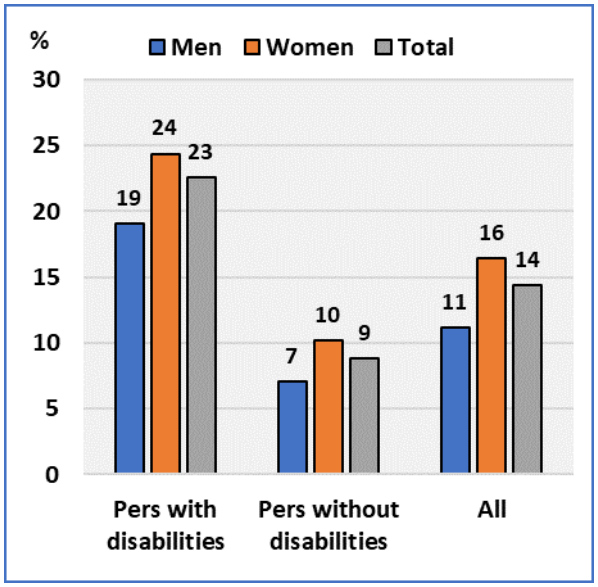
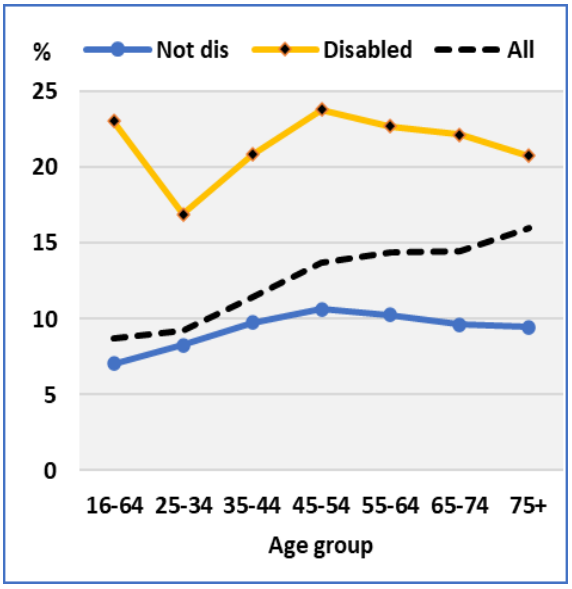
Women face more difficulties compared to men. This holds true both for persons with and without disabilities.

2.2.3 Characteristics by age group

Persons with disabilities report more difficulties to afford the cost of health care services at all age-groups.

After the age of 45-54, both disabled and non-disabled experience a decreasing percentage. However, the total is increasing (see next figure). This is due to the fact that the total is a weighted average of the percentage of both groups (disabled and non-disabled). As the proportion of persons with disabilities increases with age, in the total population, and since the rate of persons with disabilities is significantly higher compared to persons without disabilities, we have an upward pressure which overweighs any decline inside each group.

Figure 13: Percent of household respondents declaring difficulty to afford the cost of health care services. Age: 16+, 2016

By gender (1-person household respondents)	**By Age group** (All household respondents)
	
Whether we take all household respondents or 1-person household respondent the rates are similar.	We take all household respondents because the number of young 1-person household disabled respondents is small. However, the shape is similar.

Data source: EU-SILC UDB 2016– version 20 March 2018.

2.2.4 Characteristics by degree of disability

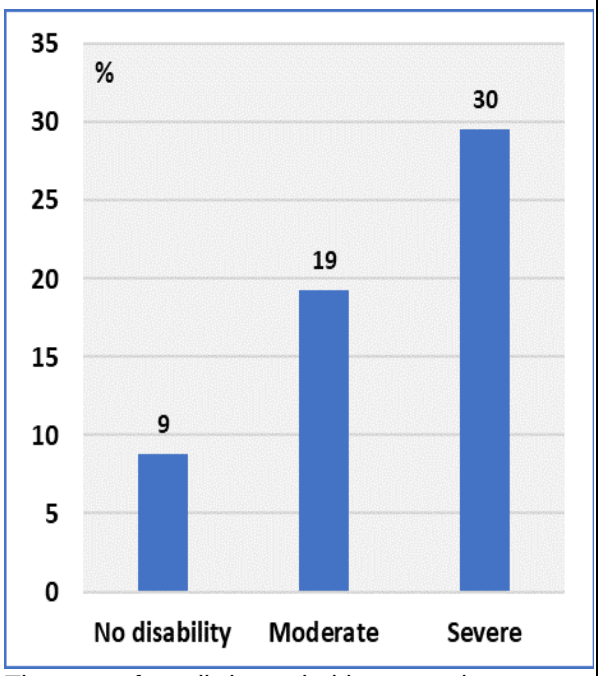
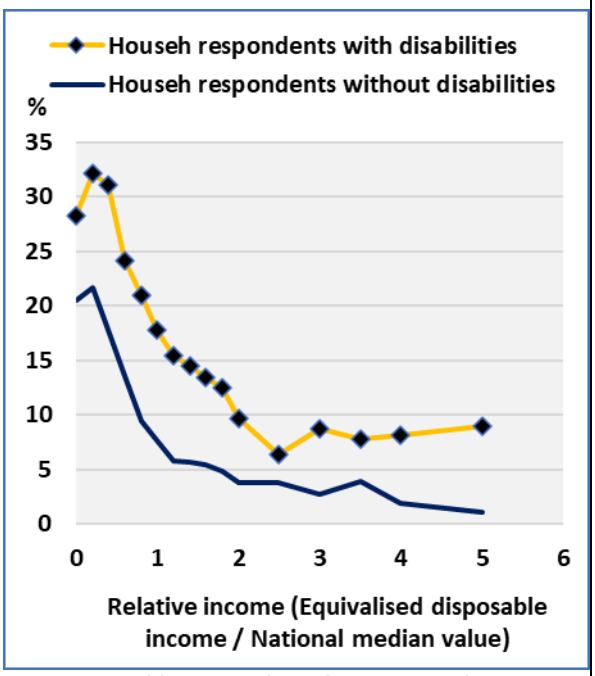
The percentage of persons (household respondents in 1-person households) declaring difficulty to afford the cost of health care services increases with the degree of disability.

2.2.5 Characteristics by income level

The percentage of household respondents declaring difficulty to afford the cost of health care services decreases steadily as equivalised disposable income increases. Equivalised disposable income is household disposable income (income available for spending or saving) divided by an index which takes into account household size.

We may note that on the following figure (presenting the evolution by relative income), the share of household respondents declaring difficulty to afford the cost of health care services is lower for zero income than for household respondent with positive income. This might be due to the specific characteristics of this income group. In fact, households declaring zero household income include households with higher regular income but declaring temporarily and exceptionally zero or negative income.

Figure 14: Percent of household respondents declaring difficulty to afford the cost of health care services. Age: 16+, 2016

By degree (1-person household respondents)	**By relative income** **(Ratio of equivalised disposable income to national median value)** (All household respondents)
	
The rates for all household respondents are: 10 % (no disabilities), 19 % (moderate) and 30 % (severe). The corresponding rates covering all persons in the sample are: 11 %, 19 % and 28 %.	Persons with negative income values are assigned a zero income. We take all households in order to include high income households.

Note: Concerning the estimation by relative income, we do not know if the difficulty to afford the cost of health care services relates to problems faced by one or several household members. For comparison, if we take only one-person households, we obtain the same shape for both groups.
Data source: EU-SILC UDB 2016– version 20 March 2018.

2.2.6 The impact of COVID-19 pandemic on the affordability of health care services

The current pandemic and the associated measures are expected to hit hard the employment in all countries.

We may note that, in the EU 27, in 2018, about 50.8 % of persons with disabilities, aged 20-64, are employed compared to 75.0 % of persons without disabilities (EU-SILC UDB 2018). About 22.7 million with disabilities are employed out of 44.7 million disabled persons, of the same age group.

The impact of COVID-19 on employment might be different in each Member States. In some countries, this might be hardest due to the productive structure of the economy and the small size of their business. Furthermore, inside each country, certain socio-economic groups might be affected more than others.

Analysis of the productive structure of Member States indicates that this might be the case in Greece and Cyprus (see Annex). Or, we have noted above that the rates of persons, disabled and not disabled, declaring difficulty to afford the cost of health care services can be found in Greece and Cyprus. Consequently, we expect an overall

stronger deterioration of employment in these two Member States compared to other countries.

Furthermore, the situation of persons with disabilities is expected to deteriorate in relation to other groups. In fact, small companies are more vulnerable to economic shocks. The analysis of employment by economic sector and size of companies indicates that persons with disabilities are overrepresented in very small business in the most hit economic sectors.

In the Annex, we note that a general health pauperisation of persons with disabilities might ensue, for example in Greece, where the percentage of persons declaring difficulty to afford the cost of health care services was 76 % in 2016.

As noted, persons with disabilities are overrepresented in very small business in several affected sectors. In order to dampen the employment deterioration, national and European policies ought to help them to survive during the crisis or reorient their activities. In this framework, job retention schemes have played an important role in helping employers keep workers in jobs.

Also, improving health care insurance coverage and access to workers (and their families) in these very small businesses ought to be reinforced.

In the case of wholesale and retail services, support for adapting to ecommerce in businesses, ought to take into account the special needs of persons with disabilities. This might include both software and hardware as well adaptation of workplaces. For example, this ought to take into account equipment, software and adaptations aiming to overcome barriers in case of reorientation to ecommerce.

Finally, measures to protect workers from COVID-19 ought not to create new barriers for persons with disabilities. Reasonable adaptations of such measures and sanitation facilities for persons with disabilities ought to be taken into account in the different employment schemes.

2.3 Unmet medical needs

Introduction

The indicator “unmet medical needs” is part of the EU Sustainable Development Goals (SDG) indicator set. It is used to monitor progress towards SDG 3 on good health and well-being and SDG 1 on ending poverty in all its forms everywhere. Dental care is excluded.

Eurostat indicates that the aim of the variable is to capture the restricted access to medical care via the person’s own assessment of whether he or she needed medical examination or treatment, but didn't get it, experienced a delay in getting it or didn't seek for it.

The indicator is also included in the Social Scoreboard for the European Pillar of Social Rights. Universal health coverage is an objective of the EU Charter of Fundamental Rights. One of the priorities of the EU’s health policy is increasing accessibility to healthcare.

2.3.1 Characteristics by Member State

The indicator retained by Eurostat[35] measures the share of the population aged 16 and over reporting unmet needs for medical care due to one of the following reasons: 'Financial reasons', 'Waiting list' and 'Too far to travel' (all three categories are cumulated).

Eurostat adds that the indicator is derived from self-reported data, so it is, to a certain extent, affected by respondents' subjective perception as well as by their social and cultural background. Another factor playing a role is the different organisation of health care services. All these factors should be taken into account when analysing the data and interpreting the results.

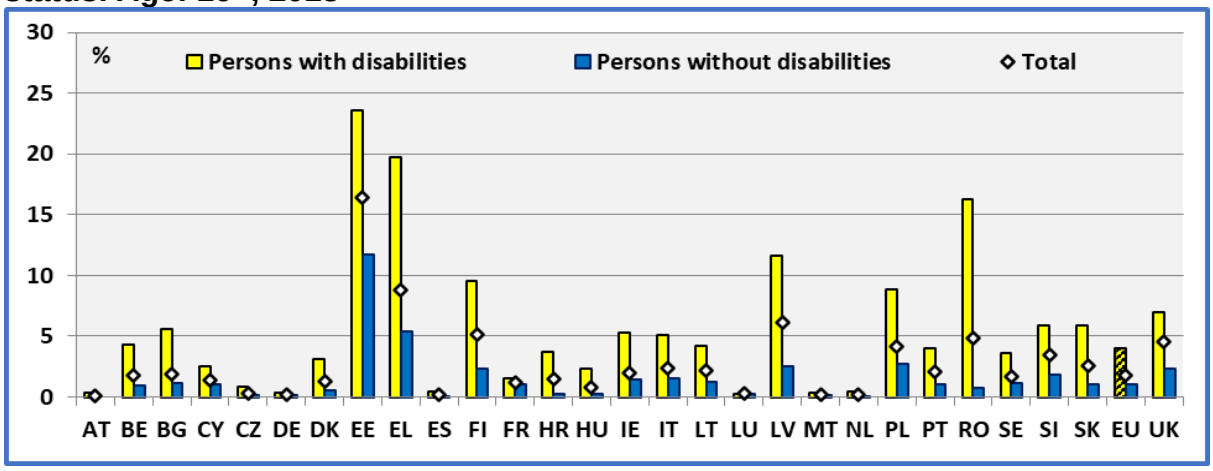
In the EU 27, about 4.0 % of persons with disabilities report unmet needs for medical care due to 'Financial reasons', 'Waiting list' or 'Too far to travel', compared to 1.0 % for persons without disabilities.

We may note that, in the big majority of Member States, the rate of unmet needs for the total population is relatively low. However, it is over 5 % in Latvia, Greece and Estonia.

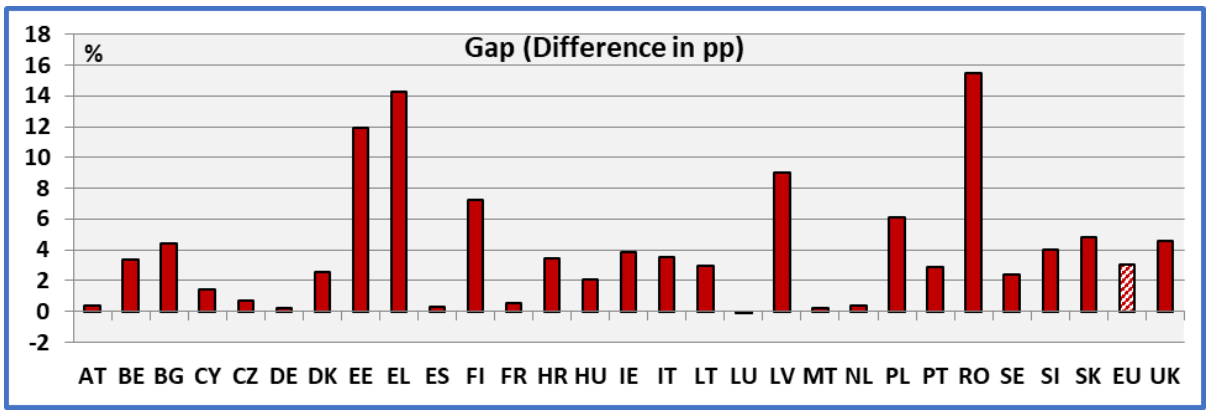
Except Luxembourg, there is a positive gap between persons with and without disabilities in the remaining Member States. This absolute gap (in percentage points) is relatively small in the majority of Member States; however, this gap is high in Romania, Greece and Estonia.

This gap measures the disadvantage of persons with disabilities in comparison to persons without disabilities. It might result, notably, from lower income or restricted social security coverage of persons with disabilities compared to persons without disabilities.

Figure 15: Self-reported unmet needs for medical examination by disability status. Age: 16+, 2018



[35] https://ec.europa.eu/eurostat/databrowser/view/sdg_03_60/.

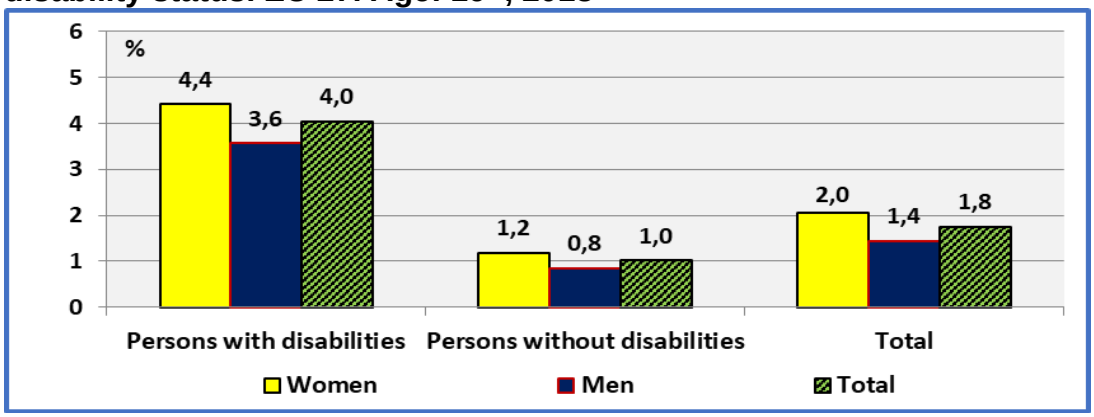


Note: Unmet needs for medical care due to: 'Financial reasons', 'Waiting list' or 'Too far to travel'.
Gap: % persons with disabilities - % persons without disabilities.
Data source: EU-SILC UDB 2018 Release 2020, Version 1. EU covers 27 MS.

2.3.2 Characteristics by gender

In the EU 27, 4.4 % of women with disabilities declare unmet needs for medical examination compared to 3.6 % of men with disabilities. We may observe that the share of women declaring unmet needs is higher compared to men both among disabled and non-disabled persons. However, gender differences inside each group is small compared to the disability gap (difference between persons with and without disabilities).

Figure 16: Self-reported unmet needs for medical examination by sex and disability status. EU 27. Age: 16+, 2018



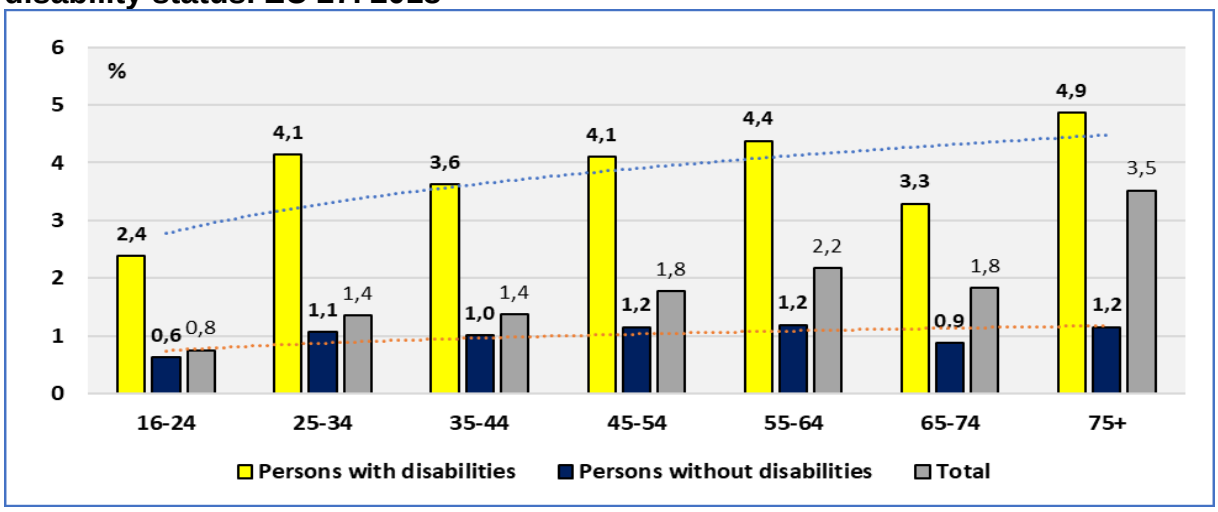
Data source: EU-SILC UDB 2018 Release 2020, Version 1.

2.3.3 Characteristics by age group

Self-reported unmet needs for medical examination increase with age, notably for very elderly people (75+). There is a tendency for the gap between persons with and without disabilities to increase with age.

In the EU 27, about 4.9 % of disabled persons aged 75 and over declare unmet needs for medical examination. This rate is 1.2 % for persons without disabilities of the same age group.

Figure 17: Self-reported unmet needs for medical examination by age group and disability status. EU 27. 2018



Data source: EU-SILC UDB 2018 Release 2020, Version 1.

Future policies ought to target better the needs of disabled persons aged 75 and over but more importantly, as was described above, persons with disabilities in countries where there is a relatively high gap between persons with and without disabilities (e.g. Romania, Greece and Estonia).

2.3.4 Characteristics by degree of disability

Self-reported unmet needs for medical examination increases with the degree of disability.

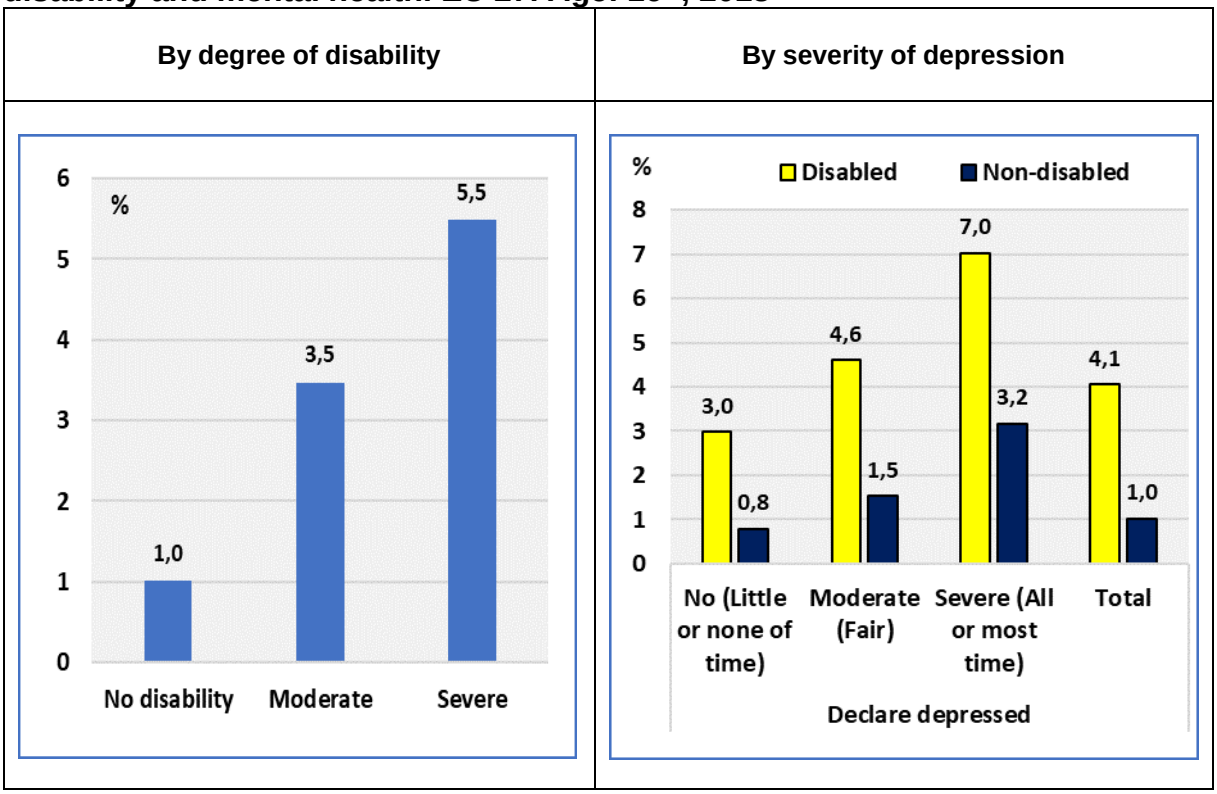
2.3.5 Mental health

The severity of declared depression increases the percentage of self-reported unmet needs for medical examination. This is notably true for persons with disabilities.

Among persons with disabilities who declare to be depressed “all or most of the time”, about 7.0 % declare unmet needs for medical examination. The most vulnerable group has the higher rate of unmet medical needs.

In a period of pandemic, the rates of unmet needs ought to increase. Economic factors (unemployment, loss of income, etc.) and other personal conditions (isolation, anxiety, stress, etc.) ought to deteriorate the situation. As noted above, to these factors we can add medical appointments reported or cancelled due to COVID-19.

Figure 18: Self-reported unmet needs for medical examination by degree of disability and mental health. EU 27. Age: 16+, 2018



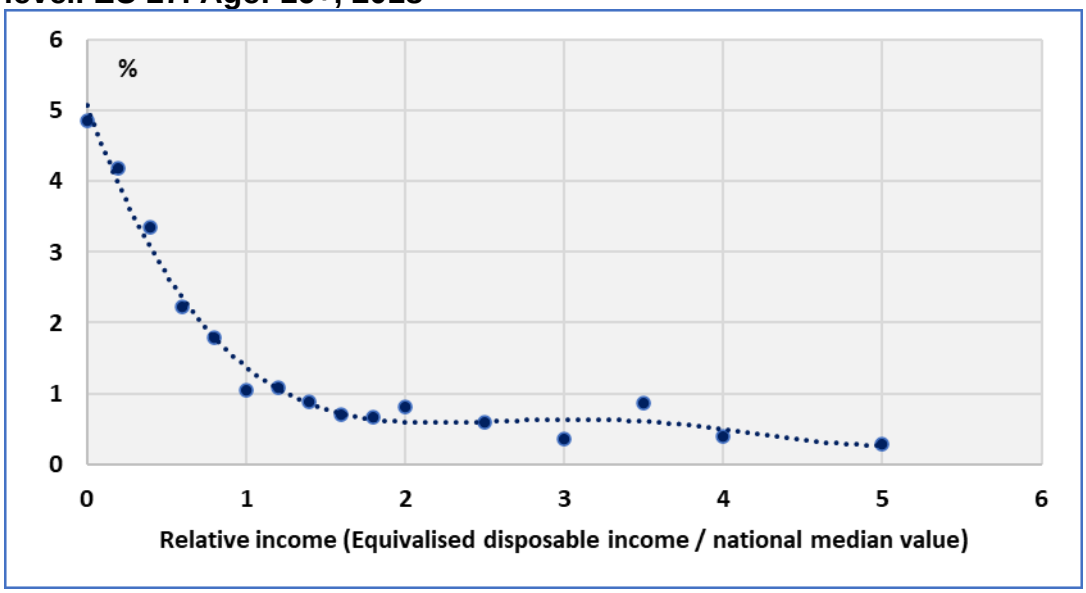
Note: As indicated in the methodological note, in the beginning of this study, disability is defined as limitations in activities (GALI). Consequently, persons with long term illness or depression might not necessarily declare limitations in activities people usually do.
Data source: EU-SILC UDB 2018 Release 2020, Version 1.

2.3.6 Income

An important factor affecting the rate of unmet needs for medical examination is disposable income.

The following graph indicates that the rate of persons declaring unmet needs for medical examination decreases steadily with relative disposable income. The relative income variable is the ratio of equivalised disposable income to the national median value. We have excluded persons with negative or zero income because this group includes persons who declare temporarily and exceptionally zero or negative income.

Figure 19: Self-reported unmet needs for medical examination by relative income level. EU 27. Age: 16+, 2018



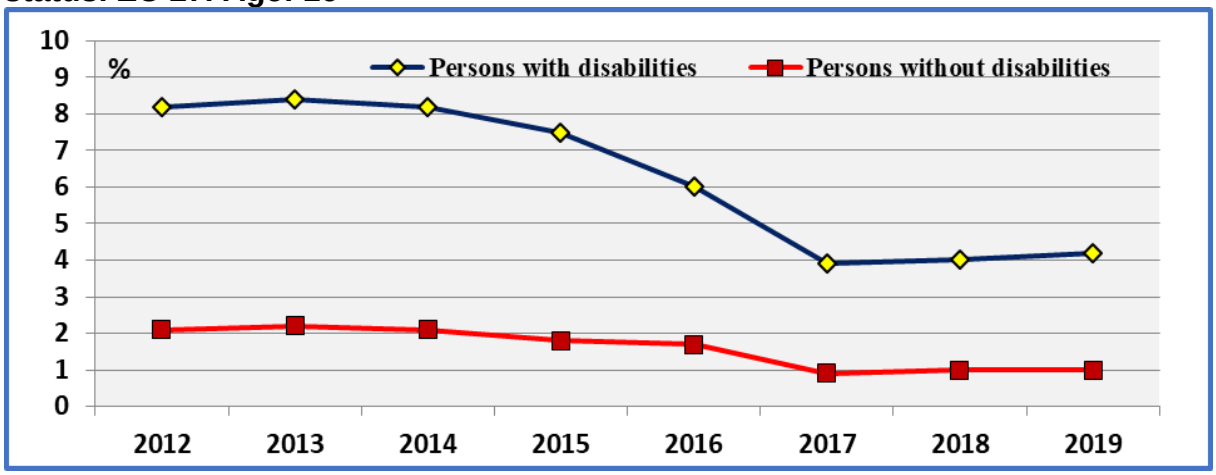
Dotted line: OLS polynomial fit (R^2=0.98).
Note: We have excluded persons with negative or zero income.
Data source: EU-SILC UDB 2018 Release 2020, Version 1.

2.3.7 Evolution

We may observe a significant improvement of the situation of persons with disabilities between 2012 and 2017. The following figure indicates a sharp decrease of the percentage of persons with disabilities reporting unmet needs for medical examination.

Also, the gap between persons with and without disabilities has been reduced significantly. However, the difference remains unchanged during the last years.

Figure 20: Self-reported unmet needs for medical examination by disability status. EU 27. Age: 16+



Data source: Eurostat. Data for 2019 are provisional estimates.

As indicated above, the COVID-19 pandemic is going to affect previous trends. As noted:

- scheduled medical appointments were postponed due to COVID-19,
- medical treatments were forgone because persons were afraid to become infected by the corona virus; and,

- appointments for a medical treatment were denied.

Consequently, we expect an increase of unmet needs either as a direct impact of COVID-19 or as an indirect impact through the economic crisis.

As S. Drefahl et Ali. notes,[36] despite the widely assumed notion that the virus does not discriminate, they show that the interaction of the virus and its environment does discriminate, exerting an unequal burden on the most disadvantaged members of society. They add that beyond the strong effects of age on COVID-19 mortality, they find that better health care resources may need to be allocated towards disadvantaged communities.

2.4 Professional home care

Introduction

The EU-SILC 2016 ad hoc module includes a question on the "Presence in the household of people who need help due to long-term physical or mental ill-health, infirmity or because of old age" (HC190). The data refer to households but, in our analysis, we will focus on household respondents with and without disabilities.

Eurostat notes that home care aims to make it possible for people to remain at home rather than use residential, long-term, or institutional-based nursing care. Home care may include health care and/or life assistance. Home health care could include notably, medical treatment, wound care, pain management and therapy. Life assistance includes help with daily tasks such as meal preparation, medication reminders, laundry, light housekeeping, shopping, transportation, and companionship. In this variable the need of home care is taken into account without distinguishing the type of care or who provides it (professional or not).

For those household respondents who answer "Yes", a follow-up question asks if professional home care was received (HC200).

Eurostat notes that "professional" care should be understood as a person for whom providing home care represents a job: work or paid activity. Friends, relatives, neighbours etc. who provide care on voluntary basis should be excluded.

We may note that in the literature the terms 'formal' vs. 'informal' care are often used. However, we prefer to use the terms employed by the interviewers and which might reflect better their representations.

2.4.1 The need for professional home care by Member State

In the EU 27, about 20.3 % of household respondents with disabilities declare the presence in their household of people who need help. This rate is 4.3 % for household respondents without disabilities.[37] As noted already, even if a household respondent

[36] Sven Drefahl, Matthew Wallace, Eleonora Mussino, Siddartha Aradhy, Martin Kolk, Maria Brandén, Bo Malmberg and Gunnar Andersson (2020) "*Socio-demographic risk factors of COVID-19 deaths in Sweden: A nationwide register study*". Stockholm Research Reports in Demography. no 2020:23; Department of Sociology. Demography Unit. Stockholm University.

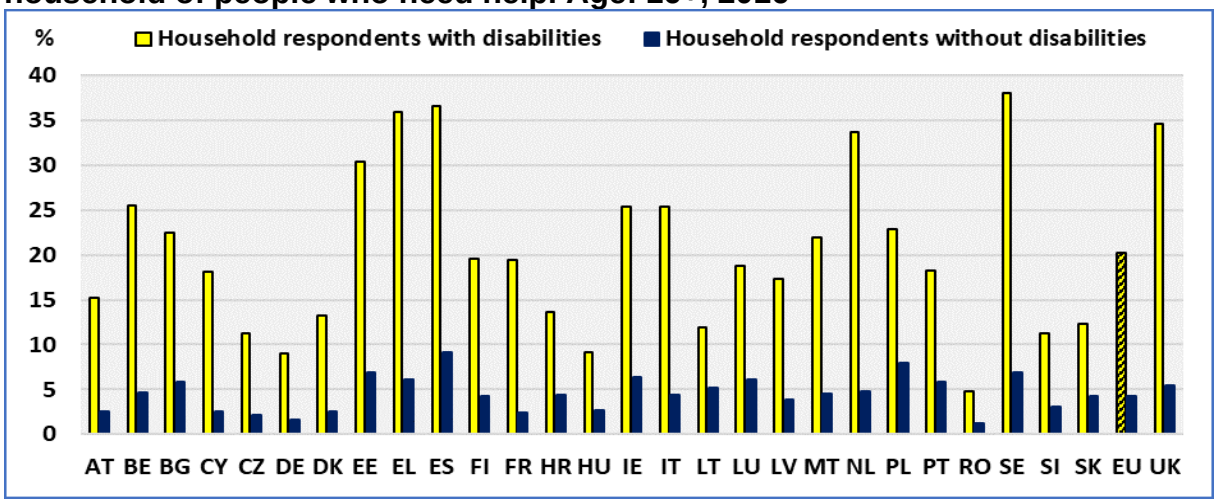
[37] For comparison, if we take all persons in the sample, about 22.5 % persons with disabilities declare the presence in their household of people who need help, compared to 4.9 % for non-disabled

does not declare a disability, other members in his household may have disabilities or needs due to chronic illness or old age. The rate for all household respondents is 8.6 %.

There is a difference of 16.0 percentage points between household respondents with and without disabilities. This represents a relative disadvantage of 377.2 %.

Concerning household respondents with disabilities, the highest rates can be found in Greece, Spain and Sweden.

Figure 21: Percent of household respondents declaring the presence in their household of people who need help. Age: 16+, 2016



How to read the figure: In Austria about 15 % of household respondents with disabilities declare the presence in their household of people who need help. This rate is about 3 % for household respondents without disabilities.
Data source: EU-SILC UDB 2016– version 20 March 2018.

Persons living alone

As indicated above, the household respondent answers for all members of the family. This variable aims at collecting information on the presence of persons (including children) in the household who requires help due to long-term health problems.

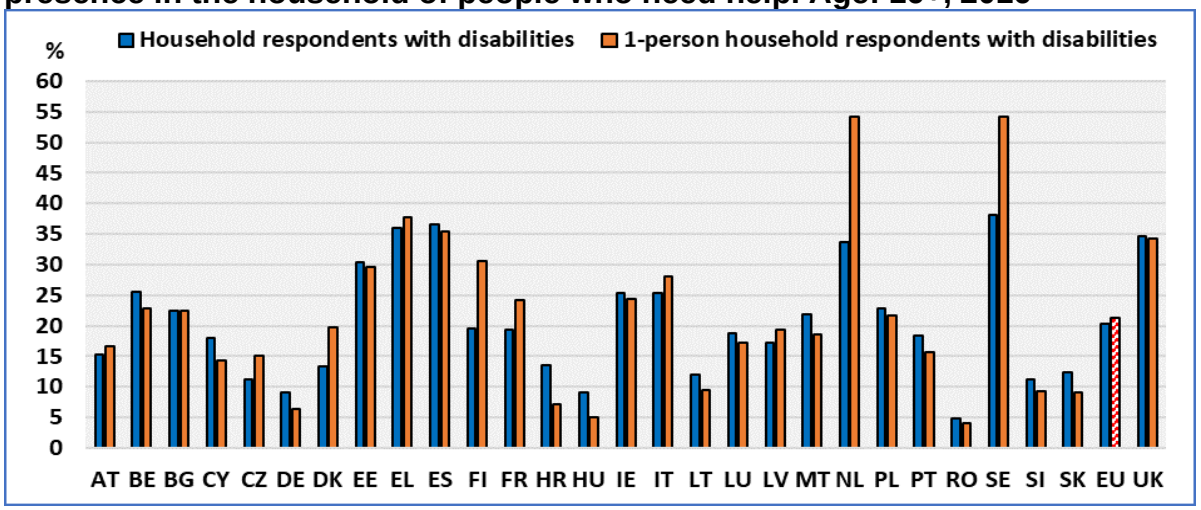
For comparison, we estimate the same rates for 1-person household respondents. In this case, we can speak about the needs of the person himself.

In the EU 27, about 21.4 % of persons (one-person household respondent) with disabilities declare needing help. This rate is 1.4 % for persons without disabilities. The rate for all persons from one-person is 8.5 %.

There is a good correlation (R^2=0.82) between the two national estimates but there are important differences for a limited number of countries (e.g. Netherlands and Sweden).

persons. These estimations are presented in the statistical annex. In this case, the value provided by the household respondent is attributed to all household members.

Figure 22: Percent of household respondents with disabilities declaring the presence in the household of people who need help. Age: 16+, 2016



Data source: EU-SILC UDB 2016– version 20 March 2018.

Characteristics by age and degree of disability

Concerning age, the needs increase slightly initially and faster after the age of 65.

The degree of disability is an important factor. In the EU 27, the percentage for household respondents without disabilities is 4.3 % and15.0 % for respondents with a moderate disability. It increases to 39.3 % for household respondents with a severe disability. The equivalent rates for 1-person household respondents are 1.4 %, 13.2 % and 39.0 %.

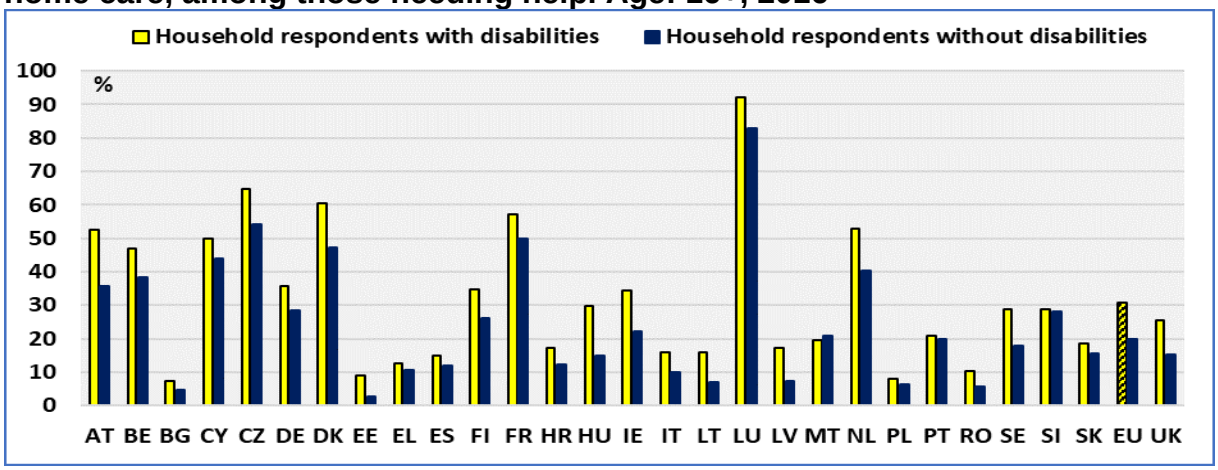
2.4.2 Persons receiving professional home care by Member State

In the EU 27, among those who need help, about 26.9 % receive home care.[38] This rate is 30.8 % for household respondents with disabilities and 19.9 % for household respondents without disabilities.[39]

[38] We may note that an important academic debate is taking place around the potential substitutability between formal and informal care See, for instance, Bonsang E. (2009), "Does informal care from children to their elderly parents substitute for formal care in Europe?", Journal of Health Economics, 28-1,143-154, https://doi.org/10.1016/j.jhealeco.2008.09.002.

[39] Estimations based on all persons in the sample are presented in the statistical annex. In this case, the value provided by the household respondent is attributed to all household members. The rates are 26.6% for persons with disabilities and 15.9% for persons without disabilities.

Figure 23: Percent of household respondents declaring receiving professional home care, among those needing help. Age: 16+, 2016



Data source: EU-SILC UDB 2016– version 20 March 2018.

It is important to note that the question is about persons receiving help and not persons who received help during the last 6 or 12 months.

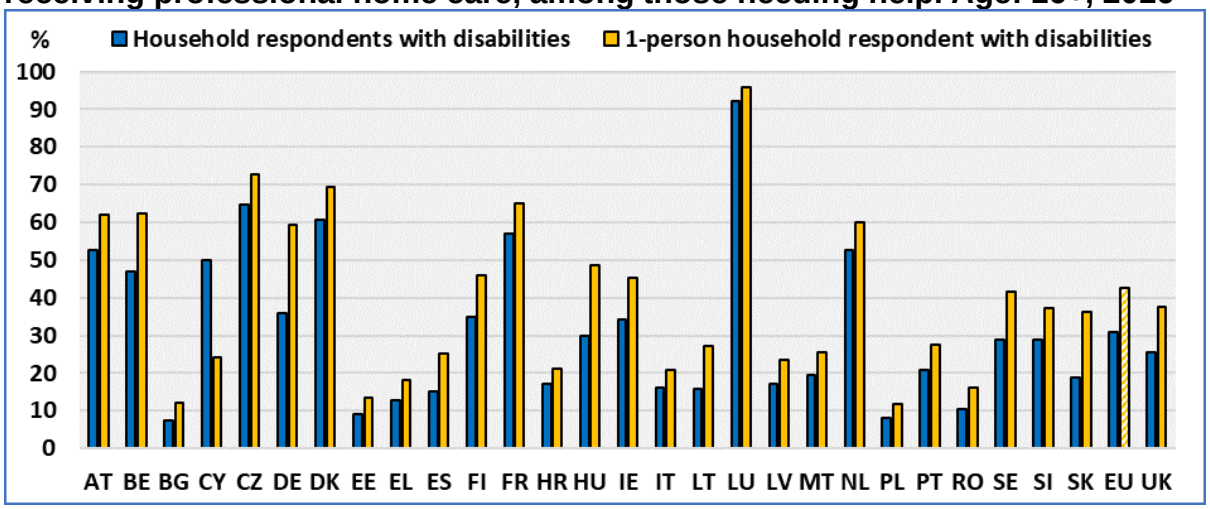
Professional home care services allow people with chronic illness and disabilities to continue living in their homes or in the community rather than in health care structures or institutions. This promotes independent living of persons who need help due to long-term physical or mental ill-health, disability or because of old age.

As noted, the household respondent answers for all members of the household. In the following figure, we compare household respondents with disabilities by size of household. The graph indicates that the national estimates for all household respondents with disabilities is correlated (R^2=0.86) with the estimates of persons with disabilities (1-person household respondent with disabilities).

However, the estimates concerning one-person household respondents with disabilities are higher compared to all household respondents with disabilities. In the EU 27, about 30.8 % of all household respondents with disabilities receive professional home care. This rate is 42.5 % for persons with disabilities from one-person households.

This might be due to the fact that persons living in households with 2 or more members might use informal mutual help which is not possible for 1-person household. Socio-economic factors might also have a differentiated impact.

Figure 24: Percent of household respondents with disabilities declaring receiving professional home care, among those needing help. Age: 16+, 2016



Data source: EU-SILC UDB 2016– version 20 March 2018.

2.4.3 Persons receiving professional home care and size of the household

Considering only households who need help, the rate of households receiving help decreases steadily with household size. About 41.8 % of one-person households needing help receive professional home care compared to 13.0 % of households with five members or more.

One explanation might be that in households, with two or more members, needing help, some form of mutual assistance might fill the needs expressed inside the household. This is not possible to one-person households. Informal care inside the household might be a substitute, at a certain degree, for professional home care. The size of the household is an important factor affecting the need for professional home care.

We might advance that isolation increases the need for professional home care. In a period of social distancing, restrictions concerning family contacts, ought to take into account that the need for professional home care might increase.

However, households composed by two or more members might cumulate several income sources. In this case, the rate of professional home care might be lower if the provision of public services is means tested. For example, if it is provided only to low-income households.

As expected, considering only one-person households, the rate of persons with disabilities receiving help is higher compared to persons without disabilities.

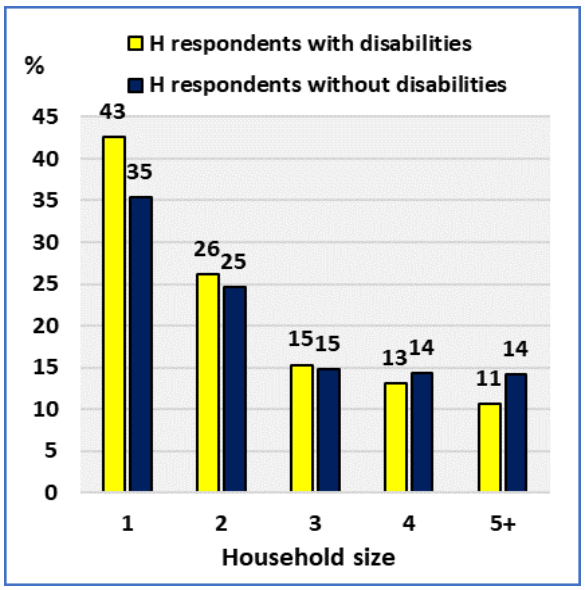
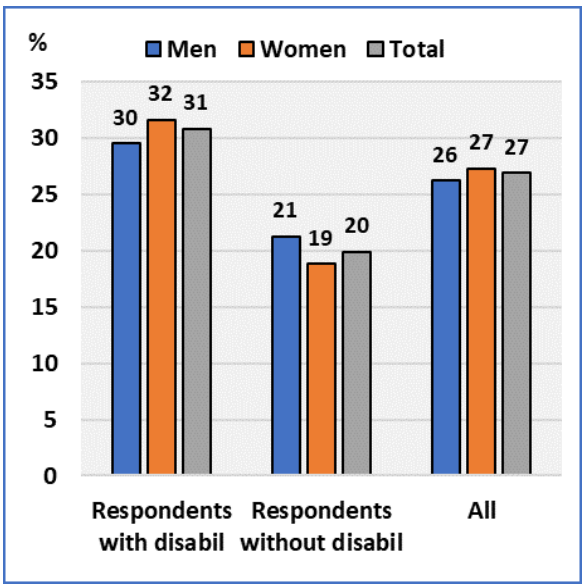
2.4.4 Characteristics by gender

The percentage of women declaring needing help is 9.6 % compared to 7.4 % for men. Considering those needing help, the rate of women respondents with disabilities receiving help is higher compared to men respondents with disabilities.

But the above gender differences might be due to the impact of different age structures. In the sample under study, the average age of women is higher compared to men and statistically significant.

As indicated, the household respondent answers for all household members. This does not enable us to study any gender difference. Consequently, we focus on one-person households. In this case, among persons with disabilities, needing help, there is no significant difference. The rates of those receiving help are 42.4 % (men), 42.4 % (women) and 42.5 % (total). As indicated, the proportion of isolated persons receiving professional home care services is higher compared to the total.

Figure 25: Percent of household respondents declaring receiving professional home care, among those needing help, by household size and gender. Age: 16+, 2016

Percent of household respondents (needing help and) declaring receiving professional home care by household size.	Percent of respondents (needing help and) declaring receiving professional home care by gender
	
% of household respondents needing help	

Data source: EU-SILC UDB 2016– version 20 March 2018.

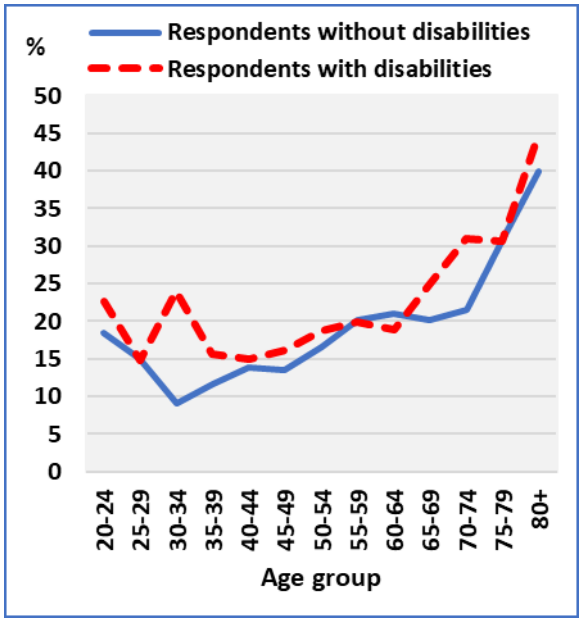
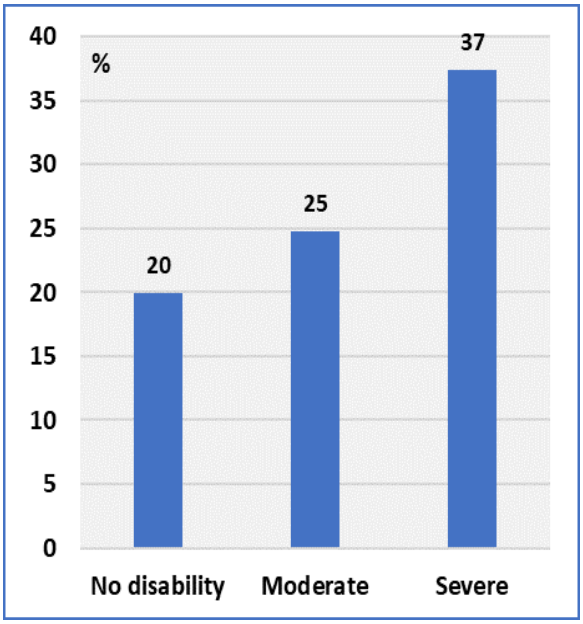
2.4.5 Characteristics by age group

As expected, the rate of persons receiving help increases with age.

2.4.6 Characteristics by degree of disability

The degree of disability significantly increases the rate of household respondents receiving professional home care services.

Figure 26: Percent of persons declaring receiving professional home care by age and degree, among those needing help. EU 27, 2016

All household respondents by age group	All household respondents by degree
	

Data source: EU-SILC UDB 2016– version 20 March 2018.

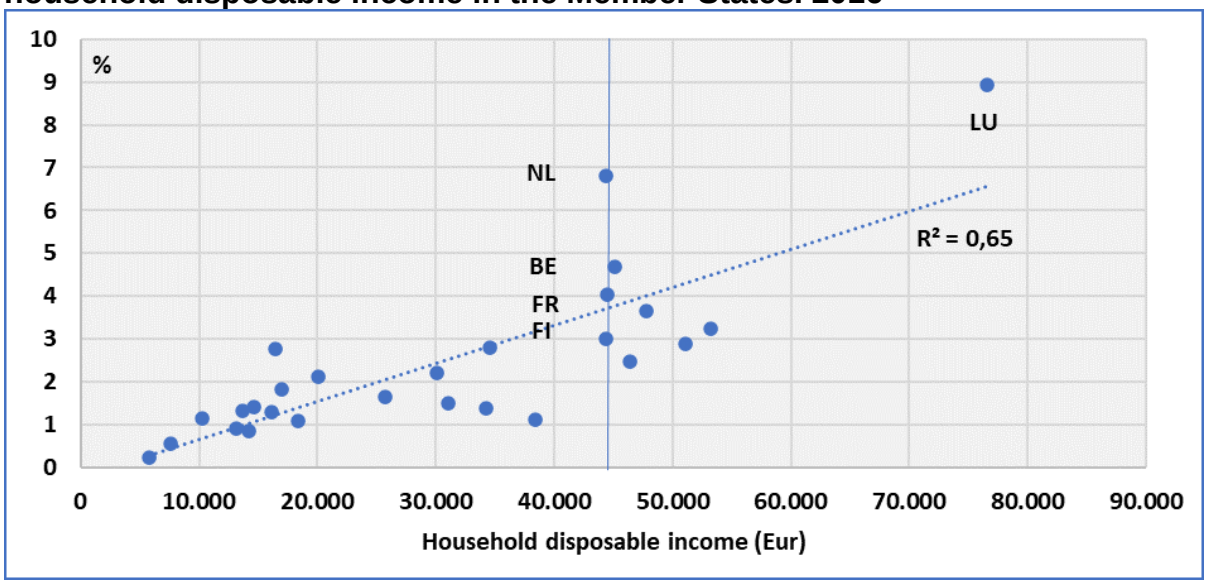
2.4.7 Characteristics by income level

In the EU 27, about 2.3 % of all households receive professional home care. Romania (0.2 %), Bulgaria (0.6 %) and Poland (0.9 %) present the lowest rates. Belgium (4.7 %), Netherlands 6.8 %) and Luxembourg 8.9 %) present the highest rates.

The following graph indicates that the percentage of households receiving professional home help increases with the economic situation of the Member State. Higher household incomes enable to finance more home care services. Richer countries have also more resources to finance such schemes.

However, for similar incomes (for example, Netherlands, Belgium, France and Finland) the percentage of households receiving professional home help may vary significantly, depending, notably, on national policy in this area.

Figure 27: Percent of households receiving professional home care and household disposable income in the Member States. 2016



Note: The data cover 27 national observations (EU 27). The percentage refers to households receiving professional home care among all households. The denominator includes both households needing and not needing help.
Income variable: If we use the mean national equivalised disposable income instead of household disposable income, we obtain similar results.
Dotted line: OLS linear regression. The coefficient of correlation R^2=0.65.
Data source: EU-SILC UDB 2016– version 20 March 2018.

2.5 The cost of professional home care

Introduction

The EU-SILC 2016 ad hoc module includes a question on whether the household paid for professional home care (HC220). This question addresses those who declared the presence in the household of people who need help (due to long-term physical or mental ill-health, infirmity or because of old age) and who received professional home care.

Finally, if the household received and paid a professional home care, the interviewer asks if the household can afford the cost (HC230).

Certain people might not have used formal home care due to financial or other reasons. Unmet needs for professional home care will be discussed below.

Again, we have to note that a household respondent without disabilities might include in his household a member with disabilities or a person with a chronic health problem.

2.5.1 Households who paid for professional home care

It is important to recall the order of questions. First, the survey asks if there is a need for home care by household members (234 810 households in the EU 27). Then, for those who answer affirmatively (23 692 households), the interviewer asks if the household received or not professional home care. Then, if the household respondent answers positively (5 287 households), the interviewer asks if the household paid for this professional home care.

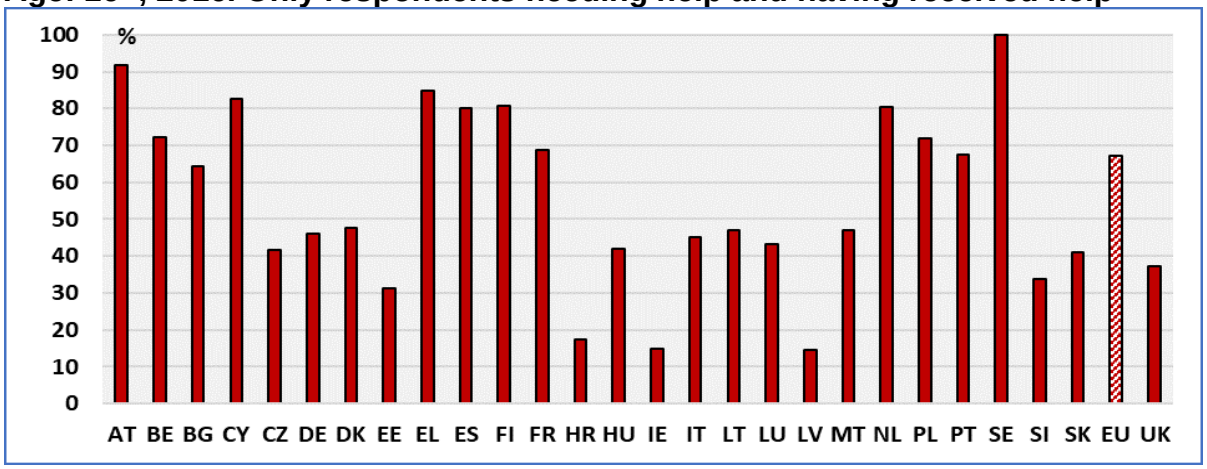
At each stage, the number of relevant household decreases. So, at the end, we have few observations. The problem increases if we distinguish persons with and without disabilities. Consequently, the analysis might be limited by statistical problems (small sample) in a certain number of Member States. Also, it restricts considerably our analysis of one-person households.

In the last step, we have less than 20 households in Romania. Consequently, our estimates will not cover this Member State. Furthermore, if we distinguish respondents with and without disabilities in the EU, we have small samples in several Member States. In any case, household respondents with disabilities (3 890) are more numerous than household respondents without disabilities (1 397). So, we can advance the argument that the aggregated results reflect more the needs of disabled respondents (or their households).

In the EU 27, among those who expressed a need and received professional home care about 67.3 % declare that they have paid for professional home care.[40] Latvia, Ireland and Croatia have the lowest rates. Greece, Austria and Sweden present the highest rates.

However, this ought to be treated with care. In certain Member States, this cost might be reimbursed. Still, it might be a constraint for low-income households. Consequently, it is more interesting to study whether households may afford this cost or not. We will study this issue below.

Figure 28: Percent of household respondents who paid professional home care. Age: 16+, 2016. Only respondents needing help and having received help



Data source: EU-SILC UDB 2016– version 20 March 2018.

2.5.2 Affordability of professional home care

As noted above, if the household received and paid a professional home care, the interviewer asks if the household can afford the cost. The question was put to 3 478 households in the EU 27, but only 3 390 present all relevant information. In this sample of households, about 63 % are women respondents and 76 % respondents with disabilities.

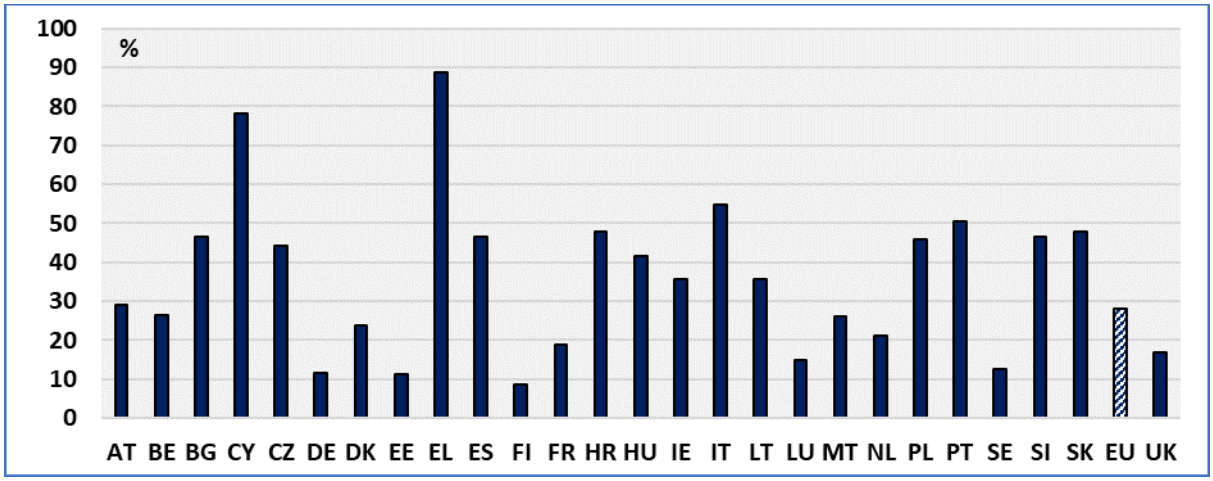
[40] If we take all persons in the sample, we obtain 62.8 %. In this case, the value provided by the household respondent is attributed to all household members. The estimations are presented in the statistical annex. The two estimation methods provide strongly correlated results (R^2=0.98).

The respondent may answer 1. With great difficulty, 2. With difficulty, 3. With some difficulty, 4. Fairly easily, 5. Easily and 6. Very easily. We have grouped the six categories into three: 1: Difficult (1+2), 2: Fair (3+4), 3: Easily (5+6).

Due to sampling limitations, the data for Bulgaria, Estonia, Croatia, Hungary, Ireland, Lithuania, Luxembourg and Malta are indicative. The sample for Latvia and Romania is extremely small (less than 20 households).

In the EU 27, among those who paid professional home care, about 28.0 % declare difficult to afford professional home care.[41] Finland, Germany and Sweden have the lowest rates. Italy, Cyprus and Greece have the highest rates.

Figure 29: Percent of household respondents declaring difficulty to afford professional home care. Age: 16+, 2016. Only respondents who have paid home care.



Note: The estimates for BG, EE, HR, HU, IE, LT, LU, MT are indicative. We have excluded Latvia and Romania due to small samples.
Data source: EU-SILC UDB 2016– version 20 March 2018.

2.5.3 Characteristics by gender and age group

The rate for men respondents is 22.8 % and for women 31.3 %. But this might be due to an age structure effect. Consequently, we have to take into account the age dimension.

The following figure indicates that the percentage of women household respondents declaring difficulty is higher at all ages compared to men. This might reflect higher economic constraints for women.

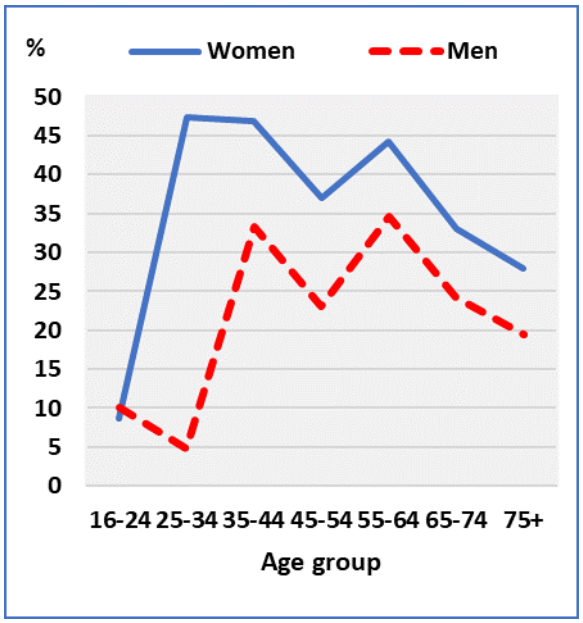
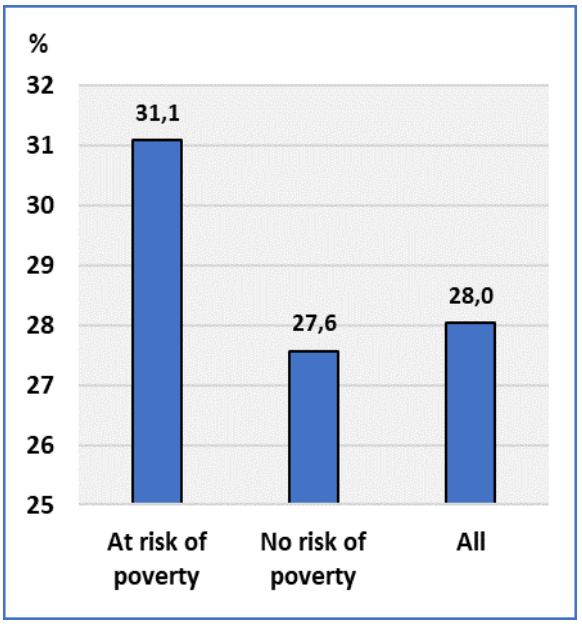
2.5.4 Characteristics by economic situation

The rate of household respondents at risk of poverty is higher compared to household respondents who are not at risk of poverty. According to Europe 2020 indicators, the risk-of-poverty threshold is set at 60 % of the national median equivalised disposable income (after social transfers).

[41] If we take all persons in the sample, the rate is 29.9 %. In this case, the value provided by the household respondent is attributed to all household members. Additional data are provided in the statistical annex.

In the EU, about 31.1 % of household respondents, at risk of poverty, declare difficulty to afford professional home care. This rate is 27.6 % for persons who are not at a risk of financial poverty.

Figure 30: Percent of household respondents declaring difficulty to afford professional home care. 2016. Only respondents who have paid home care.

By gender and age	By risk of financial poverty
	
	The risk of financial poverty is as defined as in Europe 2020 indicators.

Data source: EU-SILC UDB 2016– version 20 March 2018.

2.6 Unmet needs for professional home care

Introduction

As noted above, the EU-SILC 2016 ad hoc module includes a question on the "Presence in the household of people who need help due to long-term physical or mental ill-health, infirmity or because of old age" (HC190).

For those who answer affirmatively, the interviewer put a question on 'Unmet needs for professional home care' (HC240). The aim is to capture the household respondent's assessment of whether there are household members who require professional home care, but are not provided at all or are provided insufficiently.

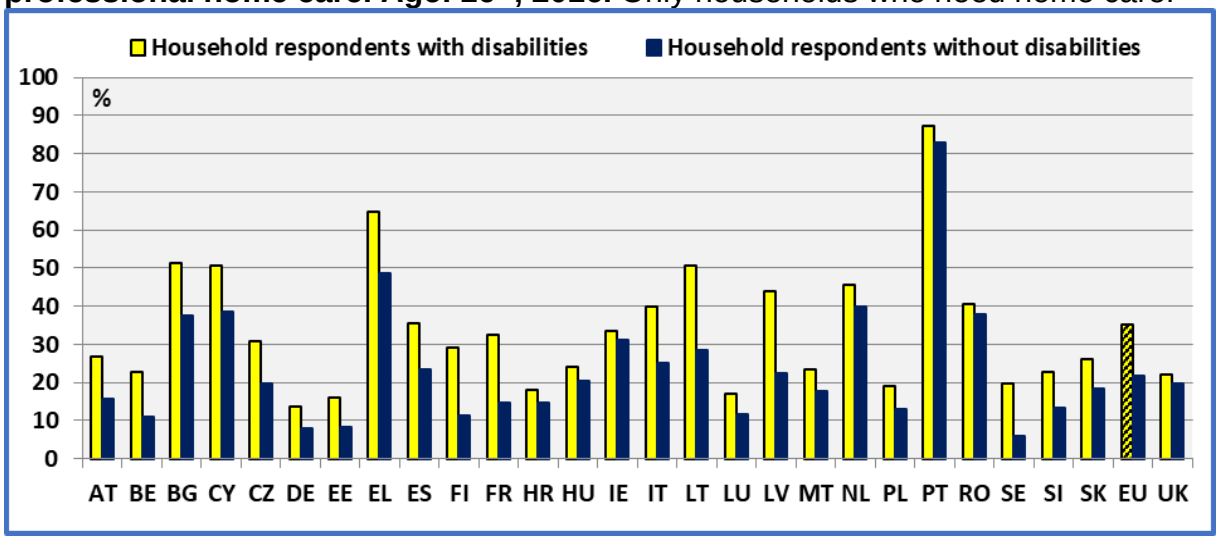
2.6.1 Characteristics by Member State

In the EU 27, considering only households who need help due to long-term physical or mental ill-health, infirmity or because of old age, about 30.2 % declare having unmet needs for professional home care.

There is an important difference between household respondents with and without disabilities. The rate for respondents with disabilities is 35.0 % and for respondents

without disabilities 21.9 %.[42] The gap is about 13.2 percentage points. It represents a relative disadvantage of 60.2 % of disabled respondents in comparison to non-disabled respondents. However, this is an approximation for the disability gap, since non-disabled respondents might have persons with disabilities needing help inside their households.

Figure 31: Percent of household respondents declaring unmet needs for professional home care. Age: 16+, 2016. Only households who need home care.



How to read the figure: In Austria, considering only household respondents who need help, about 27 % of household respondents with disabilities and 16 % of household respondents without disabilities declare unmet needs for professional home care.
Data source: EU-SILC UDB 2016– version 20 March 2018.

2.6.2 Characteristics by age group

As indicated above, the question refers to the unmet needs for professional home care by any household member. Consequently, the analysis by age group will provide only an approximation of the situation at the EU level.

In order to avoid the above bias, we will analyse age differences by focussing on one person household. In this case, we know that unmet needs refer to the respondent himself and not any other household member. However, we have to note that one-person households are not representative of the whole population. Still, they provide information on a group of persons which faces several disadvantages compared to other persons.

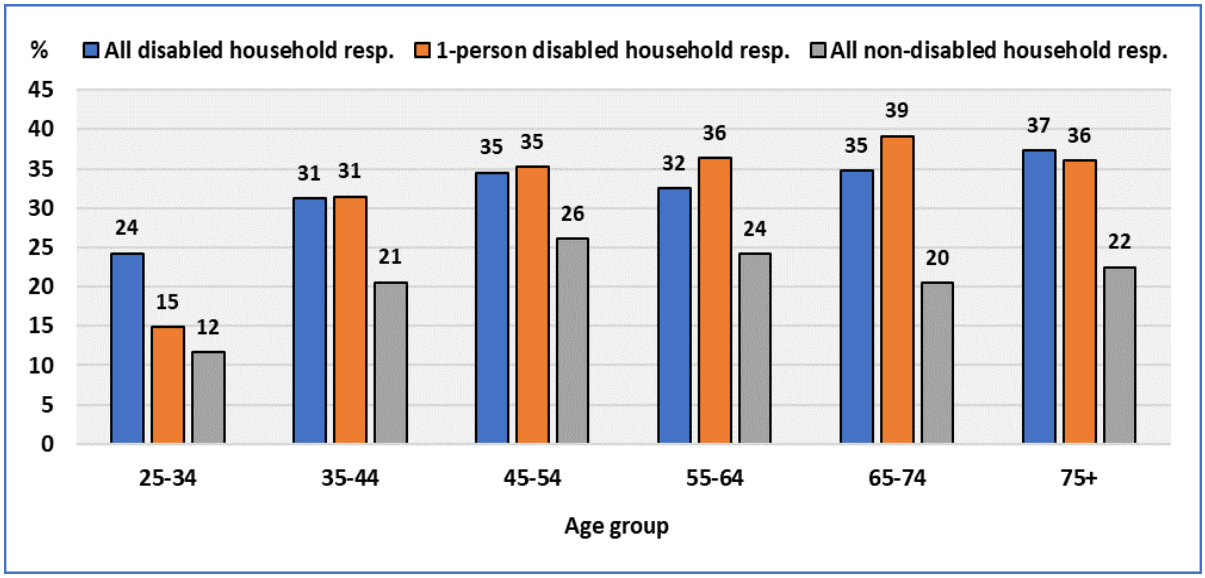
In the following figure, we try to summarise the main findings by age group for the EU 27. We present three different groups. Concerning persons with disabilities, we present the percentage of persons with unmet needs by distinguishing two categories. The first covers all household respondents with disabilities. As noted, the results might be biased. The answer refers to any household member. The second group covers one-person household respondents. There is no bias here, but this is only a special group. The third group covers all household respondents without disabilities. We use this group as base for comparison. The percentages of persons with unmet needs refer to households who need home care.

[42] If we take all persons in the sample, the rates are respectively 33.9 % (persons with disabilities) and 23.1 % (persons without disabilities). In this case, the value provided by the household respondent is attributed to all household members. Additional data are presented in the statistical annex.

For all groups, the percentage of persons declaring unmet needs is increasing initially and decreases slightly at a later age. Both groups of persons with disabilities experience significantly higher rates compared to the base group (persons without disabilities). This disadvantage is very high for older people.

In the EU 27, about 15 % of persons with disabilities (living in one -person households) declare unmet needs for professional home care. For comparison, this rate is 12 % for persons without disabilities (same household type). This rate increases to 39 % for persons with disabilities aged 65 to 74 and 20 % for persons without disabilities, same age group.

Figure 32: Percent of household respondents declaring unmet needs for professional home care by age group. EU 27, 2016. Only households who need home care.



Note: We have excluded the age group 16-24 because the respondent is young, but the household might include a high number of older persons (parents) who need care.
Data source: EU-SILC UDB 2016– version 20 March 2018.

2.6.3 Characteristics by household size

When we study the influence of household size on unmet home care, we may note a limited impact. As expected, concerning persons living alone (one-person households), the rate of persons with disabilities declaring unmet needs (36 %) is significantly higher compared to persons without disabilities (14 %). The first group might have needs related to disability, health or old age. The latter group might have unmet needs due to health or old-age problems.

2.6.4 Characteristics by gender

Gender differences are small: 30.8 % for women respondents and 29.4 % for men respondents, at the EU 27 level. But the data might underestimate any difference, since the household respondents answer for the needs of all household members.

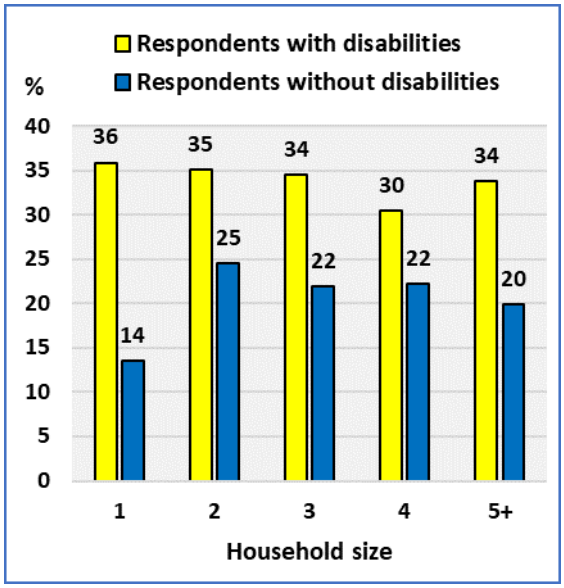
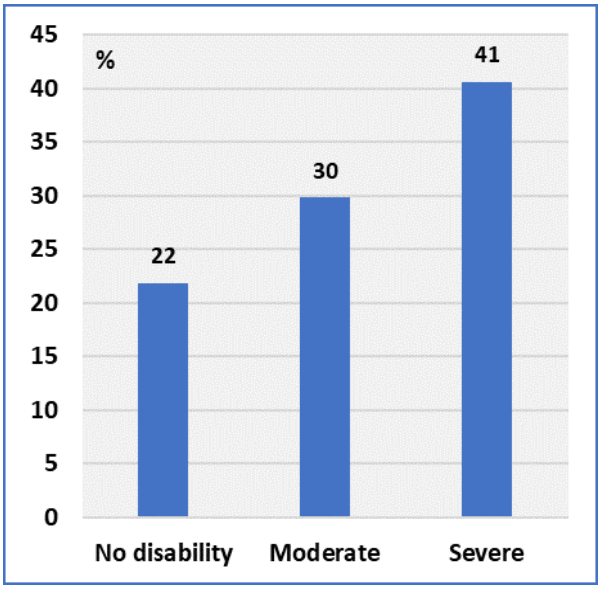
If we focus only on household respondents with disabilities, the difference is significative. The percentage is 32.4 % for men and 36.6 % for women. This difference increases if we consider only one-person households. In this case, there is no bias due

to the formulation of the question. About 38.0 % of women (one-person household) report unmet needs compared to 30.2 % of men.

2.6.5 Characteristics by degree of disability

The degree of disability has an important impact on unmet home care needs. About 40.6 % of household respondents with severe disabilities declare having unmet needs for professional home care in their household.

Figure 33: Percent of household respondents declaring unmet needs for professional home care. Age: 16+, 2016. Only household respondents who need home care

By household size	By degree of disability
	

For comparison, if we take all persons who need help in the sample, we obtain 23 %, 29 % and 39 % respectively.

Data source: EU-SILC UDB 2016– version 20 March 2018.

2.6.6 Reasons for not receiving home care services

The EU-SILC 2016 ad hoc module includes a question on “main reason for not receiving (more) professional home care services” (HC250). It distinguishes:

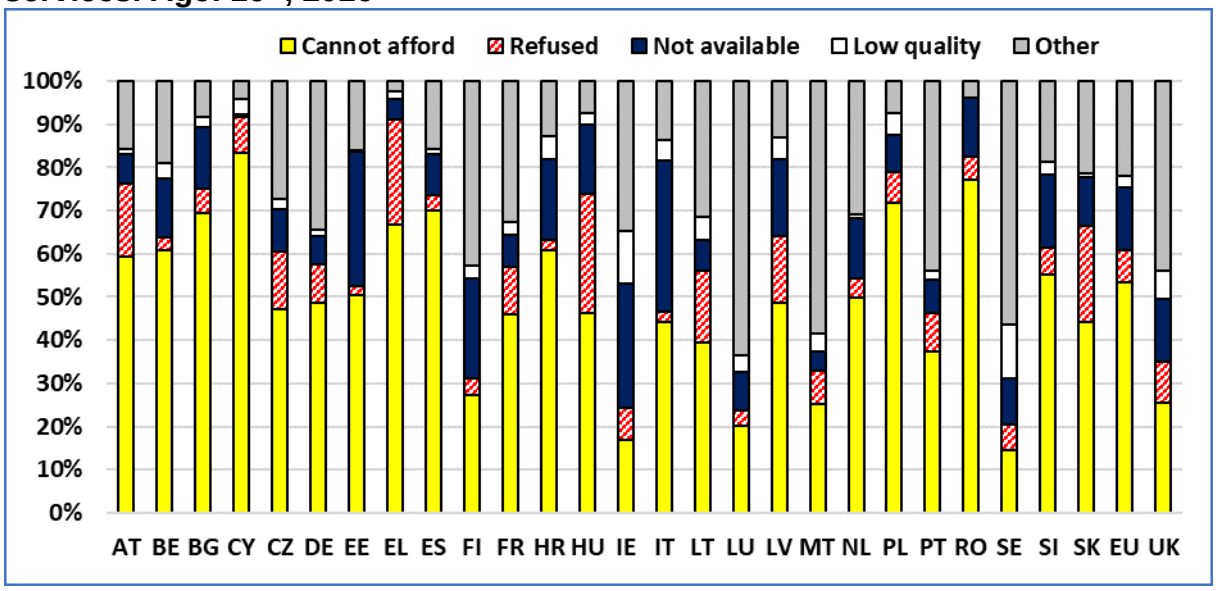
1. Cannot afford it
2. Refused by person needing such services
3. No such care services available
4. Quality of the services available not satisfactory
5. Other reasons

The question covers persons who declare a need by household members and did not receive enough home care.

In the EU 27, about 53.3 % cannot afford it; 7.6 % refused by person needing such services, 14.4 % declared that no such care services were available, 2.9 % that the quality of the services available was not satisfactory, and 21.9 % other reason.

The main reason for not receiving (more) professional home care services is an economic constraint, notably in Poland, Romania and Cyprus. On the other side, the economic constraint is very low in Sweden, Ireland and Luxembourg.

Figure 34: Main reason for not receiving (more) professional home care services. Age: 16+, 2016



Data source: EU-SILC UDB 2016– version 20 March 2018.

We might suspect that “other reason” might include accessibility and mobility problems. However, a closer look indicates that 24.3 % of respondents without disabilities use this argument compared to 21.0 % for respondents with disabilities.

2.6.7 The impact of COVID-19 pandemic

The COVID-19 pandemic might affect significantly the way home care is provided. The SHARE-COVID-19 survey (Op. cit.) includes a question (CAS025_): “Did you regularly receive home care before the outbreak of Corona?”. About 5.6 % of persons, aged 50 and over, declared receiving home care. The SHARE COVID-19 survey took place between June and August 2020.

This rate is higher compared to the equivalent rate delivered by the EU-SILC 2016 ad hoc module. In fact, the latter provides a rate of 3.5 %[43] for persons aged 50 and over. The difference between the two surveys stems mainly from the fact that the EU-SILC survey focusses on professional home care while the SHARE survey covers all types of home care. Consequently, it includes informal home care too. Also, the questions in the two surveys are different and the years covered are not the same.

The SHARE COVID-19 survey indicates that, among those receiving regularly home care before the outbreak of Corona, about 18.5 % declared that “they faced more difficulties in getting the amount of home care that they were needing”. “People who

[43] The SHARE survey does not include Austria and Ireland. Both Member States have a slightly higher rate than the EU average in the EU-SILC survey. However, the weight of these countries into the EU 27 average is marginal and does not change the conclusions.

cared for me could not come to my home" was the main reason advanced (74 %) for these difficulties.

2.7 Summary and conclusions

Use of health care services

In the EU 27, about 89.9 % of household respondents with disabilities report that their household use health care services, compared to 80.6 % of respondents without disabilities. Concerning persons living in one-person households, about 87.9 % of persons with disabilities use health care services, compared to 72.1 % of persons without disabilities. This higher rate may be explained by the fact that persons with disabilities declare more often bad or very bad health. Consequently, they might use more often health care services.

The percentage of women with disabilities is higher compared to men. But women live longer, and the use of health care services is increasing with age. Households with relatively high incomes report more often the use of health care services.

The SHARE COVID-19 survey, July to August 2020, asked if the interviewee had a medical appointment scheduled, which the doctor or medical facility decided to postpone due to Corona. In the EU, 24.9 % of persons aged 50 and over, declared such a postponement. This rate is 33.9 % for persons declaring a poor health. Also, about 11.6 % of persons forwent medical treatment since the outbreak of COVID-19 because they were afraid to become infected by the corona virus. In addition, about 5.4 % of persons declared that they were denied an appointment.

A saturation of hospitals and the postponement of cases non-related to COVID-19 may have an indirect detrimental impact on the health of persons with disabilities. In fact, the rate of persons with disabilities who use health care services is higher compared to persons without disabilities. This is partly due to a higher comorbidity by persons with disabilities. This means that a postponement of medical care might have serious negative impact on the health of persons with disabilities. WHO notes that it is critical to maintain preventive and curative services, especially for the most vulnerable populations, e.g. people with disabilities?[44]

This disruption in health care services might deteriorate the health of all persons with chronic illness and lead to activity limitations increasing consequently the number of persons with disabilities.

Affordability of health care services

In the EU 27, about 21.8 % of household respondents with disabilities declare a difficulty (with difficulty or with great difficulty), compared to 9.7 % of persons without disabilities.

Women face more difficulties compared to men. This holds true both for persons with and without disabilities. The percentage of household respondents (all household respondents) declaring difficulty to afford the cost of health care services decreases steadily as household income increases.

[44] WHO: "Maintaining essential health services during the COVID-19 outbreak" https://www.who.int/emergencies/diseases/novel-coronavirus-2019/related-health-issues.

The current pandemic and the associated measures are expected to hit hard the employment in all countries. However, in some countries, this might be hardest due to the productive structure of the economy and the small size of their enterprises. Analysis of the productive structure of Member States indicates that this might be the case in certain of them.

Furthermore, the situation of persons with disabilities is expected to deteriorate in comparison to other groups. Persons with disabilities are overrepresented in very small business, specially affected in specific sectors and countries. National programmes to support small business to adapt to constraints imposed by the pandemic, ought to take into account the special needs of persons with disabilities. Also, improving access to health care of workers (and their families) in these very small businesses ought to be reinforced.

Unmet medical needs

In the EU 27, about 4.0 % of persons with disabilities report unmet needs for medical care due to ‘Financial reasons’, ‘Waiting list’ or ‘Too far to travel’, compared to 1.0 % for persons without disabilities.

Self-reported unmet needs for medical examination increase with age, notably for very elderly people (75+). Future policies ought to target better the needs of people aged 75 and over.

There is a positive correlation between the severity of declared depression and the percentage of self-reported unmet needs for medical examination. Moreover, an important factor affecting the rate of unmet needs for medical examination is household disposable income.

As noted, due to COVID-19 pandemic scheduled medical appointments were postponed, medical treatments were forgone because persons were afraid to become infected by the corona virus; and appointments for a medical treatment were denied.

In a period of increased unemployment and general lockdowns, following the COVID-19 pandemic, the situation of the most vulnerable groups might worsen. Existing unmet needs for medical care, could be aggravated.

Consequently, we expect an increase of unmet needs either as a direct impact of COVID-19 or as an indirect impact through the resulting economic crisis.

Professional home care

In the EU 27, about 20.3 % of household respondents with disabilities declare the presence in their household of people who need help. This rate is 4.3 % for household respondents without disabilities. The rate for all household respondents is 8.6 %.

In the EU 27, among those who need help, about 26.9 % receive professional home care. This rate is 30.8 % for household respondents with disabilities and 19.9 % for household respondents without disabilities. This rate is 42.5 % for persons with disabilities from one-person households. Professional home care services allow people with chronic illness and disabilities to continue living in their homes or in the community rather than in health care structures or institutions.

The rate of households receiving help decreases steadily with household size. Informal help is replacing, at least partly, professional help. Isolation increases the need for professional home care. The rate of persons receiving help increases with age and degree of disability.

The percentage of households receiving professional home care increases with the economic situation of the Member State. But countries with similar incomes present important differences.

5. The cost of professional home care

In the EU 27, among those who expressed a need and received professional home care about 67.3 % declare that they have paid for professional home care. There are big differences across Member States. However, in certain Member States, this cost might be reimbursed. Still, it might be a constraint for low-income households.

In the EU 27, among those who paid professional home care, about 28.0 % declare difficulty to afford for it. The percentage of women household respondents declaring difficulty is higher at all ages compared to men. This might reflect higher economic constraints. The rate among household respondents at risk of poverty is higher compared to respondents who are not at risk of poverty.

Unmet needs for professional home care

In the EU 27, among those households who need help due to long-term physical or mental ill-health, infirmity or because of old age, about 30.2 % declare having unmet needs for professional home care. The rate for respondents with disabilities is 35.0 % and for respondents without disabilities 21.9 %. This rate is 40.6 % for household respondents with severe disabilities. Older women, living alone, are also disadvantaged. Concerning the reasons for not receiving (or insufficiently receiving) home care, about 53.3 % declare that they cannot afford it.

The COVID-19 pandemic might affect significantly the way home care is provided. The SHARE COVID-19 survey indicates that, among those receiving regularly home care before the outbreak of Corona, about 18.5 % declared that “they faced more difficulties in getting the amount of home care that they were needing”. “People who cared for me could not come to my home” was the main reason advanced (74 %) for these difficulties. The survey covered persons aged 50 and over and took place between June and August 2020.

More health care resources might be needed to be allocated towards disadvantaged groups.

3 Isolation, social distancing and mental health

Introduction

COVID-19 prevention measures require social distancing and might increase problems related to isolation. Also, persons at a higher risk from coronavirus might require help from family, friends and volunteers with things like getting food, medicines and other things they need. Consequently, in this part, we are going to analyse the following indicators:

1. Social networking (Getting together with friends or relatives)
2. Satisfaction with personal relationships
3. Feeling lonely
4. Material help
5. Non-material help
6. Isolation, social distancing, mental health and COVID-19

The analysis involves cross-tabulations with socio-economic characteristics such as age, gender, degree, education, income, etc.

The relation with mental health is analysed whenever this is possible by the availability of the data.

The relation between isolation, social distancing and COVID-19 is done whenever this is relevant.

3.1 Social networking (Getting together with friends or relatives)

Introduction

In a period of social distancing, getting together with friends might be limited or restricted to the close family. The ability to draw information and other resources (e. g. help) is restricted. Furthermore, isolation and lack of communication with others might affect health.

In the following, we use this capacity to get together with friends and relatives as a proxy for social interaction and networking. We use these terms in their widest sense.

From another perspective, the capacity to get together with friends and relatives might be considered as an immaterial-social capital for the individual. For example, the ability to have such a network is important since it can be used as a potential source for the collection of information and assistance.

The exact question in the EU-SILC survey is: “Do you get-together with friends/family (relatives) for a drink/meal at least once a month? (PD050)”. Possible answers are: 1. Yes, 2. No - cannot afford it and 3. No - other reason.

“Getting together” here could be interpreted as a capacity to interact, connect and draw resources from other people. Eurostat notes[45] that this variable aims to take into

[45] Eurostat: “*Methodological Guidelines and Description of EU-SILC Target Variables*”, 2018 operation (Version July 2019), op. cit.

account the multi-cultural specificities as well as the financial and social aspects of deprivation. From our perspective, deprivation here means a lack of social capital.

3.1.1 Characteristics by Member State

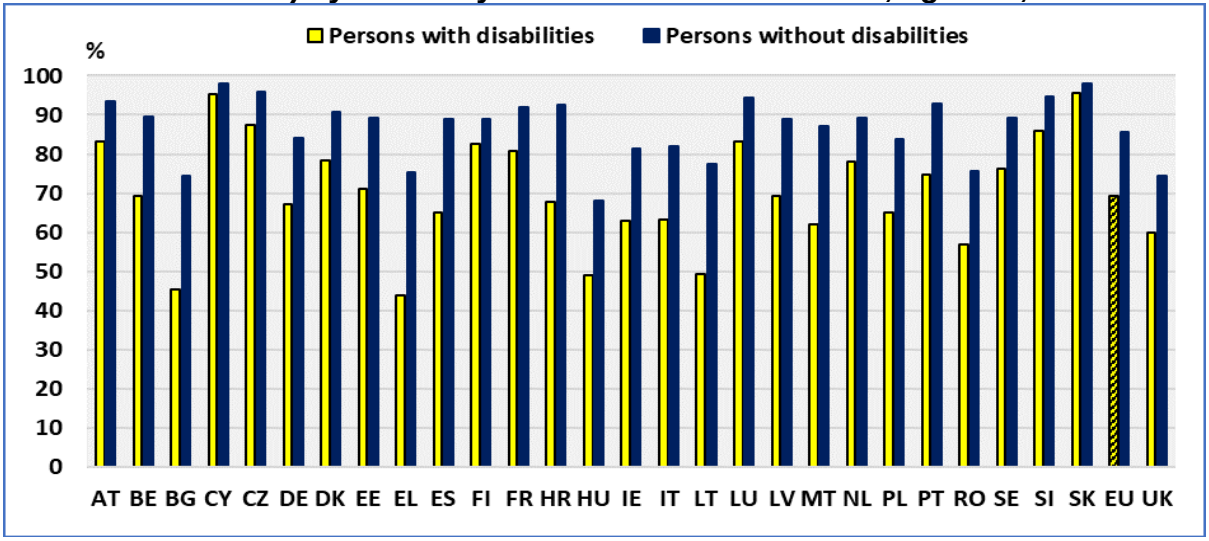
In the EU 27, the percentage of persons with disabilities who were reporting able to get together with friends or relatives, before the pandemic, was 69.3 % compared to 85.7 % of persons without disabilities.

This reveals a high risk of isolation for 30.7 % of persons with disabilities and 14.3 % for persons without disabilities.

The analysis by Member State reveals a high diversity across them. The relative disadvantage of persons with disabilities compared to persons without disabilities is low in Cyprus and Slovakia and high in Bulgaria and Greece.

In Greece and Bulgaria, a high rate of persons reports an economic constraint (it could not afford it).

Figure 35: Social networking (Percent of persons who can get together with friends or relatives) by disability and Member State. EU 27, age 16+, 2018



Relative disadvantage: 100 x (% persons without disabilities - % persons with disabilities) / (% persons without disabilities).
Data source: EU-SILC UDB 2018 Release 2020, Version 1.

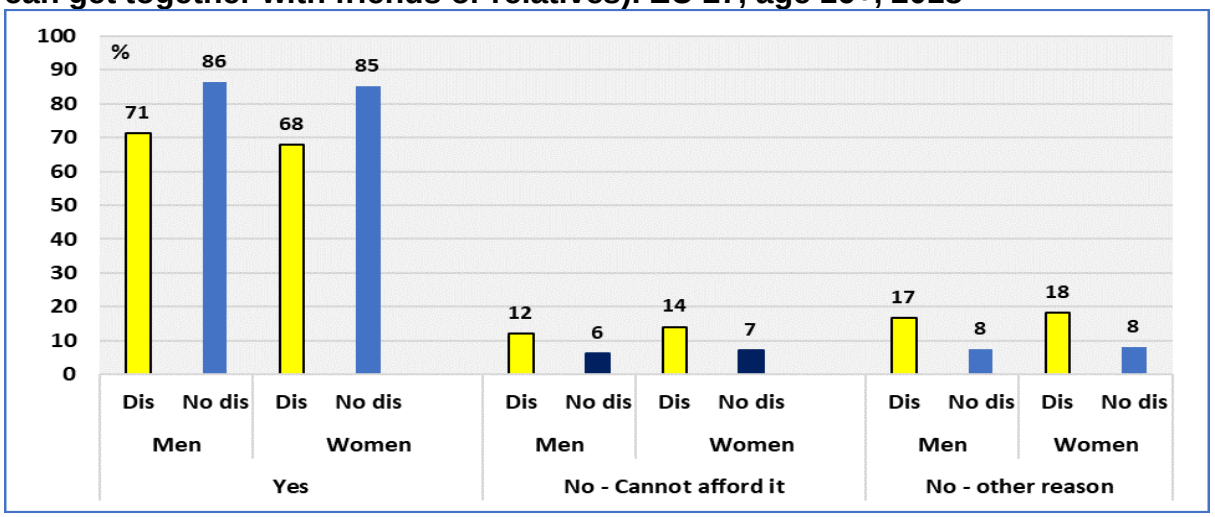
3.1.2 Characteristics by gender

The percentage of women with social networking (Yes: can get together with friends) is slightly lower compared to men. This is notably true for persons with disabilities. In the EU 27, about 68 % of women with disabilities can get together with friends or relatives. The equivalent rate for men with disabilities is 71 %.

The relative gender disadvantage (women compared to men) is stronger among persons with disabilities (4.9 %) than among persons without disabilities (1.5 %).

The relative disability gap is 17.5 % for men (disabled men compared to non-disabled men) and 20.3 % for women (disabled women compared to non-disabled women).

Figure 36: Social networking by disability and gender (Percent of persons who can get together with friends or relatives). EU 27, age 16+, 2018



Data source: EU-SILC UDB 2018 Release 2020, Version 1

3.1.3 Characteristics by age group

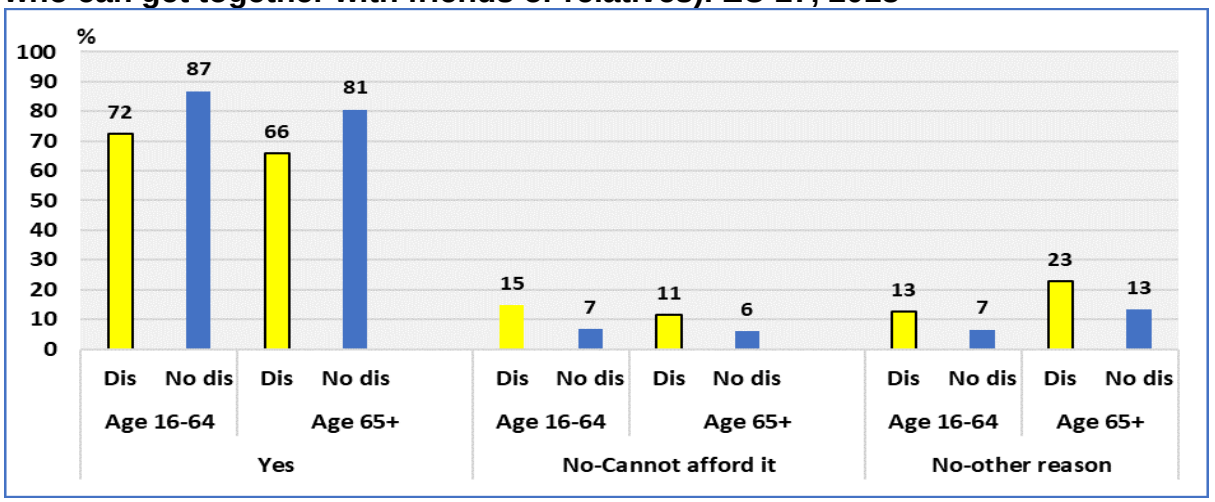
The percentage of older people (65 and over) having a social network is lower compared to younger persons (16-64). This holds both for persons with and without disabilities.

We note a very high rate of older people reporting no potential social networking "for other reasons". This might be due to health problems and mobility disabilities.

Social networking, here, refers to physical contact (getting together with friends) and exclude contacts via internet, telephone, etc. A physical contact might be constrained by mobility disabilities, and this might be true, notably, for older people. However, this might be overcome by electronic networking. But, digital poverty, among older people, might reduce such opportunities.

Concerning persons aged 16 to 64, in the EU 27, about 72 % of persons with disabilities can get together with friends or relatives compared to 81 % of persons without disabilities. A similar gap exists for the age group of persons aged 65 and more.

Figure 37: Social networking by disability and age group (Percent of persons who can get together with friends or relatives). EU 27, 2018

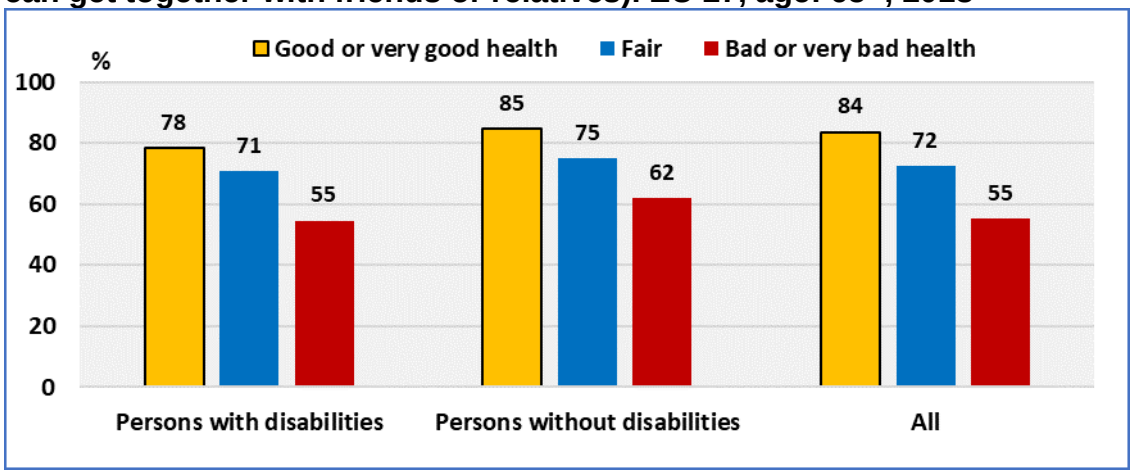


Data source: EU-SILC UDB 2018 Release 2020, Version 1.

Health plays an important role in social networking. As health deteriorates, social networking decreases. This holds both for persons with and without disabilities.

In the EU 27, 85 % of persons without disabilities in good or very good health can get together with friends or relatives, compared to 78 % of persons with disabilities.

Figure 38: Social networking by disability and health (Percent of persons who can get together with friends or relatives). EU 27, age: 65+, 2018



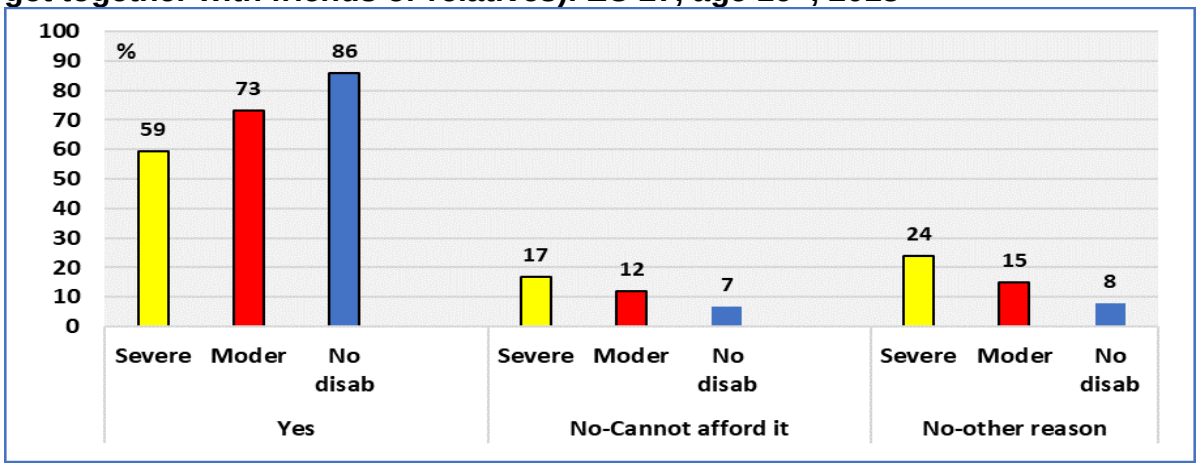
Data source: EU-SILC UDB 2018 Release 2020, Version 1.

3.1.4 Characteristics by degree of disability

The degree of disability decreases the percentage of persons reporting social networking (proportion of persons who can get together with friends or relatives). Persons with severe disabilities report more often bad health and as noted health has a significant negative impact on social networking.

In the EU 27, about 59 % of persons with severe disabilities can get together with friends or relatives, compared to 73 % of persons with moderate disabilities and 86 % of persons without disabilities.

Figure 39: Social networking by degree of disability (Percent of persons who can get together with friends or relatives). EU 27, age 16+, 2018



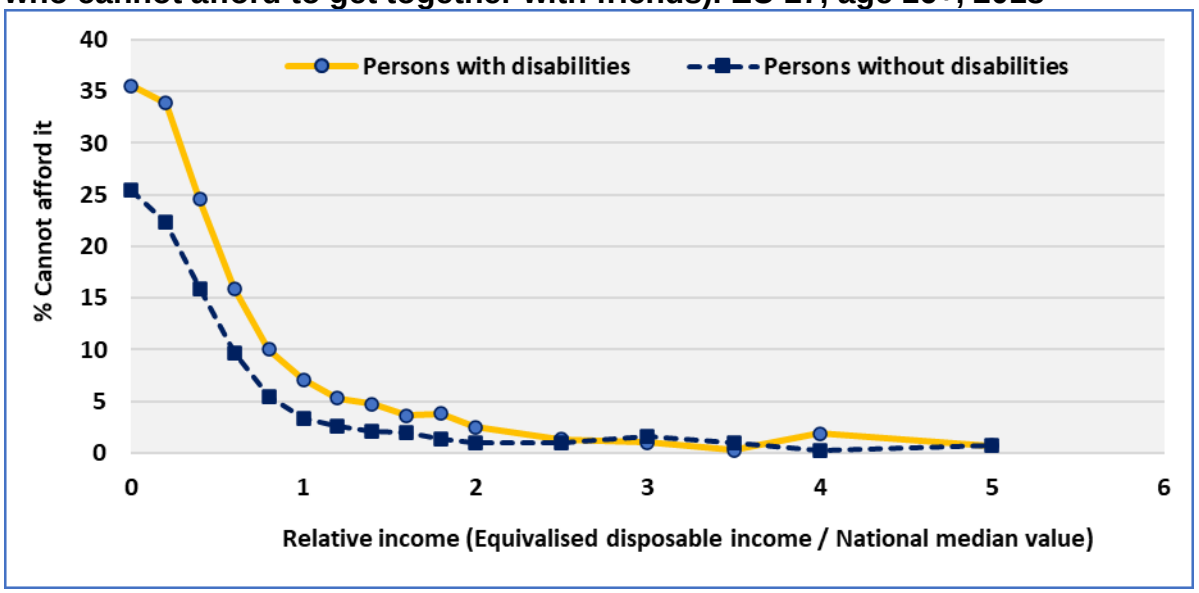
Data source: EU-SILC UDB 2018 Release 2020, Version 1.

3.1.5 Economic factors

Finally, income plays an important role. In the following graph, we can see that high relative incomes declare no or extremely low economic constraint concerning social networking (get together with friends).

In a period of social distancing and lockdown, digital skills and economic capacity appear to be important factors able to maintain social contacts and avoid isolation of vulnerable groups.

Figure 40: Social networking by income level and disability (Percent of persons who cannot afford to get together with friends). EU 27, age 16+, 2018



Note: We have excluded negative and zero incomes since they include persons with temporary and exceptionally low incomes.
Data source: EU-SILC UDB 2018 Release 2020, Version 1.

3.1.6 Social networking and mental health

In the following figure, we may observe that persons who cannot get together with friends due to economic constraints, tend to declare a very high rate of (severe) depression. However, the observed correlation is not a guarantee for a causality link, but we cannotexclude it.

The graph indicates that among persons with disabilities, who cannot afford to get together with friends, about 28 % declare a severe depression. The equivalent rate for persons without disabilities is 13 %.

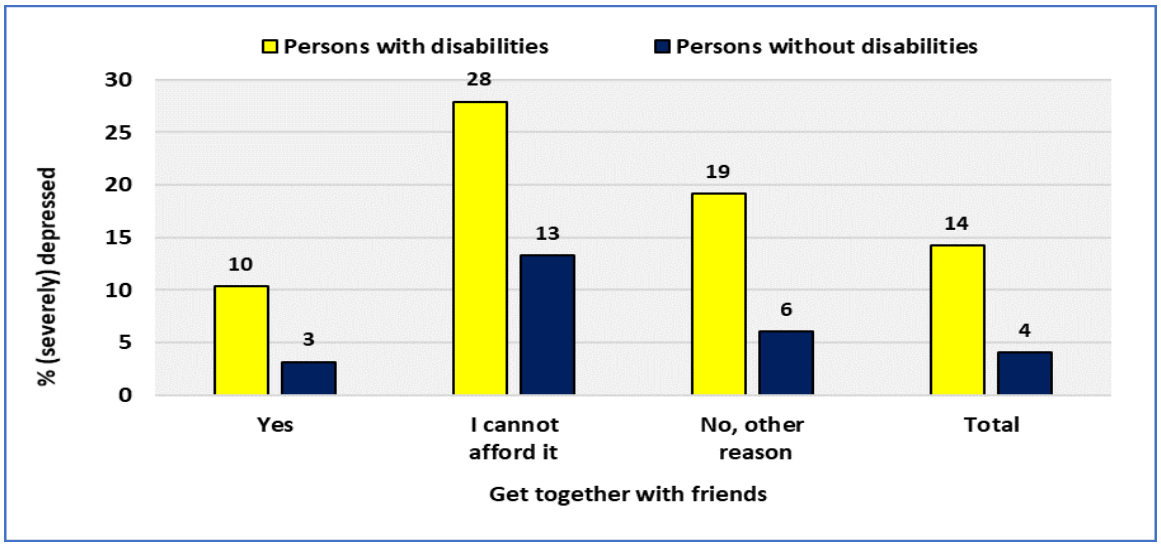
In a period of social distancing (more difficult to get together with friends) and lock-down (increased unemployment), the situation ought to increase the percentage of persons declaring not being able to meet with friends. This might have a detrimental impact on their mental health.

CDC[46] notes that public health actions, such as social distancing, can make people feel isolated and lonely and can increase stress and anxiety. It adds that stress during an infectious disease outbreak can sometimes cause a worsening of chronic health

[46] See Centres for Disease Control and Prevention (CDC). Title: “Pandemics can be stressful” in https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/managing-stress-anxiety.html.

problems and of mental health conditions. It notes that healthy ways to cope with stress include, notably, connecting with others or talk with people you trust and connecting with your community.

Figure 41: Percent declaring (severe) depression by social networking potential (Percent of persons who cannot afford to get together with friends). EU, age 16+, 2018



Note: "Severe" means all the time or most of the time during the last 4 weeks. Social networking is proxied by "get together with friends".
Data source: EU-SILC UDB 2018 Release 2020, Version 1.

3.2 Satisfaction with personal relationships

Introduction

The EU-SILC 2018 ad hoc module on well-being includes a question on satisfaction with personal relationships (PW160T). The interviewee is invited to give a score from 0 (Not at all satisfied) to 10 (Completely satisfied). The question covers all persons in the sample.

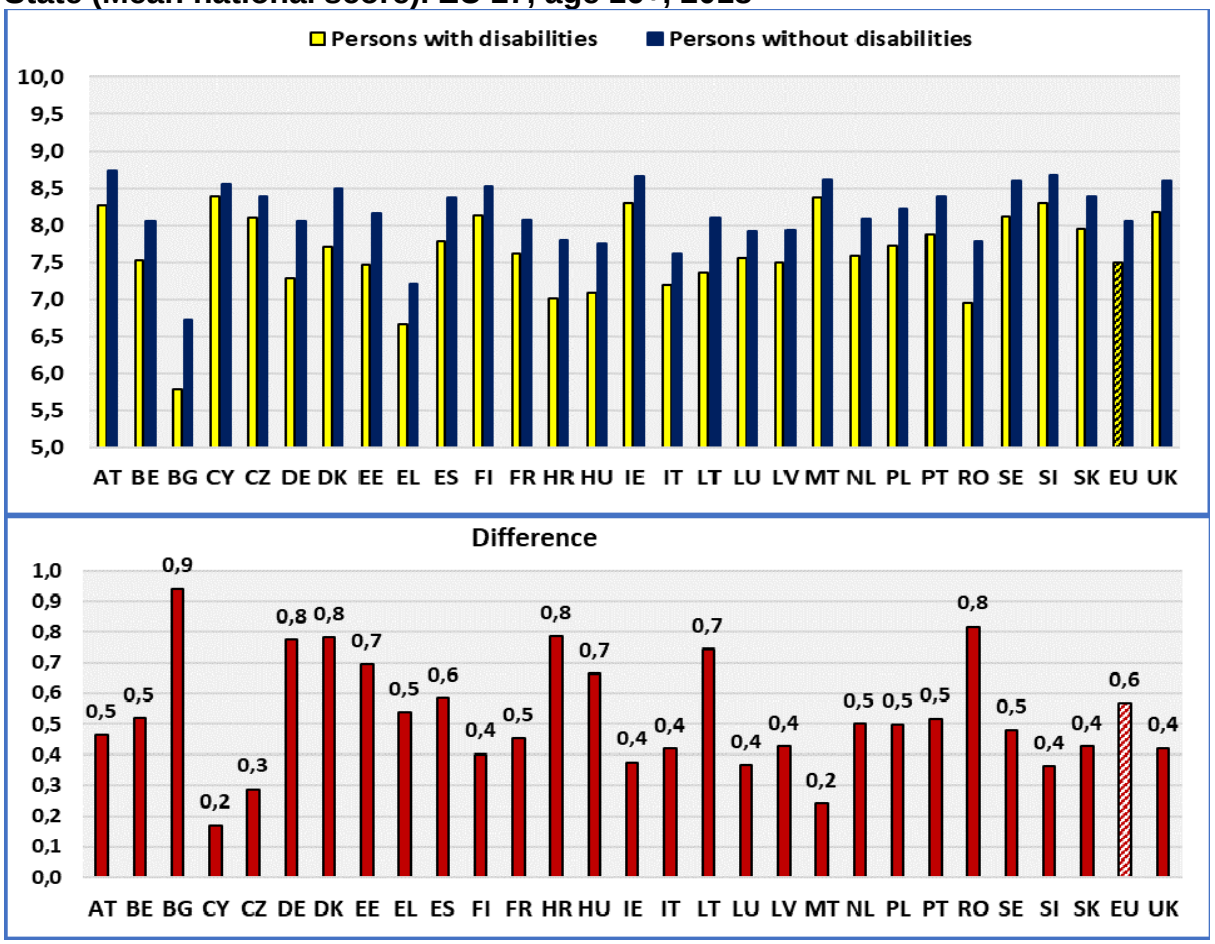
Eurostat notes that the respondent should take into consideration relationships with all the people with whom he/she spends time (e.g., family, friends, colleagues from work, neighbours).

3.2.1 Characteristics by Member State

In the EU 27, the average score for persons with disabilities is 7.5 and 8.1 for persons without disabilities. Bulgaria and Greece report the lowest scores for persons with disabilities. Malta and Cyprus report the highest scores for persons with disabilities. But Austria, Ireland and Slovenia are very close. The national scores of persons with disabilities are strongly correlated (R^2=0.93) with the national scores of persons without disabilities.

The higher difference between persons with and without disabilities can be found in (ascending order) Germany, Croatia, Romania and Bulgaria. Denmark and Croatia are very close to Germany. On the other end, Malta and Cyprus have the lowest differences, both in absolute and relative terms.

Figure 42: Satisfaction with personal relationships by disability and Member State (Mean national score). EU 27, age 16+, 2018



Note: The 'Difference' is rounded at one decimal.
Data source: EU-SILC UDB 2018 Release 2020, Version 1.

3.2.2 Characteristics by gender

Women report higher scores compared to men. This holds both for persons with and without disabilities. Although, the differences are small in absolute values, they are significant (at confidence level 95 %).

In the EU 27, the average score for women with disabilities is 7.5 and the equivalent for men is 7.4. The respective rates for persons without disabilities are 8.1 (women) and 8.0 (men).

The gender gap (difference between men and women) inside each group is lower compared to the disability gap (difference between persons with and without disabilities).

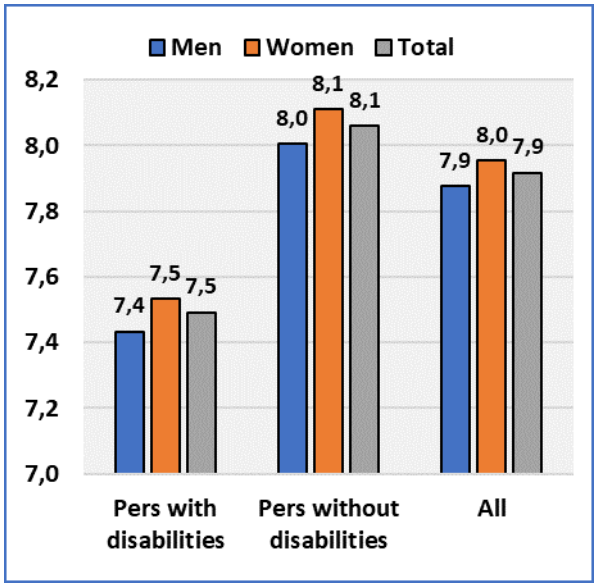
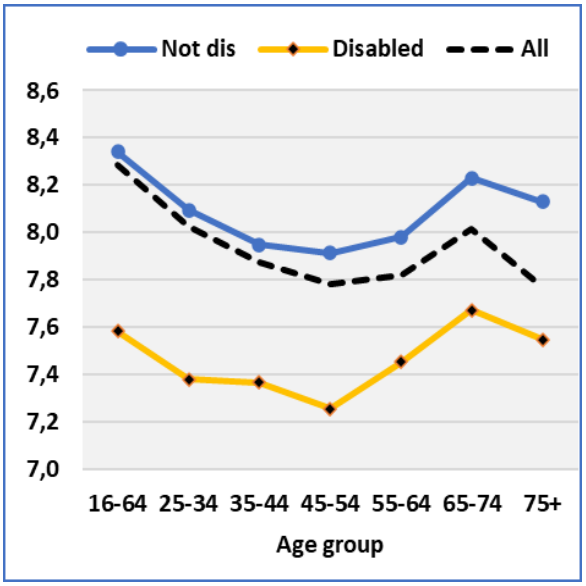
3.2.3 Characteristics by age group

Satisfaction with personal relationships decreases till the age 45-54 and increases afterwards till the age 65-74. Satisfaction decreases for the very old persons (75+).

At each age, the satisfaction level of persons with disabilities is lower compared to persons without disabilities. It is on average 0.6 points in absolute terms and 7.7 % in relative terms.

For all age groups, persons with disabilities need special measures to redress their relative disadvantage.

Figure 43: Satisfaction with personal relationships. EU 27 score, 2018

By gender (age: 16+)	By age group
	

Data source: EU-SILC UDB 2018 Release 2020, Version 1.

3.2.4 Characteristics by degree of disability

The degree of disability decreases steadily and significantly the level of satisfaction with personal relationships. Economic restrictions, health constraints, mobility limitations and accessibility barriers might explain this deterioration of personal relationships.

3.2.5 Other factors affecting satisfaction

Unemployed and one-person households report relatively low scores. This might be due to a limited array of social contacts, leading to a social isolation.

Education plays an important role. The educational level increases satisfaction. But education could act as proxy for social capital and income. Both facilitate social networks.

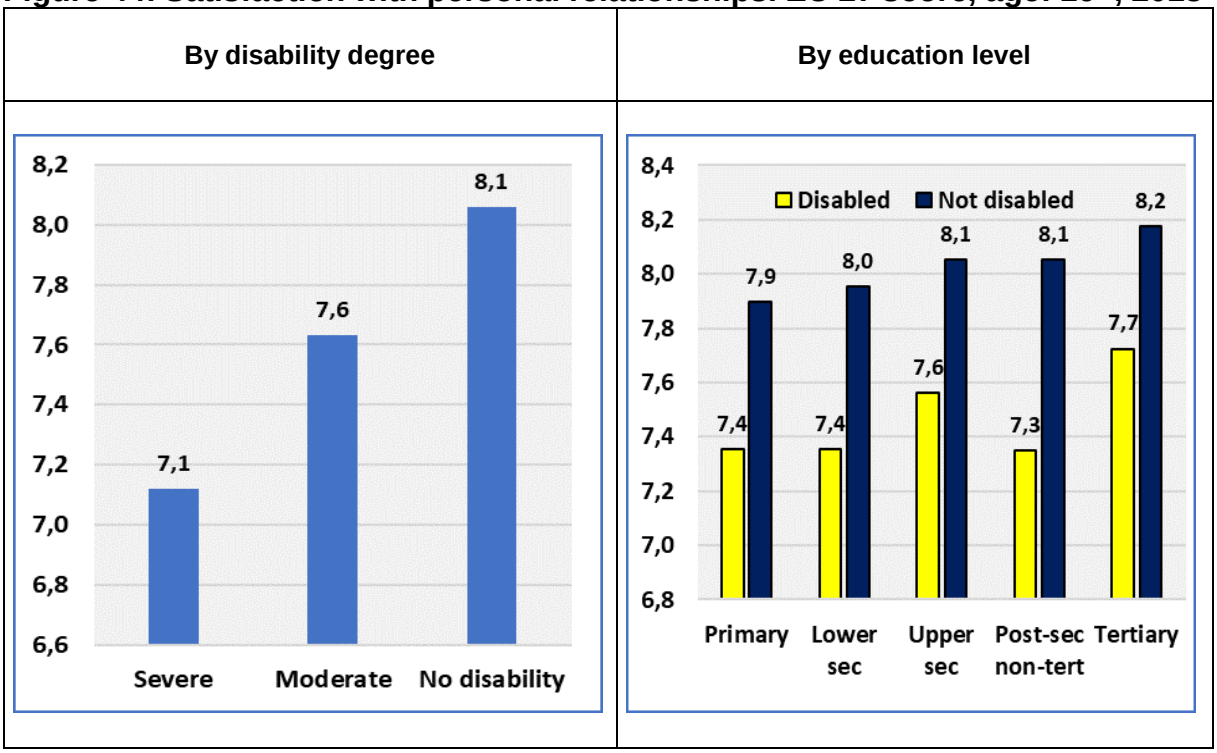
In the EU 27 and for persons with disabilities, the score is 7.4 for persons with a primary education and 7.7 for persons with a tertiary education. The respective satisfaction scores for persons without disabilities are 7.9 and 8.2.

At each educational level, persons with disabilities report a lower score.

In a period of social distancing and lockdown, several factors might exert a downward pressure to satisfaction with personal relationships. These factors might be unemployment, isolation and economic constraints. For persons with disabilities, barriers related to new information and communication technologies might decrease

further their satisfaction with personal relationships, adding further stress to existing psychological problems.

Figure 44: Satisfaction with personal relationships. EU 27 score, age: 16+, 2018



Data source: EU-SILC UDB 2018 Release 2020, Version 1.

3.3 Feeling lonely

Introduction

The EU-SILC ad hoc module 2018 on Well-Being (PW230T) includes a question on "Feeling lonely" during the past four weeks. The answers are: 1: All of the time, 2: Most of the time, 3: Some of the time, 4: A little of the time and 5: None of the time.

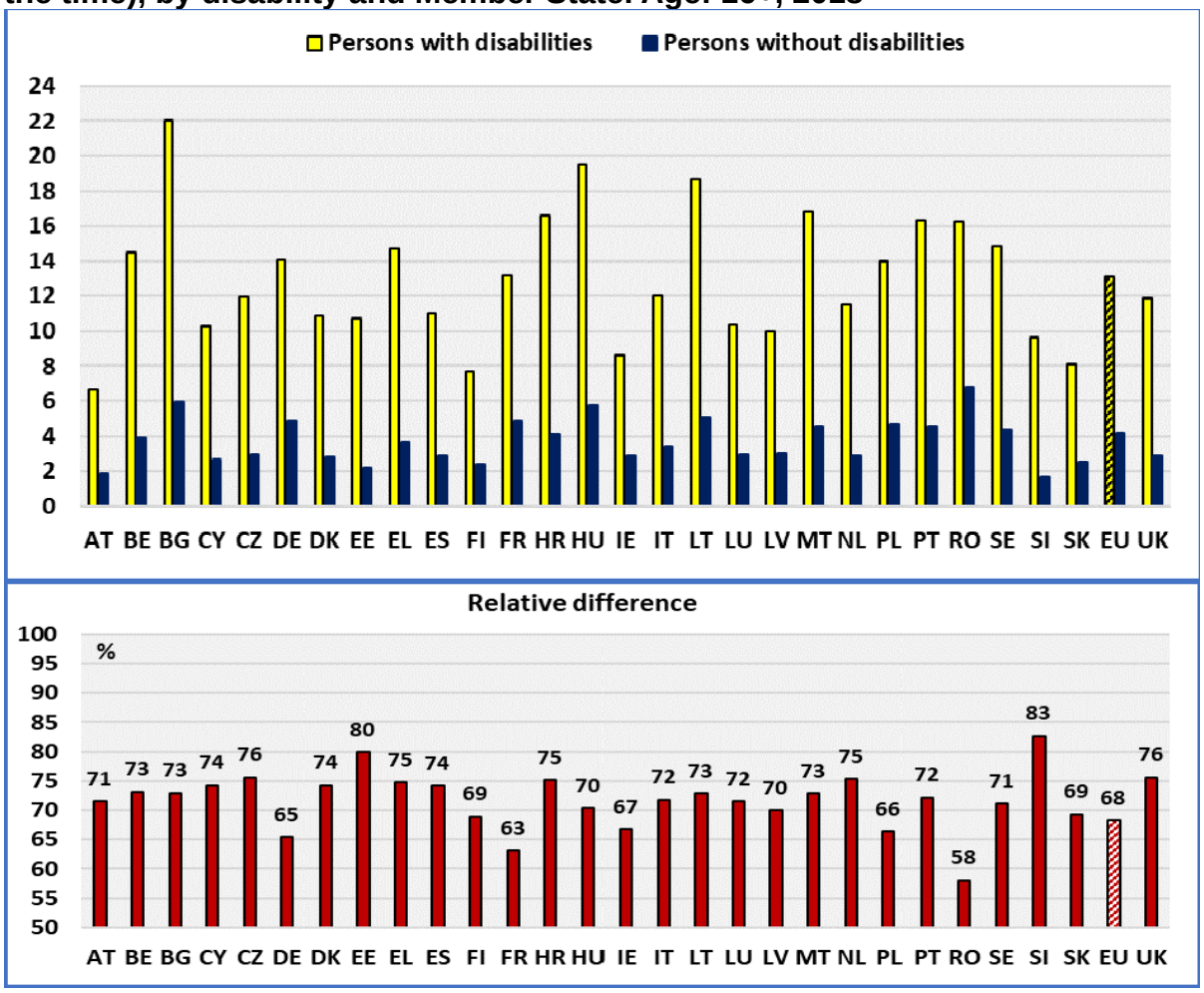
Eurostat notes that feelings of loneliness are not synonymous with being alone but instead involve feelings of isolation, feelings of disconnectedness and feelings of not belonging.

3.3.1 Characteristics by Member State

In all the Member States, the percentage of persons with disabilities declaring feeling lonely (All of the time or Most of the time), during the last four weeks, is significantly higher compared to persons without disabilities. In the EU 27, the respective rates are 11.9 % and 2.9 %.

The relative difference is high in all Member States.

Figure 45: Percent of persons declaring feeling lonely (All of the time or most of the time), by disability and Member State. Age: 16+, 2018



Relative difference: 100 x (% persons without disabilities - % persons with disabilities) / (% persons without disabilities).
Data source: EU-SILC UDB 2018 Release 2020, Version 1.

3.3.2 Characteristics by gender

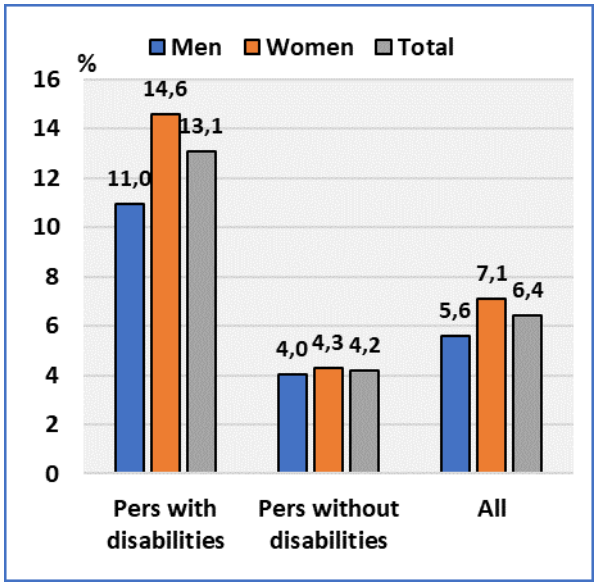
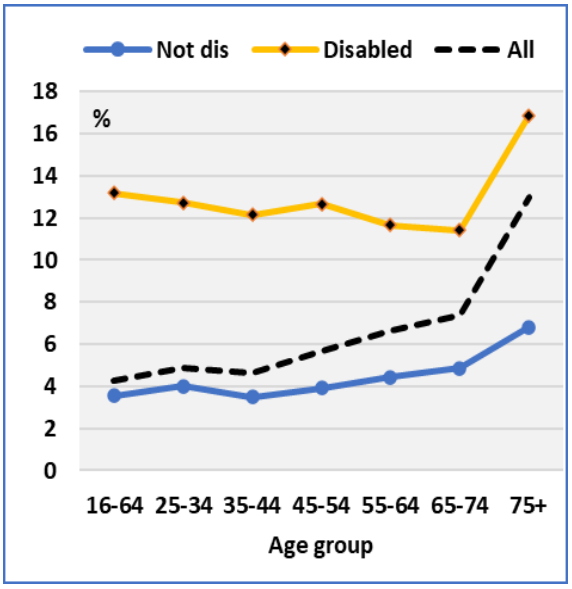
We may note an important gender difference among persons with disabilities. Among persons with disabilities, 14.6 % of women declare feeling lonely (All of the time or Most of the time) compared to 11.0 % of men. The difference among persons without disabilities is smaller.

The gender difference might be due partly to the ageing structure. Women live longer.

3.3.3 Characteristics by age group

After the age of 65, loneliness increases sharply, both for persons with and without disabilities. The percentage of people reporting feeling lonely is 16.9 % for persons with disabilities and 6.8 % for persons without disabilities. Persons aged 75 and over ought to be given a special attention.

Figure 46: Percent of persons declaring feeling lonely (All of the time or Most of the time). EU 27, 2018

By gender and disability (Age: 16+)	By age and disability
	

Data source: EU-SILC UDB 2018 Release 2020, Version 1.

3.3.4 Characteristics by degree of disability

The degree of disability increases significantly the percentage of persons which declare feeling lonely. About, 19.8 % of persons with a severe disability declare feeling lonely (All of the time or Most of the time). The rate is 10.6 % for persons with moderate disabilities and 4.2 % for persons without disabilities.

3.3.5 Other socio-economic characteristics

Other factors which affect significantly the percentage of persons declaring feeling lonely (All of the time or Most of the time) are:

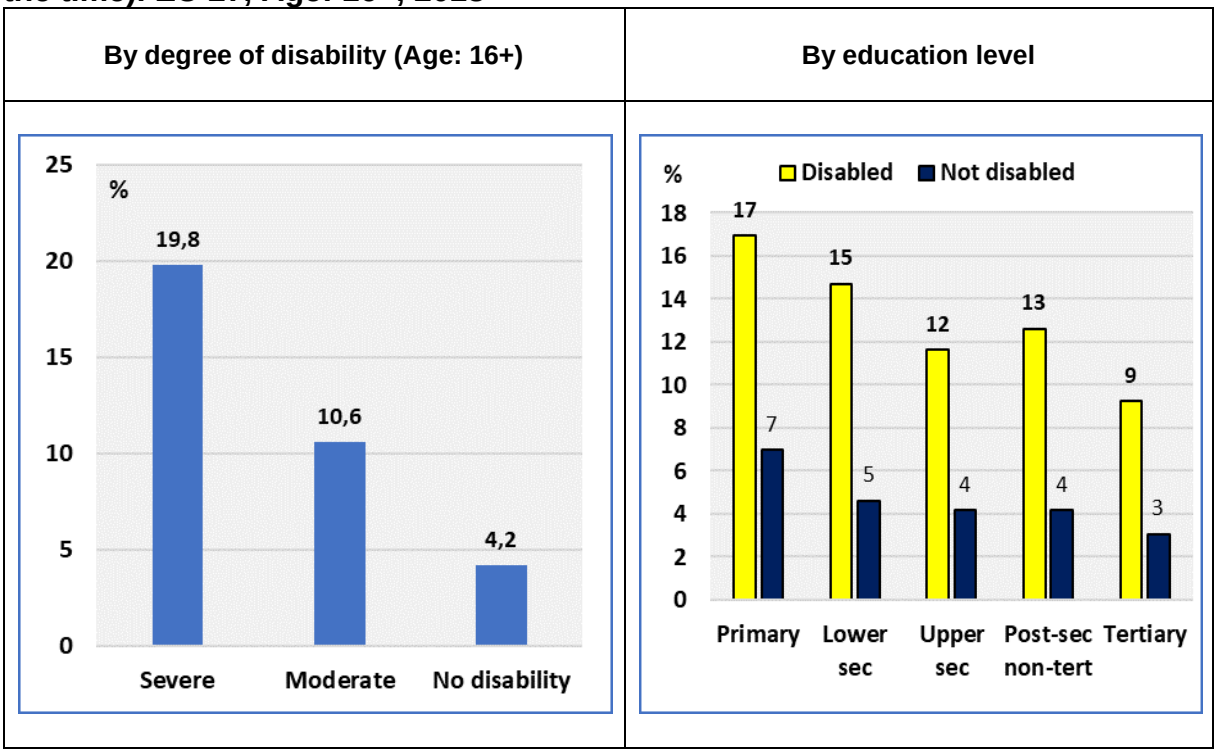
- Number of persons in the household: Living alone increases significantly the percentage
- Marital status: Being married decreases sharply the rate while being widowed or separated increases significantly the rate
- Economic status: Being unemployed increases the percentage
- Education level decreases the percentage (see figure below)
- Relative income decreases significantly the percentage (see figure below)

In a period of social distancing and lock-down, the situation ought to increase the percentage of persons declaring feeling lonely (All of the time or Most of the time). This ought to adversely affect their mental health.

The SHARE COVID-19 survey 2020,[47] indicates that 39.7 % of those feeling lonely, declared that their situation had deteriorated since the outbreak of the pandemic. The survey covers persons aged 50 and over.

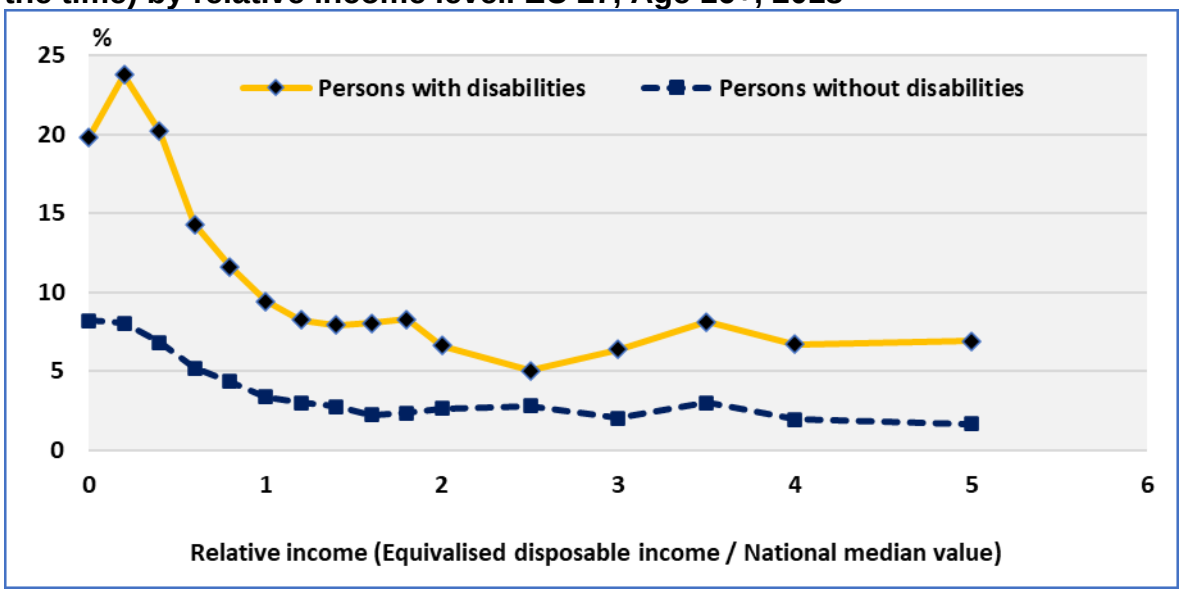
[47] SHARE COVID-19 Wave 8. Op. cit. Data collected between June and August 2020.

Figure 47: Percent of persons declaring feeling lonely (All of the time or Most of the time). EU 27, Age: 16+, 2018



Data source: EU-SILC UDB 2018 Release 2020, Version 1.

Figure 48: Percent of persons declaring feeling lonely (All of the time or Most of the time) by relative income level. EU 27, Age 16+, 2018



Note: Negative and zero incomes have been excluded since they include persons with temporary and exceptionally low incomes.
Data source: EU-SILC UDB 2018 Release 2020, Version 1.

3.3.6 Feeling lonely, mental health and material deprivation

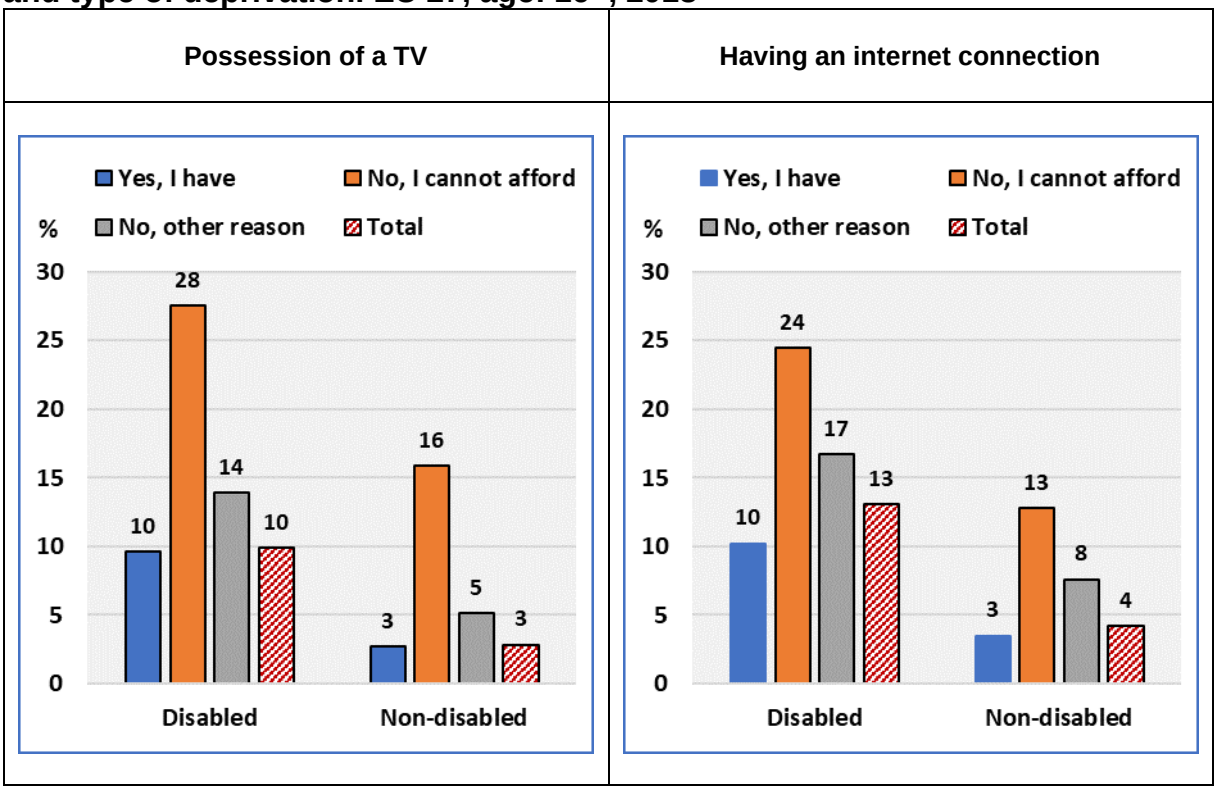
Feeling lonely may lead to mental health problems. In fact, 46.6 % of persons with disabilities, declaring feeling lonely most (or all) of the time, feel depressed all or most of the time. This rate is 32.2 % for persons without disabilities.

Different socio-economic factors might affect the percentage of persons declaring feeling lonely and thus depressed. Poverty is such a variable.

Here, we may note that material poverty and more specifically possessing a TV or an internet connection might be a significant factor. The following figure indicates that persons who cannot afford the cost of a TV or an internet connection declare often feeling alone all the time or most of the time. The observed correlation is not a guarantee for a causality link but might work in this direction.

Among those persons who cannot afford to pay a TV, about 28 % of persons with disabilities and 16 % of persons without disabilities declare feeling lonely all or most of the time. These rates are 24 % and 13 % respectively for internet connection.

Figure 49: Percent of persons declaring feeling lonely (all or most of the time) and type of deprivation. EU 27, age: 16+, 2018



Note: Feeling lonely: The different categories are: feeling lonely 1. "Most of the time (or all the time)", 2. "Fair" (Some of the time), and 3. "Little (or none of the time)".
Data source: EU-SILC UDB 2018 Release 2020, Version 1.

Policies aiming to combat material deprivation (favouring the acquisition of a TV, an internet connection, etc.) might improve the general well-being of the most vulnerable population.

In a period of social distancing and lock-down, the deteriorated situation ought to increase the percentage of persons declaring feeling lonely with a detrimental impact on their mental health.

CDC[48] notes that public health actions, such as social distancing, can make people feel isolated and lonely and can increase stress and anxiety. It adds that stress during

[48] See Centres for Disease Control and Prevention (CDC). Title: "Pandemics can be stressful" in https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/managing-stress-anxiety.html.

an infectious disease outbreak can sometimes cause, notably, worsening of chronic health problems and of mental health conditions. It notes that healthy ways to cope with stress include, notably, connecting with others or talk with people you trust and connecting with your community, for example connecting online, through social media, or by phone or mail.

The previous analysis indicates that policies aiming to alleviate material deprivation mightdampen any negative impact of the pandemic on general well-being.

3.4 Material help

Introduction

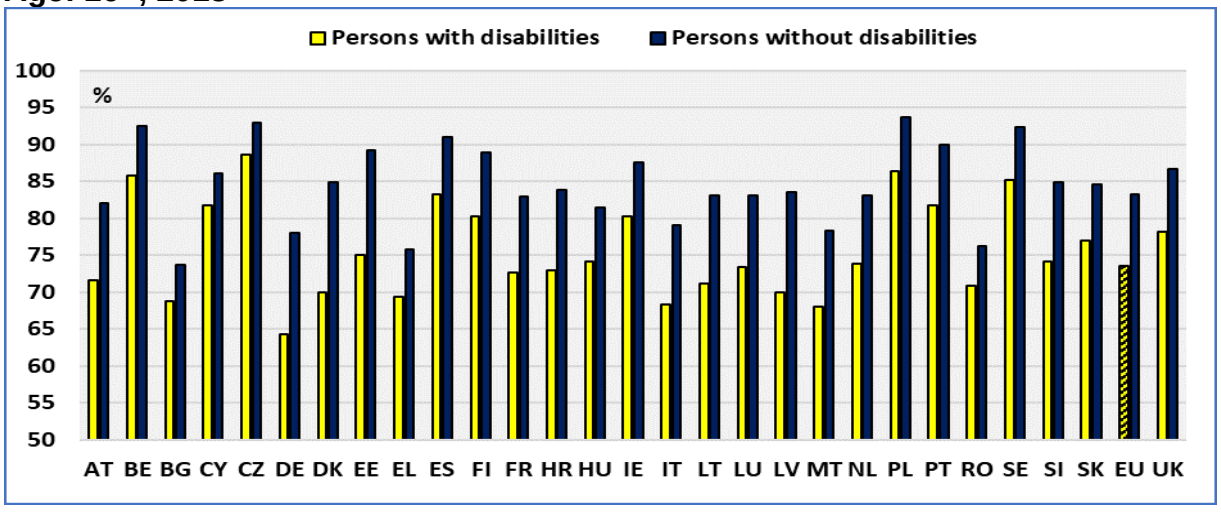
The EU-SILC ad hoc module 2018 includes a question on material help (PW040T). Eurostat notes[49] that the variable aims at measuring the quality of respondents' personal relationships. It adds that the variable refers to the respondent's possibility of asking for and receiving material help from any relatives, friends, neighbours, or other persons the respondent knows. Only persons who don't live in the same household as the respondent should be considered.

3.4.1 Characteristics by Member State

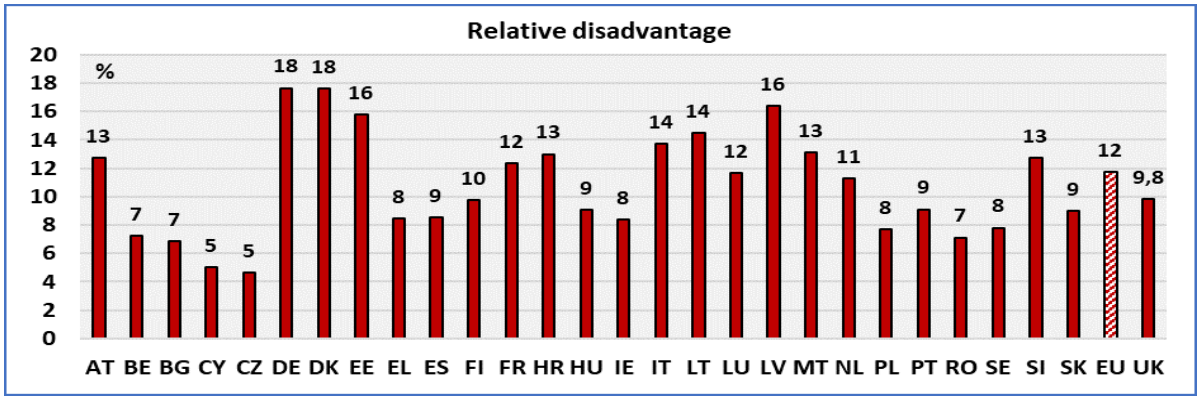
In the EU 27, about 73.5 % of persons with disabilities had the possibility of asking for and receiving material help from any relatives, friends, neighbours or other persons the respondent knows. This rate was 83.3 % for persons without disabilities.

This represents a relative disadvantage of 11.7 %. The network on which persons with disabilities may rely is narrower compared to persons without disabilities.

Figure 50: Percent of persons declaring able to ask and receive material help. Age: 16+, 2018



[49] European Commission - Eurostat: "Methodological guidelines and description of EU-SILC target variables - 2018 operation" (Version July 2019) DocSILC065 (2018 operation); European Commission – Eurostat, Directorate F: Social Statistics, Unit F-4: Quality of life.



Relative disadvantage: 100 x (% persons without disabilities - % persons with disabilities) / (% persons without disabilities).
Data source: EU-SILC UDB 2018 Release 2020, Version 1

3.4.2 Characteristics by gender

Women have a higher possibility, compared to men, of asking for and receiving material help from any relatives, friends, neighbours or other persons the respondent knows. This holds both for persons with and without disabilities.

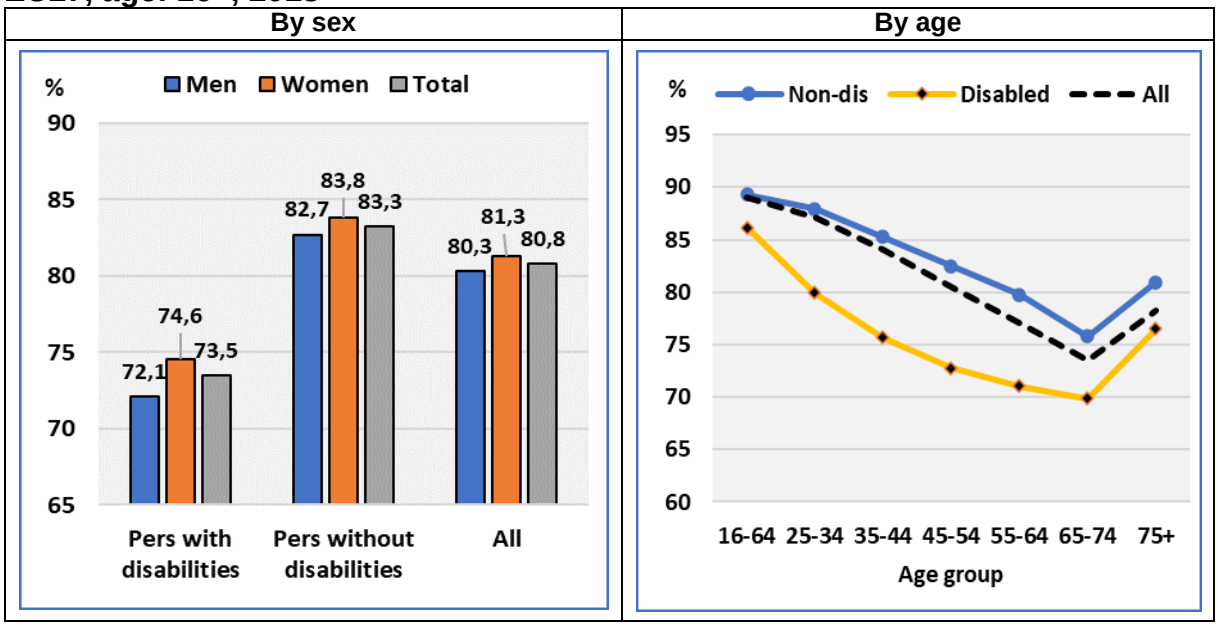
Concerning persons with disabilities, about 74.6 % of women declare able to ask and receive material help. This rate is 72.1 % for men. The respective rates for persons without disabilities are 83.8 % (women) and 82.7 % (men).

3.4.3 Characteristics by age group

The percentage of persons who can ask for and receive material help from any relatives, friends, neighbours or other persons the respondent knows, decreases with age but increases for very old people. Younger persons have a higher rate because they can rely on parents. Older people can rely on children.

At each age, persons with disabilities have a narrower network of potential help.

Figure 51: Percent of persons declaring able to ask and receive material help. EU27, age: 16+, 2018



Data source: EU-SILC UDB 2018 Release 2020, Version 1.

3.4.4 Characteristics by degree of disability

The percentage of persons who can ask for and receiving material help from any relatives, friends, neighbours or other persons the respondent knows, decreases with the degree of disability. About 69 % of persons with severe disabilities declare able to ask help compared to 83 % of persons without disabilities.

Persons with the most important needs have the narrowest network of potential material help.

3.4.5 Other socio-economic characteristics

Education increases the percentage of persons who can ask for and receiving material help from any relatives, friends, neighbours or other persons the respondent knows. This association might be an indication that education increases social capital. Similarly, household size increases this rate, probably, because a numerous household has a wider social network.

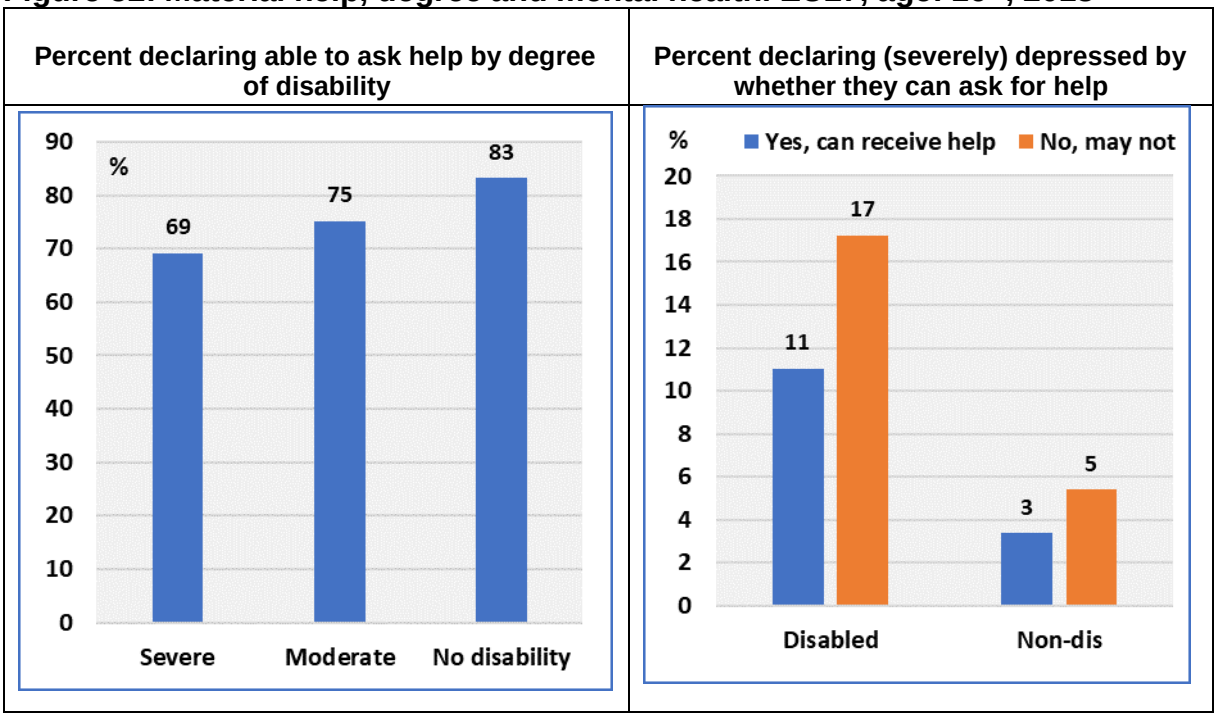
Wealth and income increase the percentage.

3.4.6 Material help and mental health

Persons who cannot ask and receive material help declare more often (severely) depressed). This is notably true for persons with disabilities. In fact, among those declaring able to ask for material help, about 11.0 % declare depressed all or most of the time, during the last four weeks. This rate is 17.2 % for persons who may not ask and receive material help. The respective rates for persons without disabilities are 3 % and 5 %.

A feeling of increased vulnerability, without any potential for help, might increase stress and mental health problems.

Figure 52: Material help, degree and mental health. EU27, age: 16+, 2018



Data source: EU-SILC UDB 2018 Release 2020, Version 1.

3.5 Non-material help

Introduction

The EU-SILC ad hoc module includes a question on non-material help (PW110T).

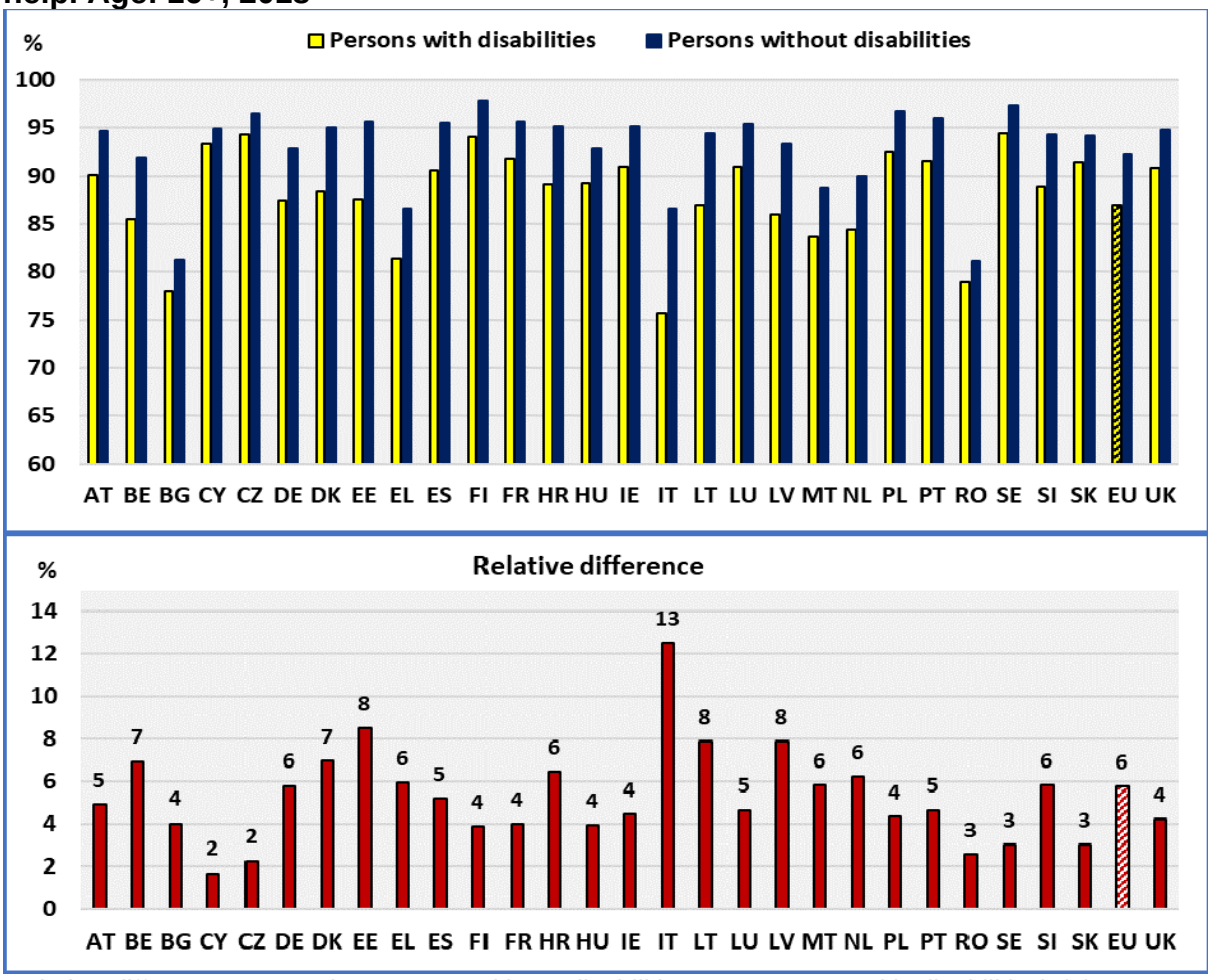
Eurostat notes that the variable aims at measuring the quality of respondents' personal relationships. It is about the possibility of asking for help, whether the respondent needs it or not. Only persons who don't live in the same household as the respondent should be considered. Non-material help should be understood as help to do some activities or moral support.

3.5.1 Characteristics by Member State

In the EU 27 about 87.0 % of persons with disabilities declare able to ask and receive non-material help. Non-material help might include help to do some activities or moral support. This rate is 92.3 % for persons without disabilities.

The relative disadvantage of persons with disabilities is 5.8 %.

Figure 53: Percent of persons declaring able to ask and receive non-material help. Age: 16+, 2018



Relative difference: 100 x (% persons without disabilities - % persons with disabilities) / (% persons without disabilities).
Data source: EU-SILC UDB 2018 Release 2020, Version 1.

We may note that the comparison of Figure 50 and Figure 53 enables us to pinpoint that the percentage of persons able to ask non-material help is higher compared to material help in all Member States (except marginally in Belgium). In the EU 27, this relative difference is 11.1 % for all persons.

3.5.2 Characteristics by gender

The percentage of persons declaring able to ask and receive non-material help is higher for women compared to men inside each group (persons with and without disabilities).

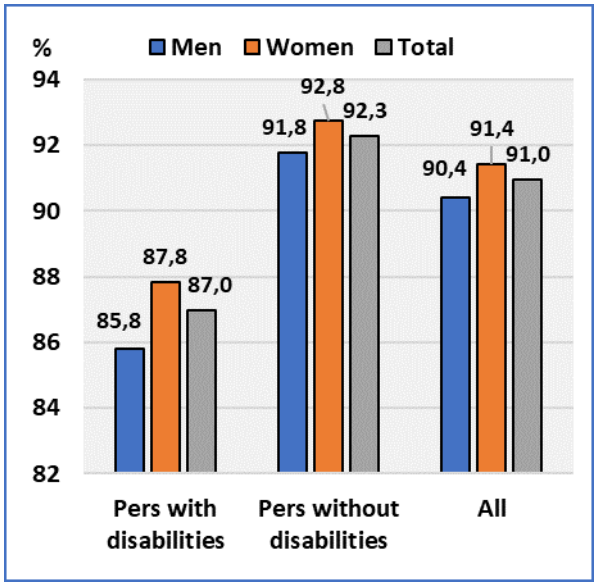
The disability gap (persons with and without disabilities) is relatively high compared to the gender difference.

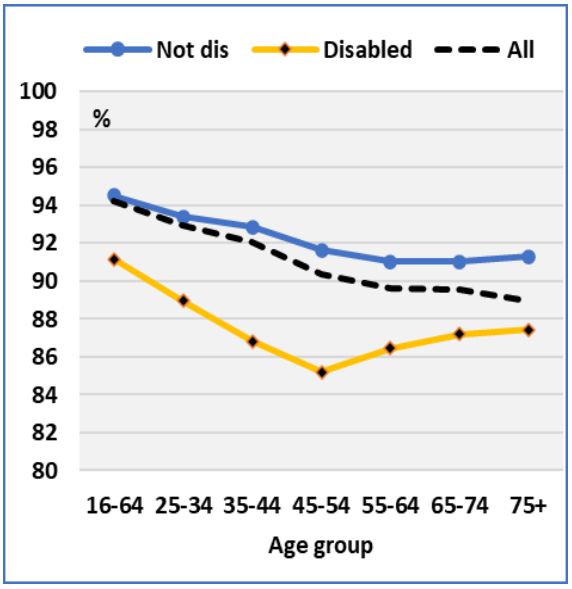
3.5.3 Characteristics by age group

The percentage decreases till the age group 45-54. Younger persons report higher rates as they might ask help from their parents. At latter ages, it increases as older people might ask help from their children.

Figure 54: Percent of persons declaring able to ask and receive non-material help. EU27, age: 16+, 2018

By gender	By age group





Data source: EU-SILC UDB 2018 Release 2020, Version 1.

3.5.4 Characteristics by degree of disability

The degree of disability decreases significantly the percentage of persons declaring able to ask and receive non-material help. About 85 % of persons with severe disabilities declare able to ask and receive non-material help compared to 92 % for persons without disabilities.

3.5.5 Characteristics by income level

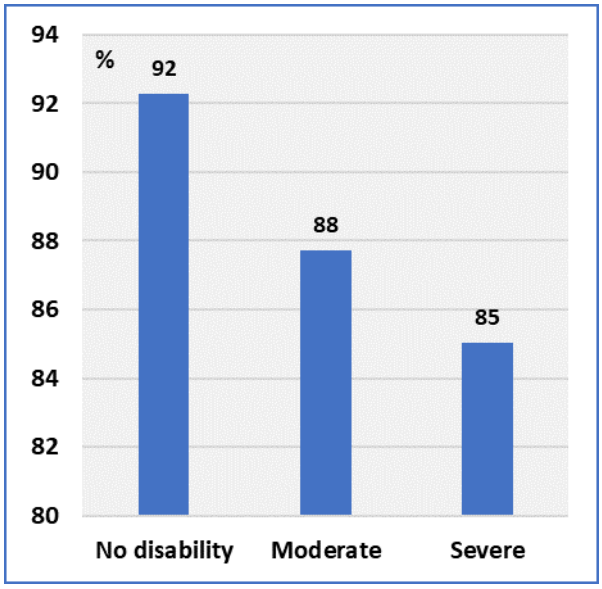
The risk of financial poverty decreases significantly the percentage of persons declaring able to ask and receive non-material help. Among persons with disabilities, the rate is 81 % for persons at risk of poverty and 89 % for others.

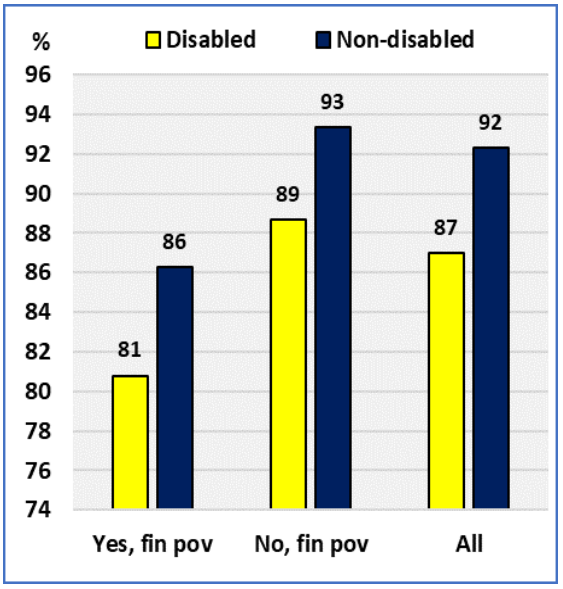
A more detailed analysis, by household income, indicates that the difference between persons with and without disabilities decreases significantly as household wealth increases. This means that the disability gap (difference between persons with and without disabilities) ought to be attributed, at least partly, to financial factors. In fact, persons with disabilities face a higher risk of financial poverty (in the sense of Europe 2020).

We may note that disability and poverty affect, in the same way, the percentage of persons declaring able to ask and receive non-material help. However, the figure presenting the percentages by risk of financial poverty and disability indicate that poverty exerts a stronger effect than disability. The difference between disabled and non-disabled is less compared to the difference between persons at risk or not of financial poverty. But this needs further analysis.

Figure 55: Percent of persons declaring able to ask and receive non-material help. EU27, age: 16+, 2018

By degree of disability	By risk of financial poverty





Financial poverty: as defined in Europe 2020

Data source: EU-SILC UDB 2018 Release 2020, Version 1.

If we take into account age, household size and risk of financial poverty, we may note that one-person household at risk of financial poverty is the most disadvantaged group. This group has the highest rate of persons who are unable to ask and receive non-material help.

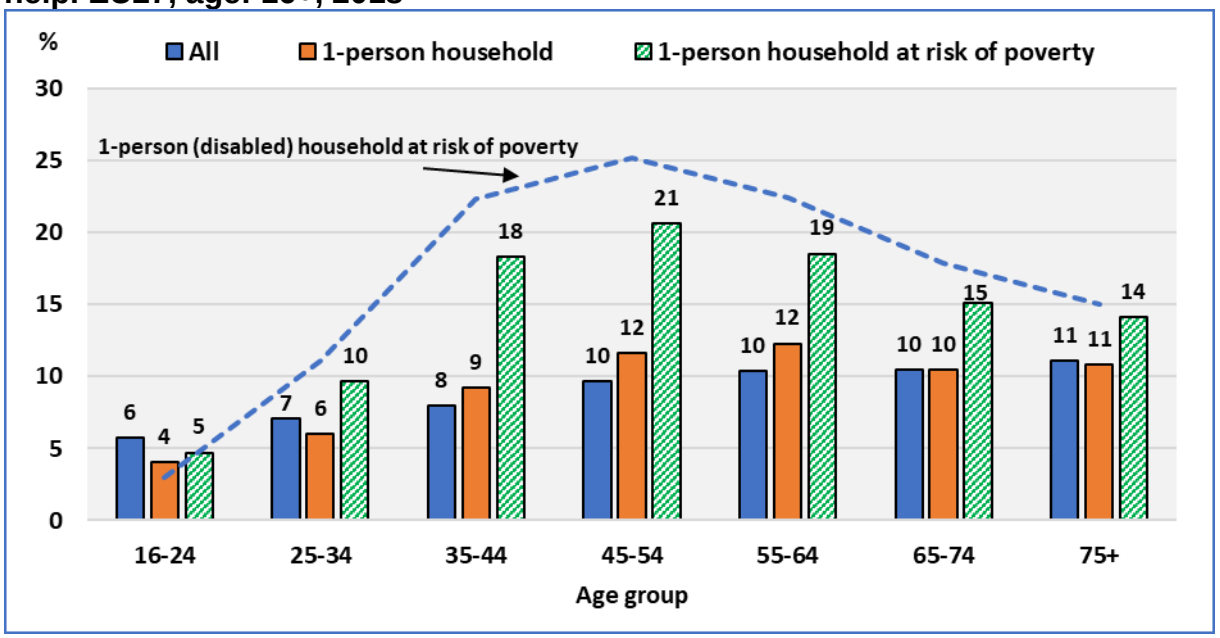
In the age group 45-54, about 21 % of persons (living in one-person household), at risk of poverty, declare unable to ask and receive non-material help. The general rate, for the same age group, is 10 %.

Concerning persons living alone (one-person households) at risk of poverty, we may note that persons with disabilities face a strong disadvantage. In the following figure, this group presents the highest rates. Inability to ask and receive non-material help, notably in the age group 45-54, might seriously affect the quality of their lives. The age group 16-24 present a low rate because it might be able to ask help from parents.
In Sweden, a study showed that unmarried older people are at particularly high risk of dying from COVID-19.[50] The authors note that this is the segment of the population that is in higher need than others to rely on external assistance in their home, or who lives in a care home. Similarly, other studies find also, that one-person household are more at risk compared to 2 persons households.[51]

[50] Sven Drefahl, Matthew Wallace, Eleonora Mussino, Siddartha Aradhy, Martin Kolk1, Maria Brandén, Bo Malmberg, Gunnar Andersson (2020) "Socio-demographic risk factors of COVID-19 deaths in Sweden: A nationwide register study"; Stockholm Research Reports in Demography, no 2020:23; Department of Sociology, Demography Unit, Stockholm University.

[51] Emily Connors and James Cooper: "COVID-19 Infection Survey"; Office for National Statistics Date of publication: 18 August 2020 Infection.survey.analysis@ons.gov.uk.
See also: Coronavirus (COVID-19) Infection Survey: characteristics of people testing positive for COVID-19 in England, August 2020. Data about the characteristics of people testing positive for the coronavirus (COVID-19) from the COVID-19 Infection Survey. This survey was delivered in

Figure 56: Percent of persons declaring unable to ask and receive non-material help. EU27, age: 16+, 2018



Note: The data for persons with disabilities aged 16-24, living alone (1-person household) at risk of poverty, are indicative. The number of observations is relatively small.
Data source: EU-SILC UDB 2018 Release 2020, Version 1.

3.5.6 Mental health

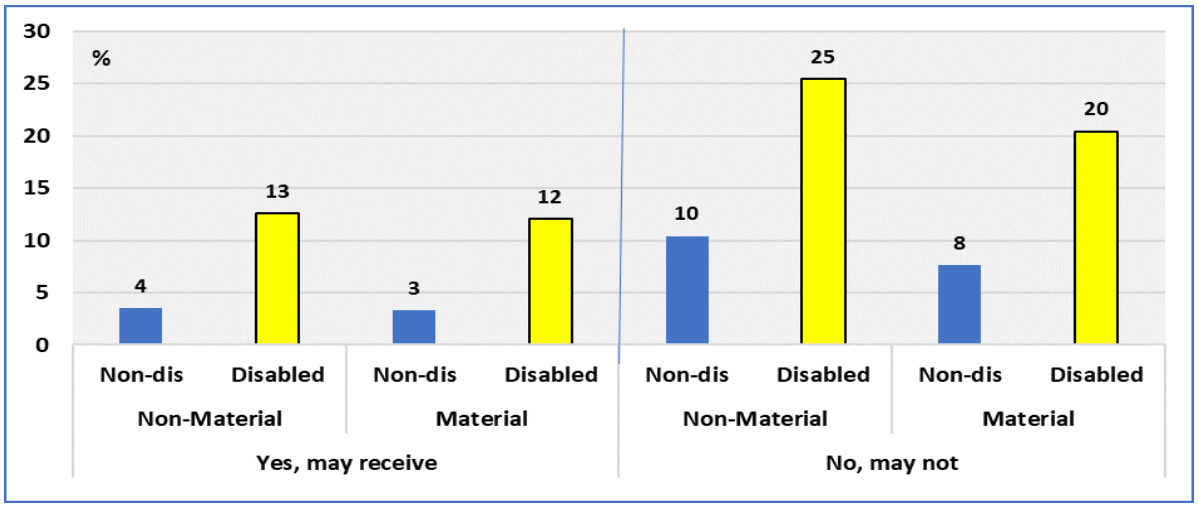
Persons who cannot ask and receive non-material health declare more often being depressed, all or most of the time, during the last four weeks. This rate is 25.5 % for persons with disabilities and 10.4 % for persons without disabilities. The respective rates for persons who may receive non-material help are 12.6 % and 3.5 %.

As noted previously, we observe a similar impact for material help.

We may observe that the lack of non-material help is associated with a more important impact on mental health than the lack of material help. Probably, persons are aware of the financial constraints of their social networks but resent more the lack of moral support.

partnership with the University of Oxford, the University of Manchester, Public Health England and Wellcome Trust. Office for National Statistics, August 2020.

Figure 57: Percent of persons declaring (severely) depressed. EU27, age: 16+, 2018



Data source: EU-SILC UDB 2018 Release 2020, Version 1.

WHO notes that the COVID-19 pandemic has disrupted or halted critical mental health services in 93 % of countries worldwide while the demand for mental health is increasing, according to a new WHO survey.[52] It adds that deprivation, isolation, loss of income and fear are triggering mental health conditions or exacerbating existing ones.

Isolation, worry, anxiety and stress might increase mental health problems in the context of the COVID-19 pandemic. CDC notes that phone calls or video chats can help you and your loved ones feel socially connected, less lonely, or isolated.[53] However, such measures might have a limited impact due to economic constraints and the low digital skills of vulnerable groups.

National helplines, through telephone or internet, may not be an adequate response to isolated and materially deprived people. Periodic visits at home of specialised personnel might be a more efficient strategy for the most vulnerable groups, at least those who do not have internet connections or relevant electronic equipment.

3.5.7 The impact of COVID-19 pandemic

The SHARE COVID-19 2020 survey (Op. cit.) asked “Since the outbreak of Corona, were you helped by others from outside of home to obtain necessities (CAS020_)?”. This question provides data which cannot be compared with previous data. The question here refers to a realised event and not a potential source of help. It covers all persons.

In the EU, about 21.9 % of persons, aged 50 and over, declared that they received help by others from outside of home to obtain necessities. As expected, this rate increases with age.

If the interviewee answers “yes” to the previous question, the interviewer asks (CAS021_): “How often did the following people from outside your home help you to

[52] https://www.who.int/news/item/05-10-2020-covid-19-disrupting-mental-health-services-in-most-countries-who-survey.

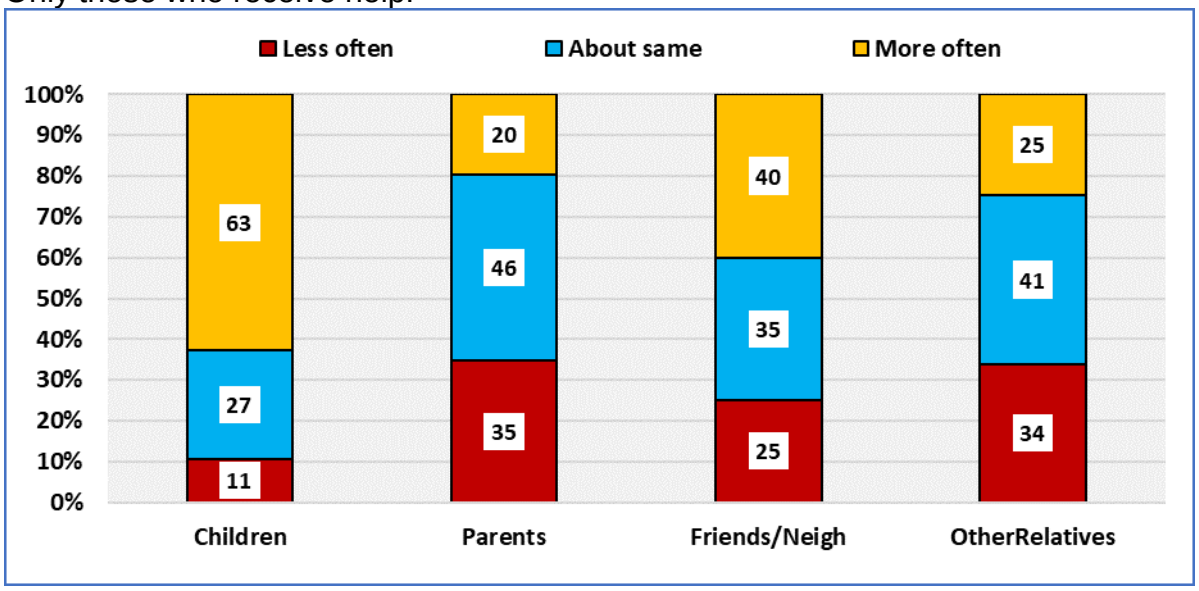
[53] https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/managing-stress-anxiety.html.

obtain necessities, compared to before the outbreak of Corona"? Less often, about the same, or more often?

The categories include own children, own parents, other relatives, and other non-relatives like neighbours, friends, or colleagues.

We may note that about 63 % declared to receive more often help from children and 40 % by friends or neighbours. The rate from parents looks small but can be considered high if we keep in mind that the survey covers persons aged 50 and more and consequently, parents are very old people. Furthermore, very old people face a higher risk to catch a serious COVID-19 infection.

Figure 58: How often did persons (from outside your home) help you to obtain necessities, compared to before the outbreak of Corona? Age: 50+, EU, 2020.
Only those who receive help.



Source of data: SHARE Wave 8. COVID-19 Survey 1. Release version: 0.0.1.

3.6 Summary and conclusions

1. Social networking (Getting together with friends or relatives)

In a period of social distancing, getting together with friends might be limited or restricted to the close family. But the ability to have such a network is important and can be used as a potential source for the collection of information and assistance.

In the EU 27, the percentage of persons with disabilities who were reporting able to get together with friends or relatives, before the pandemic, was 69.3 % compared to 85.7 % of persons without disabilities. This reveals a high risk of isolation for 30.7 % of persons with disabilities and 14.3 % for persons without disabilities.

The percentage of older people (65 and over) having a social network is lower compared to younger persons (16-64). This might be due to health problems and mobility disabilities. Electronic networking might reduce physical barriers, but digital poverty might limit such opportunities).

In a period of social distancing and lockdown, digital skills and economic capacity appear to be important factors able to maintain social contacts and avoid isolation of

vulnerable groups. Persons who cannot get together with friends due to economic constraints, tend to declare a very high rate of (severe) depression. The observed correlationis not a guarantee for a causality link, but we cannot exclude it.

Social distancing and stress during an infectious disease outbreak can cause a worsening of chronic health problems and of mental health conditions.

2. Satisfaction with personal relationships

Concerning satisfaction with personal relationships, in the EU 27, the average score for persons with disabilities is 7.5 and 8.1 for persons without disabilities, in a scale from zero to ten.

At each age, the satisfaction level of persons with disabilities is lower compared to persons without disabilities. Unemployed and one-person households report relatively low scores. This might be due to a limited array of social contacts, leading to social isolation. The educational level increases satisfaction. But education could act as proxy for social capital and income. Both facilitate social networks.

3. Feeling lonely

In all the Member States, before the COVID-19 outbreak, the percentage of persons with disabilities declaring feeling lonely (All of the time or Most of the time), during the last four weeks, is significantly higher compared to persons without disabilities. In the EU 27, the respective rates are 11.9 % and 2.9 %.

The analysis by age group reveals that persons aged 75 and over ought to be given a special attention. The percentage of people reporting feeling lonely increases significantly for this age group. This holds both for persons with and without disability.

In a period of social distancing and lock-down, the situation ought to increase the percentage of persons declaring feeling lonely (All of the time or Most of the time). This ought to adversely affect their mental health.

The SHARE COVID-19 survey, indicates that 39.7 % of those feeling lonely, declared that their situation had deteriorated since the outbreak of the pandemic.

Feeling lonely may create health problems or deteriorate mental health. Materially deprived people (e.g., cannot afford the cost of a TV or an internet connection) tend to declare very high rates of (severe) depression. The observed correlation is not a guarantee for a causality link but might work in this direction. Policies aiming to combat material deprivation might improve the general well-being of the most vulnerable population.

In a period of social distancing and lock-down, the situation ought to increase the percentage of persons declaring feeling lonely with a detrimental impact on their mental health. Healthy ways to cope with stress include, notably, connecting with others. Policies aiming to alleviate material deprivation might dampen any negative impact of the pandemic on general well-being.

4. Material help

In the EU 27, about 73.5 % of persons with disabilities had the possibility of asking for and receiving material help from any relatives, friends, neighbours or other persons the respondent knows. This rate was 83.3 % for persons without disabilities.

Persons who cannot ask and receive material help declare more often (severely) depressed).

5. Non-material help

In the EU 27 about 87.0 % of persons with disabilities declare able to ask and receive non-material help. Non-material help might include help to do some activities or moral support. This rate is 92.3 % for persons without disabilities. The difference between persons with and without disabilities decreases significantly as household wealth increases. One-person households at risk of financial poverty seems to be very disadvantaged.

Persons who cannot ask and receive non-material health declare more often being depressed, all or most of the time, during the last four weeks. The lack of non-material help is associated with a more important impact on mental health than the lack of material help. Probably, persons are aware of the financial constraints of their social networks but resent more the lack of moral support.

Isolation, anxiety and stress might increase mental health problems in the context of the COVID-19 pandemic. Social connections through internet can reduce the impact of social distancing policies. However, e-contacts might be limited due to economic constraints and the low digital skills of vulnerable groups.

Children, parents, friends and neighbours might provide non-material help. But how often did people from outside the household help to obtain necessities, compared to before the outbreak of Corona? The SHARE COVID-19 survey indicates that about 63 % of those receiving help, declared to receive more often help from children and 40 % more often by friends or neighbours.

4 Access to online services

Rules to stop the spread of the coronavirus require new forms of employment, training and social contacts.

If a person has symptoms of coronavirus and needs medical advice, he is often asked to use the national online coronavirus service. Furthermore, social services ask people to plan different ways of communicating from home and work that can be used rapidly in an emergency (e.g., landline phone, cell phone, text messaging, email).

The capacity to use these alternative communication methods depends on digital connectivity. Consequently, we propose to study whether persons with disabilities have the necessary software, hardware and infrastructure in order to be able to benefit from these new opportunities.

In this part, we will analyse the following issues:

1. Possession of a telephone (including mobile phone)
2. Possession of a computer
3. Internet connection for personal use at home

A summary and conclusions are presented at the end.

4.1 Possession of a telephone (including mobile phone)

Introduction

The EU-SILC 2018 includes a question on the whether the household has a telephone (including mobile phone) or whether the household does not have a telephone because it cannot afford it (enforced lack) or for other reasons (HS070). If the item is shared between households, the answer is ‘yes’.

4.1.1 Characteristics by Member State

Eurostat publishes on its webpage estimates for all persons. However, the data refer to household and the same value is attributed to all household members. If we keep only household respondents, the difference between the two estimates is marginal. This difference is 0.07 percentage points for the EU 27, in 2016.[54] Also, it is zero or marginal in the majority of Member States.

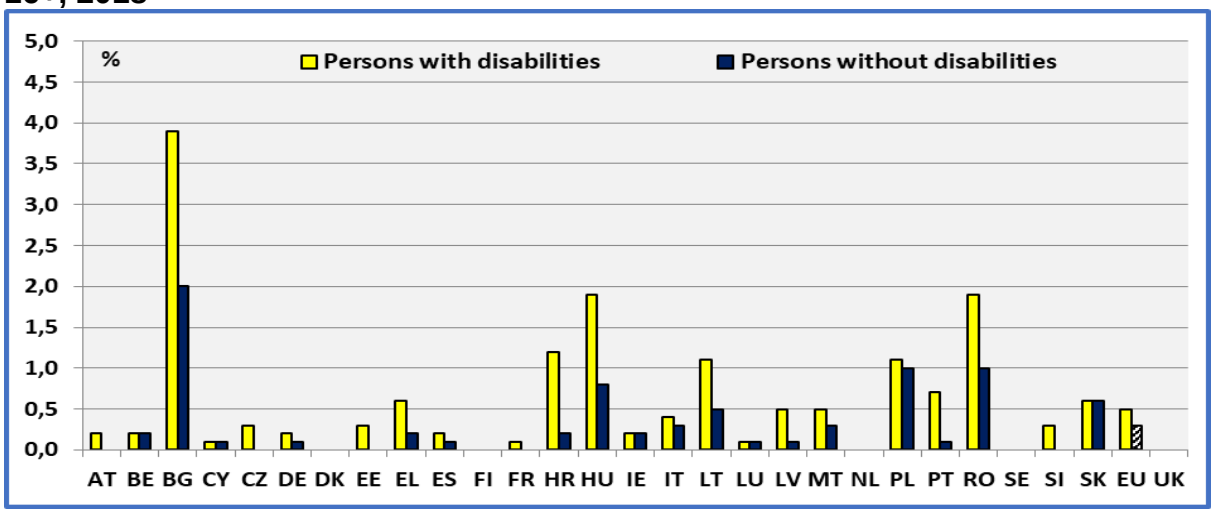
Health care and home care indicators refer, also, to household. But these services can only be used by one person. Unlike these services, the possession of a telephone can be used, in a certain extent, by all household members. Consequently, the answer of the respondent can be applied to all household members. In the following, we will speak about persons and not household respondents.

Another issue concerns persons who answer “No, for other reasons”. This was 1.6 % (2.0 % for respondents only), in 2016. Consequently, its impact is small.

[54] Available micro-data for 2018 cover a limited number of Member States. Consequently, we use for this chapter, estimates published by Eurostat.

In the EU 27, about 0.5 % of persons with disabilities declare that their household cannot afford a telephone (including mobile phone). There is a difference of 0.2 percentage points between persons with and without disabilities, but this difference is relatively high in Bulgaria (1.9 pp), Hungary (1.1 pp) and Croatia (1.0 pp).
The question does not distinguish between fix or mobile telephone. Still, for internet connection this distinction has a big importance.

Figure 59: Percent of persons who cannot afford a telephone by disability. Age: 16+, 2018



Note: The question refers to household. The same value is attributed to all household members.
Data source: Eurostat. Data extracted on 18/12/2020 from [ESTAT].

4.1.2 Characteristics by gender

There is no difference by gender, but the data refer to household and might underestimate any gender difference.

4.1.3 Characteristics by age group

The percentage of persons with disabilities who cannot afford a telephone, increases with age. But this is partly due to more persons with severe disabilities among elderly people.

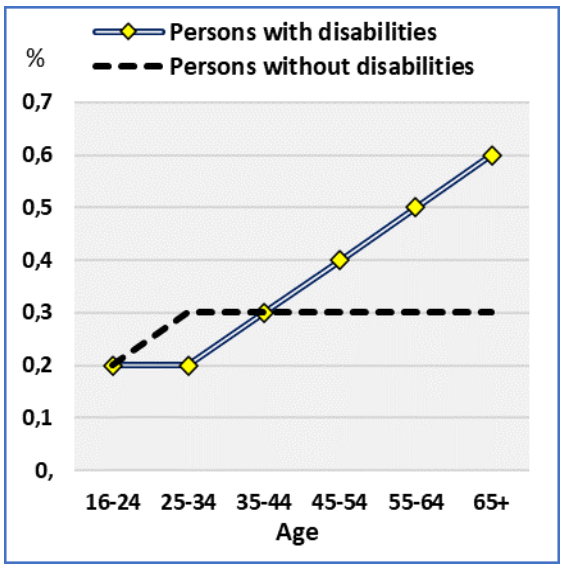
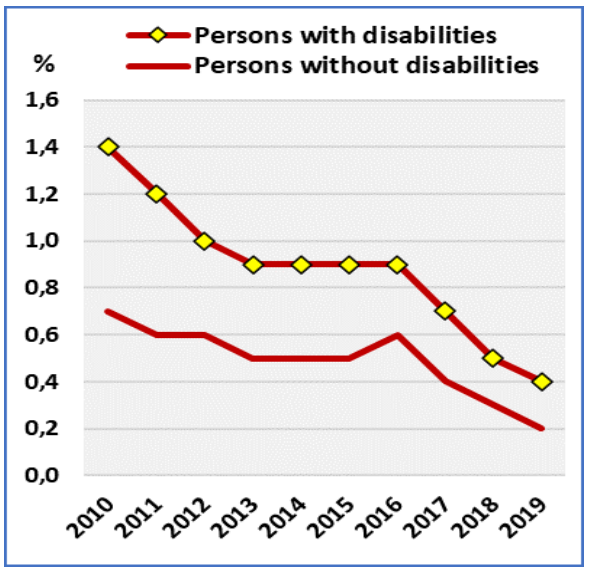
4.1.4 Characteristics by degree of disability

In the EU 27, the percentage of persons with disabilities who cannot afford a telephone, increases slightly with the degree of disability. It is 0.6 % for persons with severe disabilities. However, it is 4.3 % in Bulgaria, 3.6 % in Romania and 2.3 % in Hungary.

4.1.5 Evolution

The absolute gap between persons with and without disabilities is decreasing continuously, at the EU level.

Figure 60: Percent of persons who cannot afford a telephone by disability. EU

By age group and disability status	Evolution by disability status
	
	Age: 16+

Note: The question refers to household. The same value is attributed to all household members.
Data source: Eurostat. Data extracted on 18/12/2020 from [ESTAT].

4.2 Possession of a computer

Introduction

The EU-SILC 2018 includes a question on the whether the household has a computer or whether the household does not have a computer because it cannot afford it (enforced lack) or for other reasons (HS090). If the item is shared between households, the answer is 'yes'.

Health care and home care indicators refer, also, to household. But these services can only be used by one person. Unlike these services, the possession of a computer can be used, in a certain extent, by all household members. Consequently, the answer of the household respondent can be applied to all household members. In the following, we will speak about persons and not household respondents.

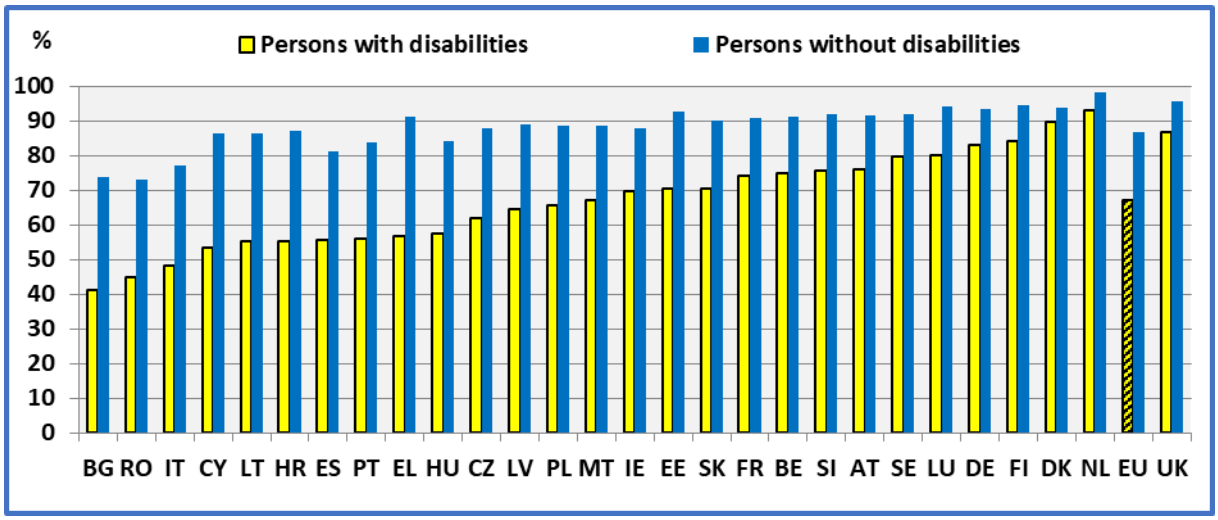
4.2.1 Characteristics by Member State

In the EU 27, about 67.2 % of persons with disabilities and 86.9 % of persons without disabilities possess a computer. There is a difference of 19.8 percentage points.

Concerning persons with disabilities, the rates are dramatically low in Bulgaria (41.2 %), in Romania (44.8 %) and in Italy (48.1 %).

This might be a serious impediment to the efficacy of a policy requiring the use of telework, eLearning, eHealth, etc.

Figure 61: Percent of persons who possess a computer by disability. Age: 16+, 2018



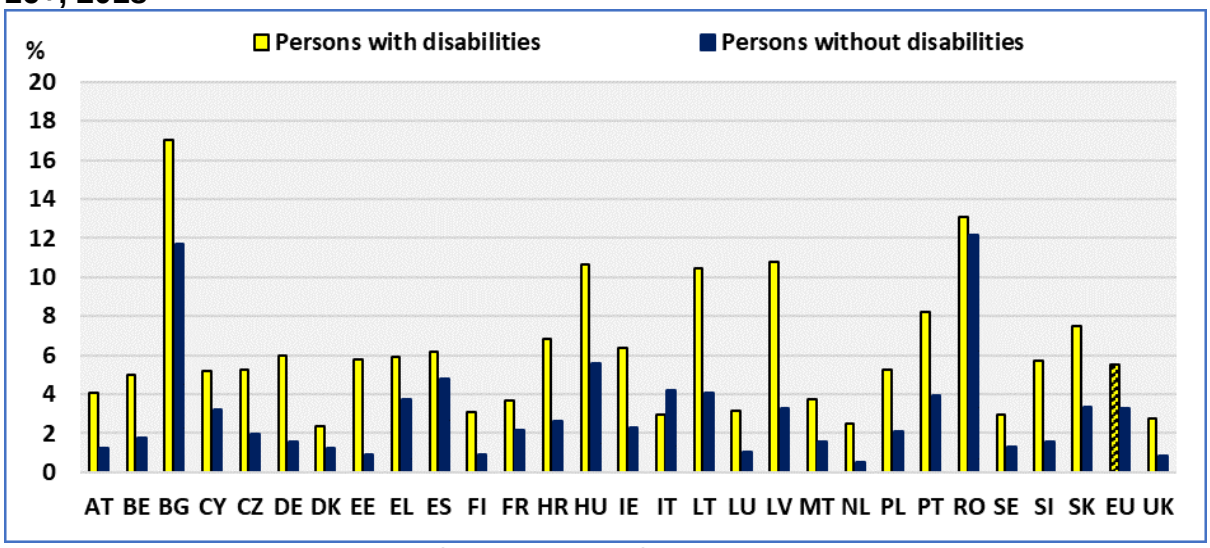
Note: The possession of a computer can be used, in a certain extent, by all household members. Consequently, the answer of the household respondent can be applied to all household members.
Data source: EU-SILC UDB 2018 Release 2020, Version 1.

In order to understand the reasons behind these low rates, it is important to distinguish economic reasons from other reasons of not possessing a computer.

In the EU 27, about 5.5 % of persons with disabilities and 3.3 % of persons without disabilities cannot afford a computer. There is a difference of 2.2 percentage points.

The share of persons with disabilities who cannot afford a computer is high in Romania (13.1 %) and Bulgaria (17.0 %). Denmark (2.3 %) and the Netherlands (2.5 %) have the lowest rates.

Figure 62: Percent of persons who cannot afford a computer by disability. Age: 16+, 2018



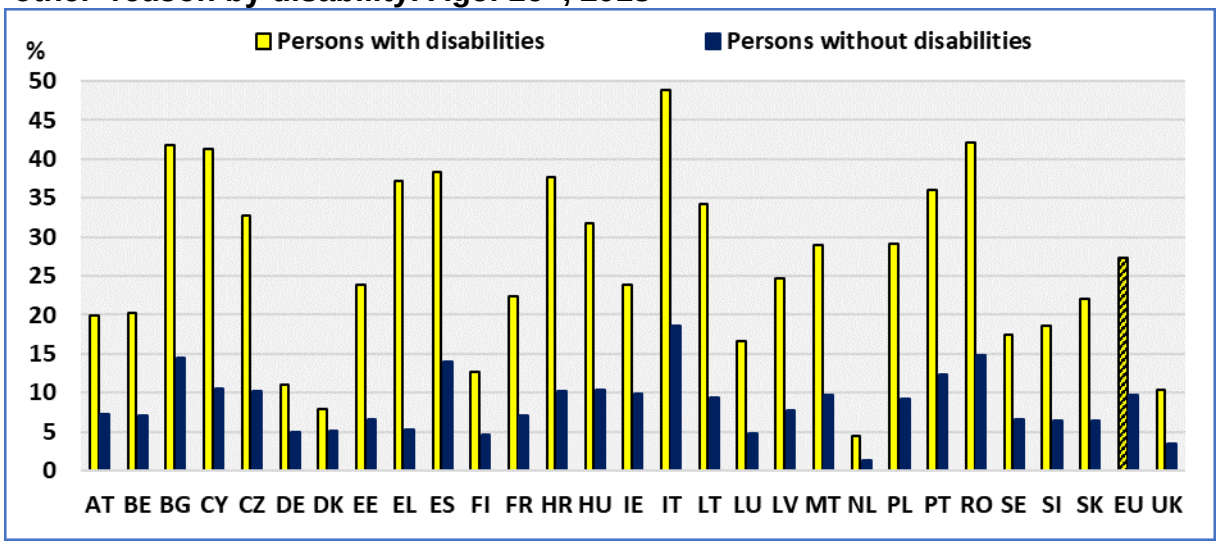
Data source: EU-SILC UDB 2018 Release 2020, Version 1.

It is important to note that a high number of persons does not have a computer for other reasons. In the EU 27, about 27.3 % of persons with disabilities and 9.8 % of persons without disabilities does not possess a computer because of 'other' reasons.

Concerning persons with disabilities, the highest rates can be found in Bulgaria (40.8 %), Romania (42.1 %) and Italy (48.9 %). Again, the lowest rates can be found in the Netherlands (4.5 %) and Denmark (7.9 %).

It is important to assess whether these high rates are due to digital poverty, accessibility issues or any other reason. This will determine whether there is a need for education programmes, abolishing barriers linked to disability, etc.

Figure 63: Percent of persons who cannot possess a computer because of 'other' reason by disability. Age: 16+, 2018

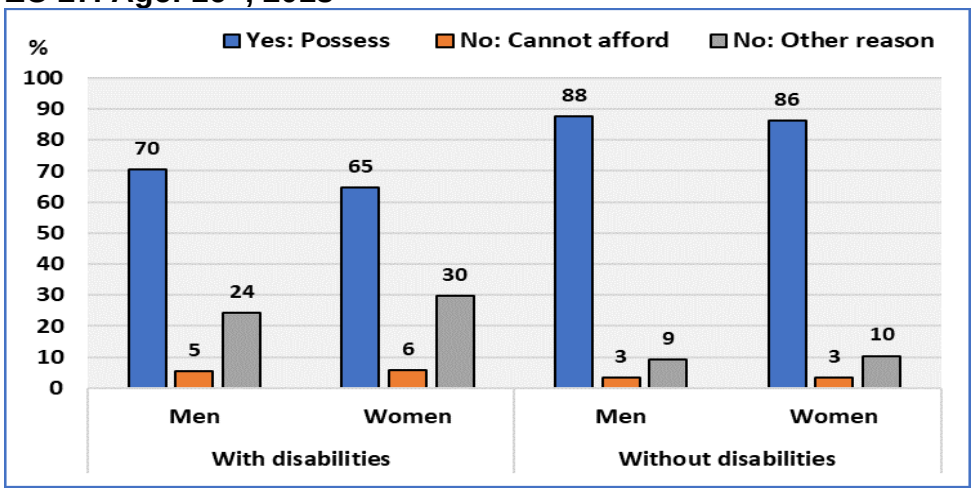


Data source: EU-SILC UDB 2018 Release 2020, Version 1.

4.2.2 Characteristics by gender

In the EU 27, about 65 % of women with disabilities declare possessing a computer compared to 70 % of men with disabilities. Women face a disadvantage relative to men, but this indicator might under-estimate this difference since the respondent answers for the household and the same value is attributed to all household members.

Figure 64: Percent of persons who possess a computer by disability and gender. EU 27. Age: 16+, 2018

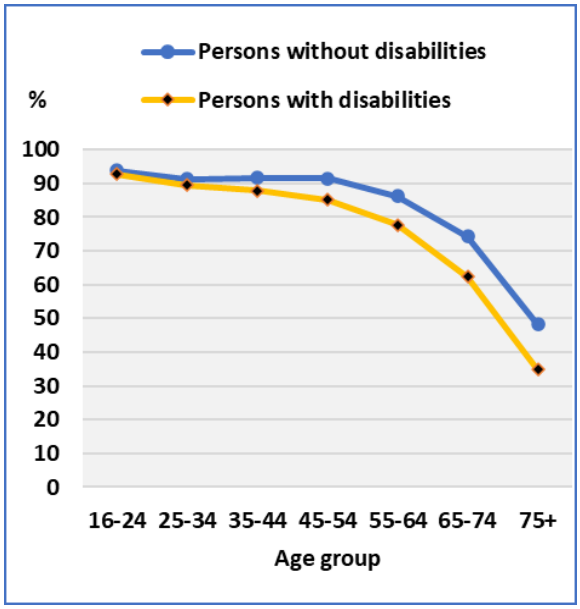
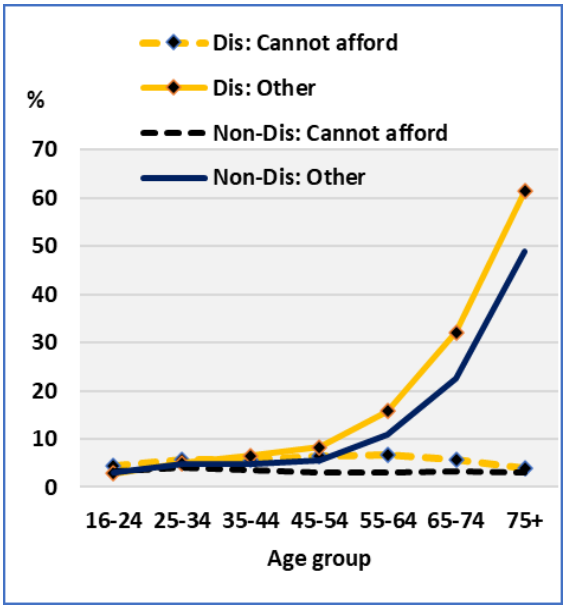


Data source: EU-SILC UDB 2018 Release 2020, Version 1.

4.2.3 Characteristics by age group

The percentage of persons who possess a computer decreases with age for all persons, with and without disabilities, at a similar rate.

Figure 65: Percent of persons who possess or do not possess a computer by disability. EU 27

Persons who possess a computer By age group	**Persons who don't possess a computer** Reasons for not possessing by disability
	
2018	2018

Data source: EU-SILC UDB 2018 Release 2020, Version 1.

Concerning the reasons for not possessing a computer, we may note that the economic reason (cannot afford) is relatively small and constant for all age groups. On the contrary, 'No, other reason' increases significantly for all groups after the age of 45-54. The question is whether, this is due to age or to factors which are correlated with age. Such a factor might be the education level.

4.2.4 Characteristics by education level

The percentage of persons who possess a computer increases significantly with the educational level. This rate is 47.4 % for persons with a primary or less education but rises to 95.7 % for persons with a tertiary education.

This implies a reduction of the share answering 'No, I cannot afford' and 'No, other reason' y educational level. The economic reason for not possessing a computer passes from 8 % (primary education) to 1 % (tertiary education). Similarly, 'No, other reason' passes from 45 % (primary education) to 4 % (tertiary education). This requires further analysis.

In the following, we focus on the lack of a computer due to 'other reason'. We try to clarify whether this is a result of age, education or barriers.

The following figure indicates that the percentage of persons who declare not possessing a computer due to 'No, other reason' decreases as the educational level increases.

If we take only persons with a primary education or less, we may observe in the graph below that the evolution by age is similar for persons with and without disabilities. Furthermore, the difference is relatively small.

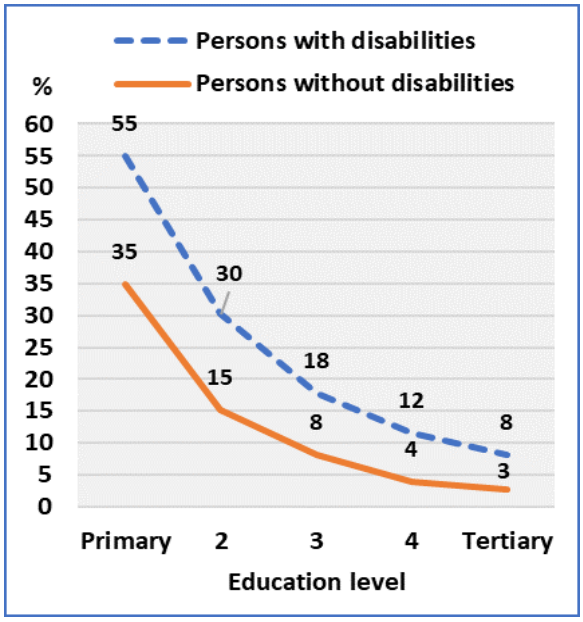
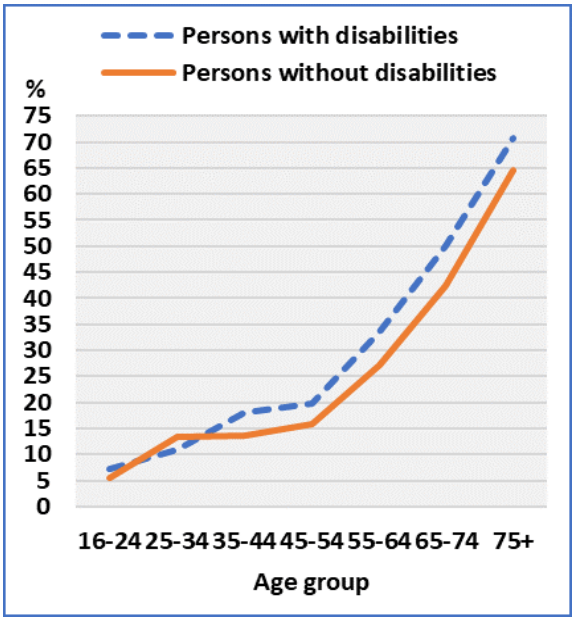
We may conclude that education is the dominant factor explaining the high rates of 'No, other' reason. Any disability related barrier might play a relatively less important role compared to education. Digital poverty among older people seems to constitutea significant factor explaining the high percentage of not possessing a computer due to "No, other reason'.

This is important for policy action. In fact, this means that, we ought to promote the acquisition of digital skills among the older before any initiative promoting eLearning, tele-shopping, eHealth and generally using internet by this group of persons.

4.2.5 Characteristics by degree of disability

The degree of disability decreases sharply the share of persons possessing a computer. This share is 61.9 % for persons with severe disabilities, 69.3 % for persons with moderate disabilities and 86.9 % for persons without disabilities.

Figure 66: Education level and lack of a computer due to 'Other' reason. EU 27, 2018

% of persons who lack a computer By education level	**% of persons with a primary education who lack a computer**
	

Note 1: Primary or less, 2: Lower secondary, 3: Upper secondary, 4: Post-secondary, non-tertiary, 5: Tertiary (International Standard Classification of Education (ISCED 2011)).
Data source: EU-SILC UDB 2018 Release 2020, Version 1.

4.3 Internet connection for personal use at home

Introduction

The EU-SILC includes a question “Do you have an Internet connection for personal use when needed?” (PD080). Possible answers are: 1. Yes, 2. No - cannot afford it and 3. No - other reason. Example of internet activities for personal use are social networking, sending/receiving emails, using services related to travel and accommodation, blogs, Internet banking, etc.[55]

4.3.1 Characteristics by Member State

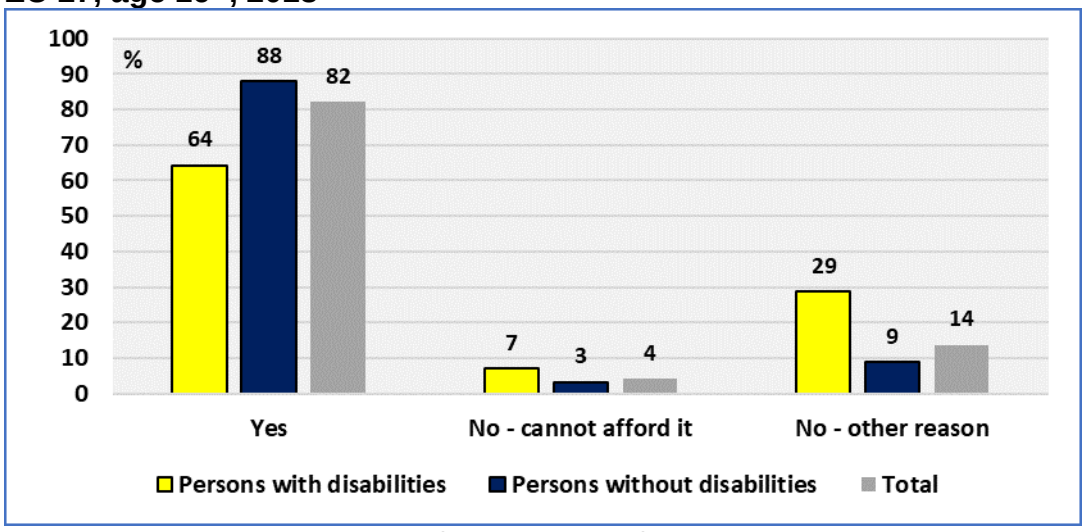
In the EU 27, about 82.1 % of persons aged 16 and over have an internet connection for personal use at home. This rate is 64.3 % for persons with disabilities and 87.9 % for persons without disabilities.

The proportion of persons who report that they do not have an internet connection for personal use at home because they cannot afford it is relatively small but important differences arise across Member States (see below). Also, this is an aggregate and might hide important inequalities.

We observe that about 8.8 % declare no internet connection for personal use at home but there is a big difference between persons with and without disabilities which require further study (see below).

In summary, there is a disability gap between persons with and without disabilities of 23.7 percentage points (26.9 % relative to persons without disabilities). This low rate might be a serious obstacle for economic, social and cultural participation of persons with disabilities in a period of lockdown and social distancing.

Figure 67: Percent of persons with/without internet connection by disability. EU 27, age 16+, 2018



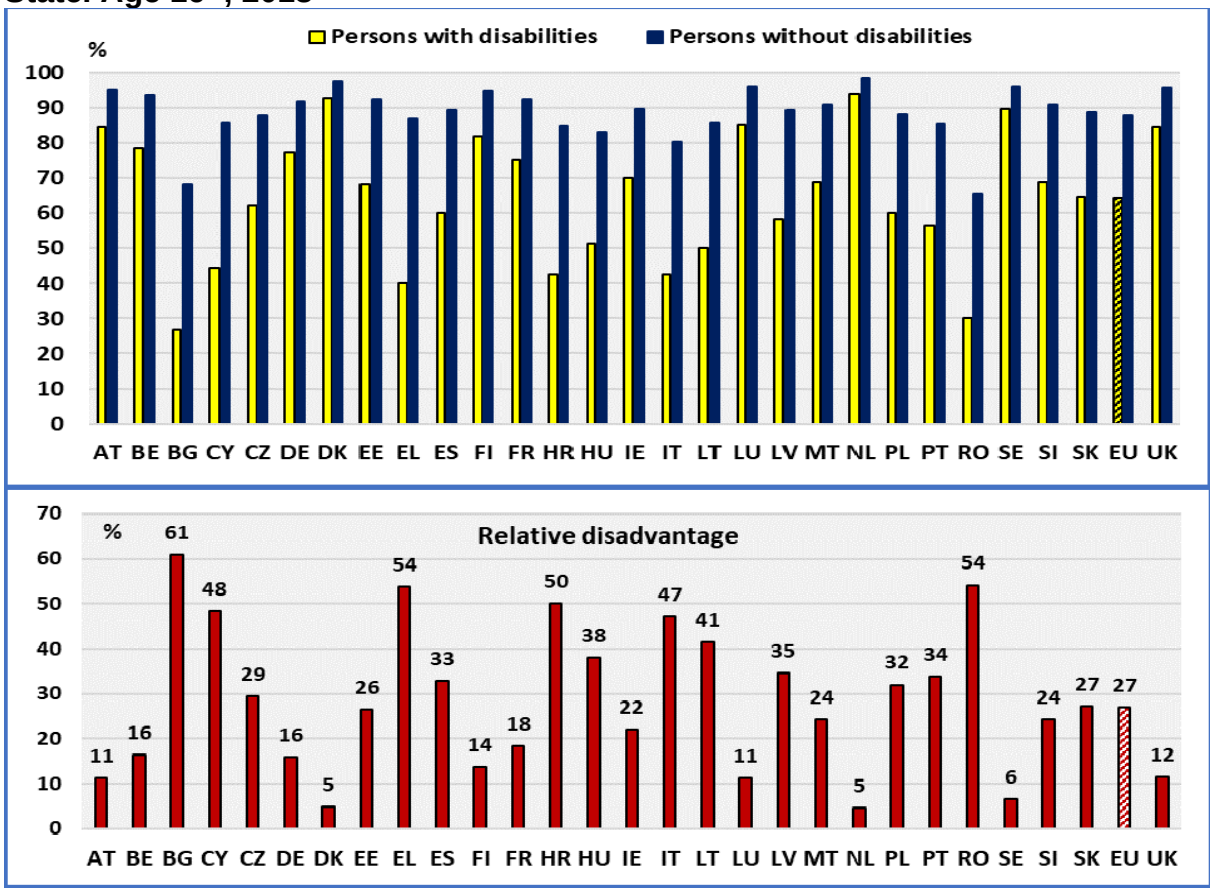
Data source: EU-SILC UDB 2018 Release 2020, Version 1.

[55] European Commission - Eurostat: “Methodological guidelines and description of EU-SILC target variables - 2018 operation” (Version July 2019) DocSILC065 (2018 operation); European Commission – Eurostat, Directorate F: Social Statistics, Unit F-4: Quality of life.

Persons who have an internet connection

Further analysis, of persons having an internet connection for personal use at home, reveals that the disadvantage of persons with disabilities relative to persons without disabilities ranges from 4.6 % in the Netherlands to 60.9 % in Bulgaria.

Figure 68: Percent of persons with internet connection by disability and Member State. Age 16+, 2018



Relative disadvantage: 100 x (% persons without disabilities - % persons with disabilities) / (% persons without disabilities).
Data source: EU-SILC UDB 2018 Release 2020, Version 1.

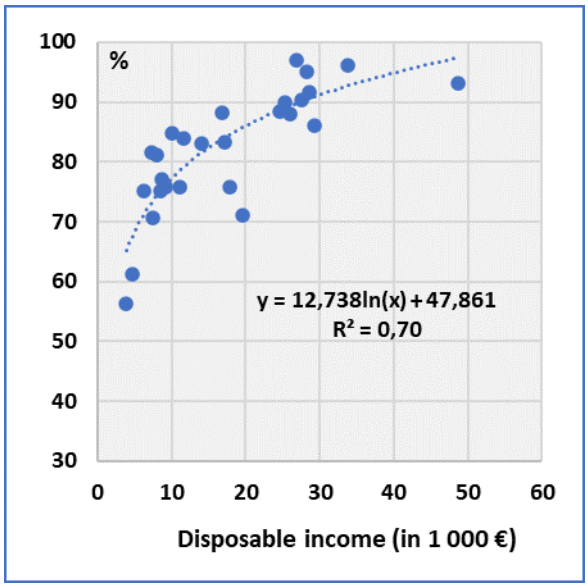
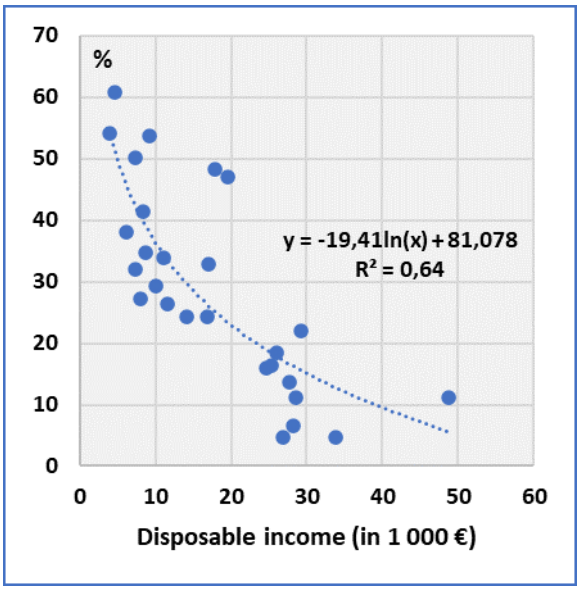
The rate of persons who have an internet connection for personal use at home is strongly correlated with the disposable income (equivalised). As income increases, the percentage of persons with an internet connection increases very fast.

Similarly, but in a lesser extent, the national disability gap is correlated with the national economic constraints. In the following graph, we may observe that the disability gap is inversely correlated to disposable income (equivalised).

The small proportion of people who declare that they don't have an internet connection because they cannot afford it might be misleading. This is an aggregate measure which hides differences across Member States and, inside a given Member State, across individuals.

A financial subsidy to poor individuals (households) might be a powerful incentive for the acquisition of an internet connection. The increase might be substantial as indicated by the following tables. This ought to reduce the disability gap at the same time.

Figure 69: Relation between internet connection and disposable income, 2018

Relation between the percentage (%) of persons with internet connection and disposable income	Relation between relative gap (%) and disposable income
	

The data cover the 27 Member States. They include persons aged 16+, in 2018. Income refers to national mean equivalised disposable income, but similar results are obtained with total disposable household income.

Data source: EU-SILC UDB 2018 Release 2020, Version 1.

The economic crisis following the COVID-19 pandemic might put a downward pressure to the number of persons with an internet connection. However, two important factors might outweigh this negative effect.

First, social distancing and lockdowns might be a strong incentive to buy an internet connection, perhaps at the expense of other goods or services. This ought to ensure a certain level of economic, social and cultural activities. This ought also to ensure the continuation of some health services, e.g. physician consultations.

Secondly, it is important for take measures in order to avoid the isolation of vulnerable and disadvantaged groups. Member States ought to take measures into this direction.

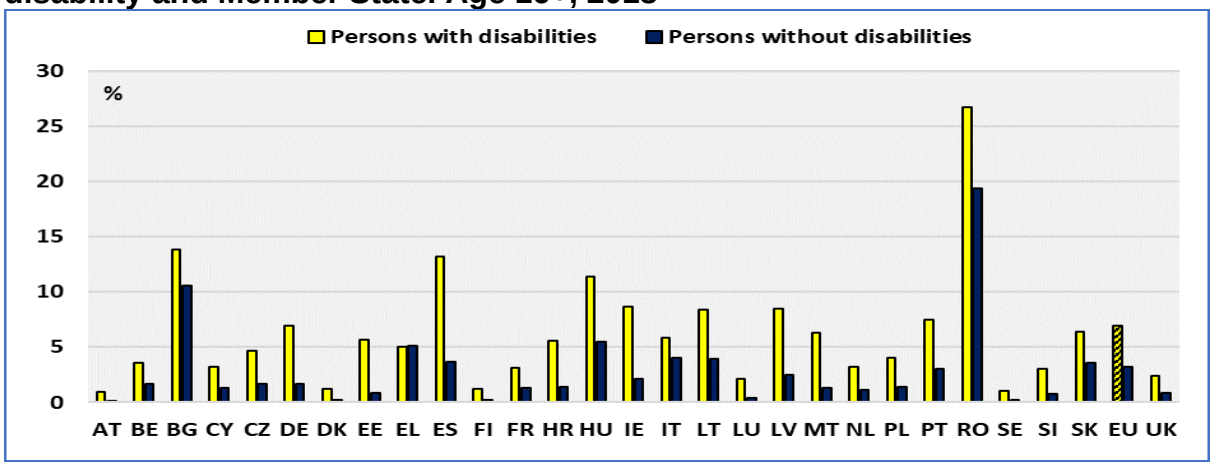
Persons who cannot afford it (an internet connection)

In the EU 27, about 6.9 % of persons with disabilities declare unable to afford the cost of an internet connection. This rate is 3.2 % for persons without disabilities. The highest rates can be found in Romania and Bulgaria.

As indicated above, financial constraints might play an important role. This is notably true in certain Member States with a relatively low disposable income. In fact, Romania and Bulgaria have the lowest disposable income in the EU 27.

On the other end, we find Denmark and Luxembourg with the highest disposable income and low rates of persons reporting economic constraints, as expected.

Figure 70: Percent of persons who cannot afford an internet connection by disability and Member State. Age 16+, 2018

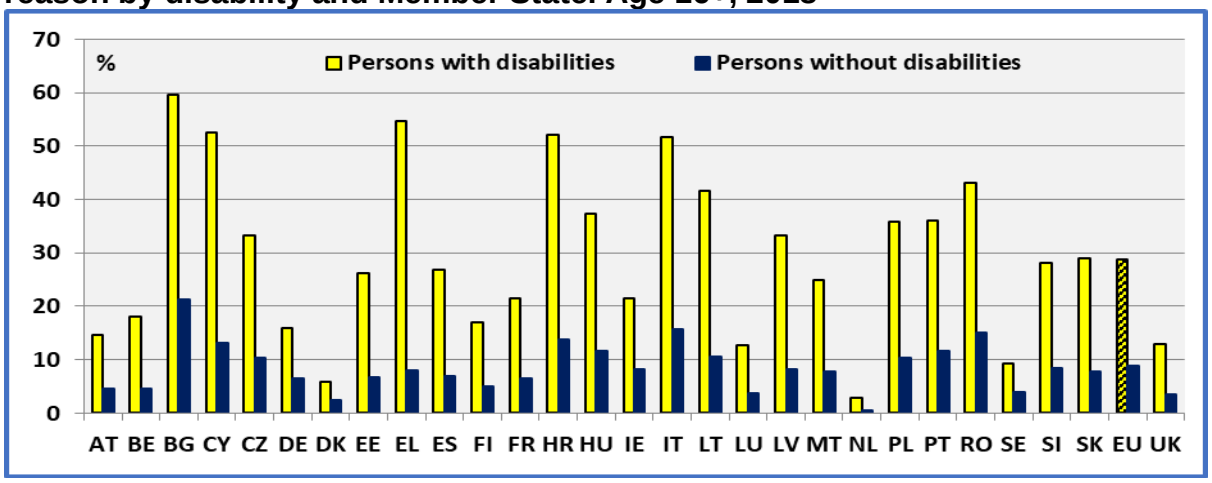


Data source: EU-SILC UDB 2018 Release 2020, Version 1.

Persons who cannot have an internet connection for other reason

In the EU 27, about 28.8 % of persons with disabilities who cannot have an internet connection for other reason. This rate is 8.8 % for persons without disabilities.

Figure 71: Percent of persons wo cannot have an internet connection for other reason by disability and Member State. Age 16+, 2018



Data source: EU-SILC UDB 2018 Release 2020, Version 1.

The rate of persons with disabilities reporting other reasons is significantly higher compared to persons without disabilities. This might be the result of age structure, education (digital skills) or accessibility issues. We study below age and education.

4.3.2 Characteristics by gender

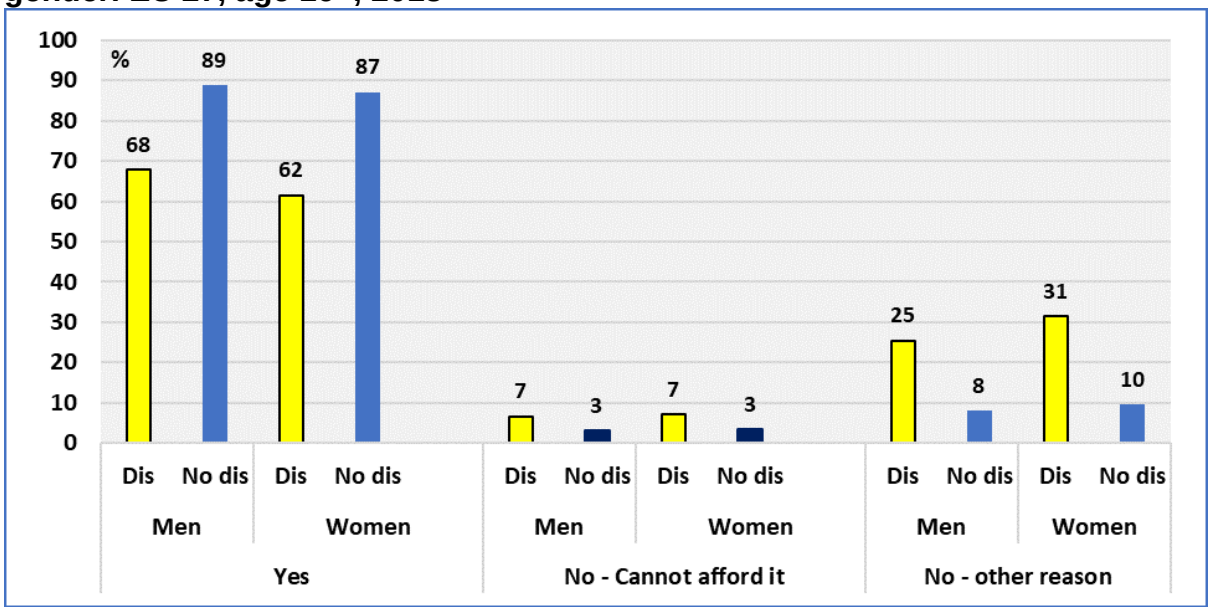
In the following, we focus on the percentage of women with internet connection (Yes answer).

The percentage of women reporting an internet connection is lower compared to men. This holds both for persons with disabilities and for persons without disabilities. Among persons with disabilities, 61.5 % of women have an internet connection compared to 67.9 % of men.

The gender relative disadvantage (women compared to men) is stronger among persons with disabilities (9.4 %) than among persons without disabilities (2.0 %).

The relative disability gap is stronger than the relative gender gap. In fact, the relative disadvantage of persons with disabilities compared to persons without disabilities is much higher. It is 23.5 % for men (disabled men compared to non-disabled men) and 29.4 % for women (disabled women compared to non-disabled women).

Figure 72: Percent of persons with/without internet connection by disability and gender. EU 27, age 16+, 2018



Data source: EU-SILC UDB 2018 Release 2020, Version 1.

4.3.3 Characteristics by age group

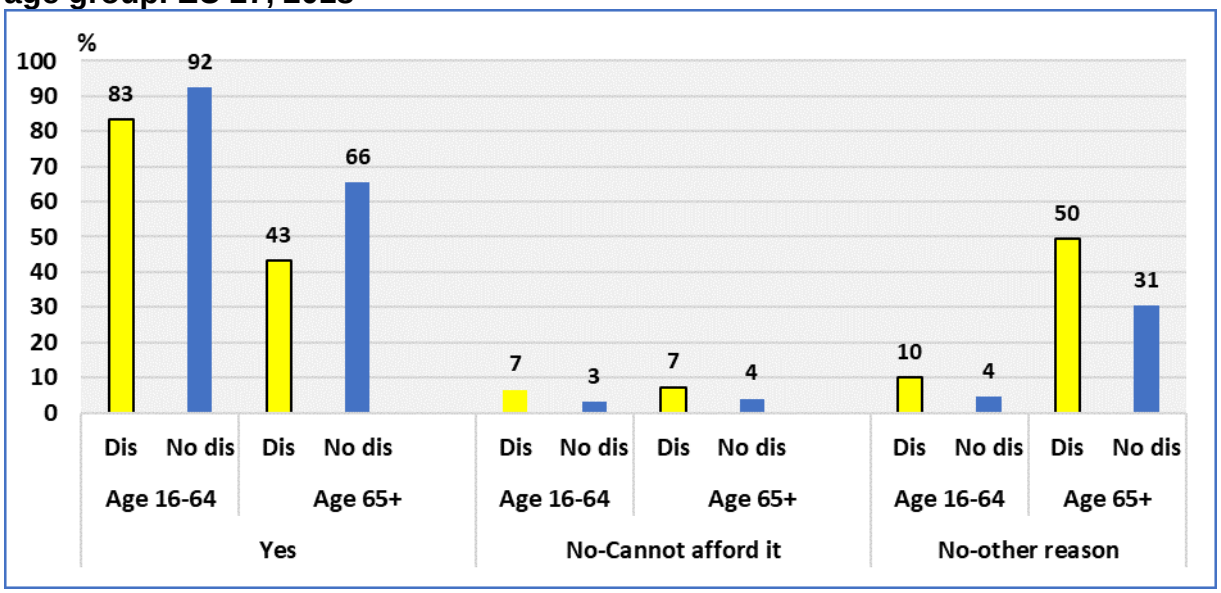
The percentage of elderly people (65 and over) reporting an internet connection is very low compared to younger persons (16-64). This holds both for persons with and without disabilities.

In the EU 27, among persons with disabilities, about 43.2 % of persons with disabilities aged 65 and over have an internet connection compared to 83.4 % of disabled persons aged 16-64.

The mirror-image, of this low internet connection rate among older people, is a very high rate of older people reporting no internet connection for other reasons.

Further analysis by education level reveals that the connection rate increases significantly with the educational level, while the rate of “No – other reason” decreases substantially. This leads us to the conclusion that the answer “No – other reason” measures, notably, digital skills literacy.

Figure 73: Percent of persons with/without internet connection by disability and age group. EU 27, 2018



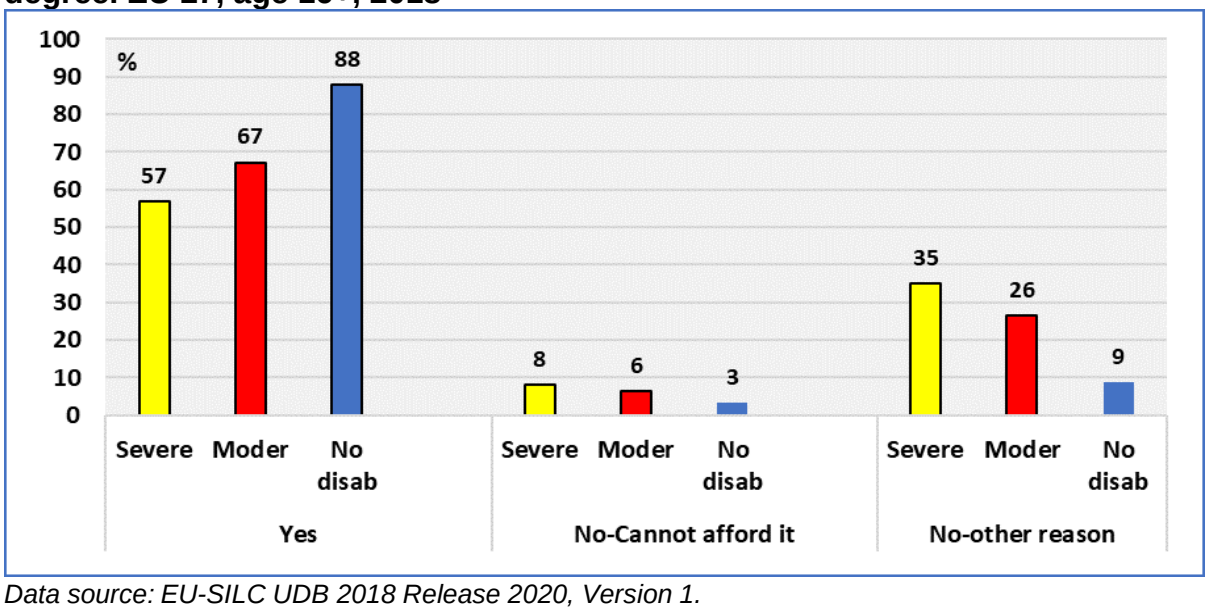
Data source: EU-SILC UDB 2018 Release 2020, Version 1.

4.3.4 Characteristics by degree of disability

The degree of disability decreases the proportion of people who report having an internet connection.

In the EU 27, about 56.9 % of persons with severe disabilities have an internet connection compared to 87.9 % of persons without disabilities.

Figure 74: Percent of persons with/without internet connection by disability degree. EU 27, age 16+, 2018



Data source: EU-SILC UDB 2018 Release 2020, Version 1.

4.3.5 Internet connection and mental health

CDC[56] notes that public health actions, such as social distancing, can make people feel isolated and lonely and can increase stress and anxiety. It adds that stress during an infectious disease outbreak can sometimes cause, notably, worsening of chronic health problems and of mental health conditions. It notes that healthy ways to cope with stress include, notably, connecting with others or talk with people you trust and connecting with your community, for example connecting online, through social media, or by phone or mail.

4.4 Summary and conclusions

1. Possession of a telephone (including mobile phone)

In the EU 27, about 0.5 % of persons with disabilities declare that their household cannot afford a telephone (including mobile phone). The question does not distinguish between fix or mobile telephone. Still, for internet connection this distinction has a big importance.

The percentage of persons with disabilities who cannot afford a telephone, increases with age. But this is partly due to more persons with severe disabilities among elderly people.

2. Possession of a computer

In the EU 27, about 67.2 % of persons with disabilities and 86.9 % of persons without disabilities possess a computer. The question refers to households. However, the possession of a computer can be used, in a certain extent, by all household members.

In the EU 27, about 5.5 % of persons with disabilities and 3.3 % of persons without disabilities cannot afford a computer. About 27.3 % of persons with disabilities and 9.8 % of persons without disabilities does not possess a computer because of 'other' reasons.

Concerning the reasons for not possessing a computer, we may note that the economic reason (cannot afford) is relatively small and constant for all age groups. On the contrary, 'No, other reason' increases significantly after the age of 45-54. Skills are likely the dominant factor explaining the high rates of 'No, other' reason. Levels of digital literacy among older people seem to constitute a significant factor explaining the high percentage of not possessing a computer.

This means that, we ought to promote the acquisition of digital skills among the older people before any initiative promoting eLearning, tele-shopping, eHealth and generally usinginternet by this group of persons.

3. Internet connection for personal use at home

In the EU 27, about 82.1 % of persons aged 16 and over have an internet connection for personal use at home. This rate is 64.3 % for persons with disabilities and 87.9 % for persons without disabilities. There is a disability gap between persons with and

[56] See Centre for Disease Control and Prevention (CDC). Title: "Pandemics can be stressful" in https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/managing-stress-anxiety.html.

without disabilities of 23.7 percentage points. There are big differences across Member States.
The rate of persons who have an internet connection for personal use at home is strongly correlated with disposable income.

The economic crisis following the COVID-19 pandemic might put a downward pressure to the number of persons with an internet connection. However, social distancing might be a strong incentive to buy an internet connection (perhaps at the expense of other goods or services) in order to ensure a certain level of economic, social and health related activities. Member States ought to take measures in order to avoid the isolation of vulnerable and disadvantaged groups.

ANNEXES

A. Statistical tables

1. Health of persons with disabilities

1.1 Self-perceived health

Table 3: General health, 2018

	Good or Very good	Fair	Bad or very bad	Total	Good or very good	Fair	Bad or very bad	Total
AT	33.3	43.5	23.1	100	91.6	8.1	0.3	100
BE	25.7	41.4	32.9	100	91.4	8.0	0.6	100
BG	8.5	39.0	52.4	100	78.0	19.7	2.3	100
CY	24.6	53.8	21.5	100	94.6	5.2	0.3	100
CZ	15.7	48.3	36.0	100	80.1	19.1	0.8	100
DE	15.5	52.6	31.9	100	80.4	18.2	1.4	100
DK	30.0	45.6	24.4	100	88.2	11.3	0.5	100
EE	16.5	46.9	36.7	100	75.0	24.9	0.2	100
EL	16.8	45.3	37.9	100	95.0	4.8	0.2	100
ES	17.4	49.8	32.8	100	88.3	11.0	0.7	100
FI	35.4	49.3	15.4	100	86.7	12.7	0.6	100
FR	23.5	46.7	29.9	100	82.6	16.4	1.0	100
HR	14.4	37.9	47.6	100	84.0	14.2	1.8	100
HU	11.3	45.2	43.5	100	77.5	21.4	1.1	100
IE	36.1	45.4	18.5	100	93.2	6.4	0.5	100
IT	25.2	48.1	26.8	100	88.6	11.0	0.4	100
LT	5.3	50.6	44.1	100	62.6	34.9	2.5	100
LU	25.4	40.2	34.4	100	84.7	14.2	1.1	100
LV	9.2	54.2	36.6	100	72.2	26.4	1.5	100
MT	9.9	62.9	27.2	100	83.8	15.1	1.1	100
NL	35.8	49.6	14.6	100	93.6	6.1	0.4	100
PL	10.0	46.4	43.6	100	74.6	22.4	3.1	100
PT	11.5	46.5	42.0	100	68.4	29.5	2.1	100
RO	21.3	52.7	26.1	100	88.4	11.4	0.2	100
SE	23.5	44.9	31.6	100	83.7	14.3	2.0	100
SI	28.1	45.8	26.1	100	85.9	13.4	0.7	100
SK	18.3	44.2	37.5	100	88.9	10.6	0.5	100
EU	**20.5**	**48.2**	**31.4**	**100**	**84.2**	**14.8**	**1.1**	**100**
UK	31.4	43.7	24.9	100	88.9	10.2	0.9	100

Data source: EU-SILC UDB 2018 Release 2020, Version 1.

1.2 Health conditions and diseases

Table 4: Per cent of persons reporting a disease or condition during the last 12 months, EU 27, age: 15+, 2014

	Age standardised			Not age standardised
	Persons with limitations	Persons without limitations	Total	Total
A. Asthma	10.7	3.5	5,4	5.3
B. Chronic bronchitis	8.5	2.5	4,5	4.1
C. Myocardial infarction	3.3	0.7	1,8	1.5
D. Coronary heart disease	6.7	1.9	3,8	3.3
E. High blood pressure	31.3	20.2	23,8	21.0
F. Stroke	2.9	0.5	1,5	1.3
G. Arthrosis (arthritis excl)	28.9	11.4	17,5	15.4
H. Low back disorder	43.4	18.3	25,5	24.0
I. Neck disorder	31.6	14.0	19,0	18.0
J. Diabetes	12.3	5.5	7,8	6.9
K. Allergy,	22.8	14.0	15,8	16.1
L. Cirrhosis of the liver	0.9	0.2	0,4	0.4
M. Urinary	9.7	3.3	5,8	5.1
N. Kidney	5.6	1.5	2,9	2.6
O. Depression	17.0	3.6	7,0	6.7

**: A person may report several diseases/conditions.*
Source: EHIS Wave 2.

The exact answers (CD1) in the EHIS W2 survey are:

A. Asthma (allergic asthma included)
B. Chronic bronchitis, chronic obstructive pulmonary disease, emphysema
C. Myocardial infarction (heart attack) or chronic consequences of myocardial infarction
D. Coronary heart disease or angina pectoris
E. High blood pressure (hypertension)
F. Stroke (cerebral haemorrhage, cerebral thrombosis) or chronic consequences of stroke
G. Arthrosis (arthritis excluded)
H. Low back disorder or other chronic back defect
I. Neck disorder or other chronic neck defect
J. Diabetes
K. Allergy, such as rhinitis, hay fever, eye inflammation, dermatitis, food allergy or other allergy (allergic asthma excluded)
L. Cirrhosis of the liver
M. Urinary incontinence, problems in controlling the bladder
N. Kidney problems
O. Depression

2. Access to health and home care

2.1 Use of health care services

Table 5: Use of health care services during the last 12 months, 2016

	Persons with disabilities			Persons without disabilities		
	Yes	No	Total	Yes	No	Total
AT	97.3	2.7	100	92.7	7.3	100
BE	91.1	8.9	100	85.3	14.7	100
BG	82.2	17.8	100	68.7	31.3	100
CY	94.1	5.9	100	88.1	11.9	100
CZ	97.3	2.8	100	92.9	7.2	100
DE	87.8	12.2	100	82.5	17.5	100
DK	89.1	10.9	100	83.3	16.7	100
EE	92.4	7.6	100	86.1	13.9	100
EL	91.0	9.0	100	62.8	37.2	100
ES	94.4	5.7	100	88.7	11.3	100
FI	98.7	1.3	100	94.5	5.5	100
FR	95.2	4.9	100	85.7	14.3	100
HR	78.2	21.8	100	68.2	31.8	100
HU	84.6	15.4	100	70.9	29.2	100
IE	68.0	32.0	100	48.9	51.1	100
IT	82.5	17.5	100	65.7	34.3	100
LT	92.4	7.6	100	90.4	9.6	100
LU	97.2	2.8	100	95.6	4.4	100
LV	82.3	17.7	100	78.5	21.5	100
MT	85.5	14.5	100	58.6	41.4	100
NL	97.6	2.4	100	89.6	10.5	100
PL	93.4	6.6	100	88.7	11.3	100
PT	95.2	4.8	100	93.4	6.6	100
RO	66.7	33.3	100	33.5	66.5	100
SE	95.8	4.2	100	91.2	8.8	100
SI	91.2	8.8	100	82.3	17.7	100
SK	93.1	6.9	100	81.5	18.5	100
EU	**89.9**	**10.1**	**100**	**80.6**	**19.4**	**100**
UK	84.6	15.4	100	75.1	24.9	100

Note: The data cover only household respondents.
Data source: EU-SILC UDB 2016 – version 20 March 2018.

Table 6: Use of health care services during the last 12 months, 2016

	Persons with disabilities			Persons without disabilities		
	Yes	No	Total	Yes	No	Total
AT	97.8	2.2	100	94.6	5.4	100
BE	91.5	8.5	100	86.9	13.1	100
BG	82.3	17.7	100	70.8	29.2	100
CY	94.4	5.6	100	90.8	9.2	100
CZ	97.3	2.7	100	93.3	6.7	100
DE	89.5	10.5	100	84.5	15.5	100
DK	89.6	10.5	100	83.9	16.1	100
EE	93.3	6.8	100	89.2	10.9	100
EL	91.4	8.6	100	65.4	34.6	100
ES	94.9	5.1	100	90.7	9.3	100
FI	98.8	1.2	100	94.9	5.1	100
FR	95.7	4.3	100	88.0	12.0	100
HR	79.5	20.5	100	70.7	29.3	100
HU	86.2	13.8	100	74.6	25.4	100
IE	69.6	30.4	100	51.3	48.7	100
IT	83.6	16.4	100	69.1	30.9	100
LT	94.0	6.0	100	91.8	8.2	100
LU	97.3	2.7	100	96.3	3.7	100
LV	84.4	15.6	100	79.3	20.8	100
MT	84.9	15.1	100	60.2	39.8	100
NL	97.7	2.3	100	90.8	9.2	100
PL	94.3	5.7	100	90.3	9.7	100
PT	96.0	4.0	100	94.3	5.7	100
RO	66.8	33.2	100	39.6	60.4	100
SE	95.8	4.2	100	91.2	8.8	100
SI	91.9	8.1	100	82.8	17.2	100
SK	93.0	7.1	100	84.1	15.9	100
EU	**90.4**	**9.6**	**100**	**81.6**	**18.4**	**100**
UK	86.1	13.9	100	74.4	25.6	100

Note: The value expressed by the household respondent is assigned to all household members.
Data source: EU-SILC UDB 2016 – version 20 March 2018.

Table 7: Use of health care services during the last 12 months by gender, 2016

	Persons with disabilities						
	Men		Women		Total		
	Yes	No	Yes	No	Yes	No	Total
AT	93.0	7.0	97.3	2.7	95.7	4.3	100
BE	89.5	10.5	90.2	9.8	89.9	10.1	100
BG	78.6	21.4	80.6	19.4	80.1	19.9	100
CY	90.7	9.4	90.2	9.8	90.3	9.7	100
CZ	93.5	6.5	97.1	2.9	96.0	4.0	100
DE	84.8	15.2	88.2	11.8	86.8	13.2	100
DK	85.8	14.3	91.1	8.9	88.8	11.2	100
EE	83.0	17.0	93.6	6.4	90.3	9.7	100
EL	87.9	12.1	94.2	5.8	92.6	7.4	100
ES	91.4	8.6	92.1	7.9	91.9	8.1	100
FI	96.0	4.0	99.2	0.8	98.0	2.0	100
FR	94.3	5.7	94.2	5.8	94.2	5.8	100
HR	64.1	35.9	79.2	20.8	74.8	25.2	100
HU	72.3	27.7	86.0	14.0	81.9	18.1	100
IE	60.0	40.0	66.2	33.9	63.3	36.7	100
IT	74.9	25.1	80.6	19.4	79.0	21.0	100
LT	87.6	12.4	92.3	7.7	91.2	8.8	100
LU	96.9	3.1	95.9	4.1	96.3	3.7	100
LV	73.3	26.7	80.0	20.0	78.4	21.6	100
MT	83.1	16.9	81.9	18.1	82.5	17.5	100
NL	95.4	4.6	97.8	2.2	96.9	3.2	100
PL	86.6	13.4	92.9	7.2	91.2	8.8	100
PT	85.6	14.4	94.7	5.4	92.6	7.4	100
RO	65.6	34.4	64.5	35.5	64.8	35.2	100
SE	85.7	14.3	93.7	6.3	90.5	9.5	100
SI	82.4	17.6	90.3	9.7	87.8	12.3	100
SK	91.3	8.7	92.2	7.8	92.0	8.0	100
							100
EU	**86.1**	**13.9**	**88.8**	**11.2**	**87.9**	**12.1**	**100**
UK	81.3	18.7	83.8	16.2	82.7	17.3	100

Data source: EU-SILC UDB 2016 – version 20 March 2018.

2.2 Affordability of health care services

Table 8: Affordability of health care services (persons who use health care services), 2016. Only household respondents

	Persons with disabilities				Persons without disabilities			
	With difficulty	Fair	Easily	Total	With difficulty	Fair	Easily	Total
AT	15.4	42.8	41.9	100	5.2	36.8	58.0	100
BE	26.8	40.7	32.5	100	9.5	32.7	57.8	100
BG	38.0	21.6	40.4	100	22.6	34.4	43.1	100
CY	57.1	37.7	5.1	100	39.4	47.6	13.0	100
CZ	24.2	44.9	31.0	100	8.4	42.3	49.3	100
DE	14.9	51.0	34.2	100	4.1	39.9	56.0	100
DK	13.1	49.1	37.8	100	3.1	37.3	59.6	100
EE	27.1	62.6	10.4	100	10.3	65.3	24.4	100
EL	75.5	23.2	1.4	100	61.2	34.9	3.9	100
ES	15.7	37.4	46.9	100	9.1	33.7	57.2	100
FI	8.4	42.2	49.4	100	1.4	23.3	75.3	100
FR	14.1	38.5	47.4	100	7.1	35.6	57.4	100
HR	30.8	26.7	42.5	100	12.6	33.1	54.3	100
HU	49.4	46.5	4.1	100	29.5	62.4	8.1	100
IE	28.8	30.6	40.6	100	16.6	45.8	37.6	100
IT	29.6	45.8	24.5	100	16.2	61.8	21.9	100
LT	11.4	8.6	80.1	100	6.6	17.8	75.6	100
LU	15.9	43.7	40.4	100	4.1	39.7	56.2	100
LV	50.7	35.5	13.8	100	23.8	53.1	23.1	100
MT	34.8	55.2	10.0	100	18.7	59.6	21.8	100
NL	24.1	33.3	42.6	100	8.7	28.9	62.4	100
PL	20.1	25.7	54.2	100	10.4	36.1	53.5	100
PT	30.4	38.3	31.4	100	16.1	49.9	34.0	100
RO	28.0	26.0	46.1	100	14.6	27.6	57.8	100
SE	17.8	50.1	32.1	100	6.5	32.6	61.0	100
SI	21.8	25.6	52.6	100	9.3	22.6	68.1	100
SK	37.3	59.2	3.5	100	17.9	71.3	10.8	100
EU	**21.8**	**39.8**	**38.5**	**100**	**9.7**	**39.1**	**51.2**	**100**
UK	5.8	19.81	74.39	100	4.7	25.1	70.2	100

Note: With difficulty: 1 With great difficulty or 2 With difficulty; Fair:3 With some difficulty or 4 Fairly easily; Easily: 5 Easily or 6 Very easily.
Data source: EU-SILC UDB 2016 – version 20 March 2018.

Table 9: Affordability of health care services (persons who use health care services), 2016. All persons in the sample

	Persons with disabilities				Persons without disabilities			
	With difficulty	Fair	Easily	Total	With difficulty	Fair	Easily	Total
AT	14.0	45.4	40.6	100	6.4	38.2	55.4	100
BE	25.1	40.1	34.8	100	10.1	32.7	57.2	100
BG	36.8	23.6	39.6	100	23.5	34.8	41.6	100
CY	56.8	37.1	6.1	100	41.9	47.1	10.9	100
CZ	22.2	47.4	30.4	100	8.7	43.1	48.3	100
DE	12.4	52.3	35.3	100	4.3	41.2	54.5	100
DK	13.2	49.0	37.8	100	3.3	37.8	58.9	100
EE	26.1	63.3	10.7	100	10.2	66.6	23.2	100
EL	75.5	22.9	1.6	100	63.6	33.0	3.4	100
ES	16.0	36.8	47.1	100	9.9	34.8	55.3	100
FI	8.1	41.8	50.1	100	1.6	24.3	74.2	100
FR	13.6	39.5	46.9	100	7.7	36.2	56.2	100
HR	30.4	27.7	41.9	100	15.1	33.0	51.9	100
HU	48.0	48.0	4.0	100	31.6	60.9	7.5	100
IE	28.9	32.5	38.6	100	17.9	45.7	36.4	100
IT	29.9	48.2	22.0	100	18.1	61.6	20.3	100
LT	11.8	10.7	77.5	100	7.2	19.4	73.4	100
LU	14.0	45.6	40.4	100	4.9	41.7	53.4	100
LV	47.2	39.1	13.7	100	25.9	53.6	20.5	100
MT	32.9	56.6	10.6	100	21.0	59.3	19.8	100
NL	23.3	32.4	44.3	100	8.1	28.9	63.0	100
PL	18.9	29.2	51.9	100	10.8	36.8	52.4	100
PT	29.5	40.4	30.1	100	17.6	49.7	32.7	100
RO	27.1	28.7	44.2	100	16.2	28.5	55.4	100
SE	17.8	50.1	32.1	100	6.5	32.6	61.0	100
SI	21.8	26.3	51.9	100	9.9	23.5	66.6	100
SK	34.4	61.9	3.7	100	19.0	70.7	10.3	100
EU	21.3	40.9	37.8	100	11.2	40.5	48.3	100
UK	6.3	21.8	71.9	100	4.9	27.0	68.2	100

Note: The value reported by the household respondent is attributed to all household members.
With difficulty: 1 With great difficulty or 2 With difficulty; Fair:3 With some difficulty or 4 Fairly easily; Easily: 5 Easily or 6 Very easily.
Data source: EU-SILC UDB 2016 – version 20 March 2018.

2.3 Unmet medical needs

Table 10: Unmet need for medical examination or treatment during the last 12 months, 2018

	Persons with disabilities				Persons without disabilities			
	No need	1 Expensive 2 Wait list 4 Too far	Other reason	Total	No need	1 Expensive 2 Wait list 4 Too far	Other reason	Total
AT	99.2	0.3	0.5	100	99.8	0.0	0.2	100
BE	95.0	4.3	0.7	100	98.8	1.0	0.3	100
BG	92.3	5.6	2.1	100	97.7	1.2	1.2	100
CY	97.4	2.5	0.1	100	98.6	1.1	0.3	100
CZ	96.8	0.8	2.4	100	97.9	0.1	2.0	100
DE	99.0	0.4	0.7	100	99.5	0.2	0.3	100
DK	86.6	3.1	10.3	100	96.6	0.5	2.9	100
EE	71.9	23.6	4.5	100	87.2	11.7	1.1	100
EL	77.4	19.7	3.0	100	93.7	5.4	0.9	100
ES	99.3	0.4	0.3	100	99.7	0.1	0.3	100
FI	89.1	9.5	1.4	100	97.3	2.3	0.5	100
FR	96.4	1.6	2.1	100	96.7	1.0	2.3	100
HR	92.9	3.7	3.4	100	97.2	0.3	2.5	100
HU	91.1	2.3	6.6	100	95.5	0.3	4.2	100
IE	93.7	5.3	1.1	100	98.5	1.4	0.1	100
IT	94.7	5.1	0.3	100	98.3	1.5	0.2	100
LT	93.9	4.2	1.9	100	98.3	1.3	0.5	100
LU	98.8	0.3	1.0	100	99.3	0.3	0.5	100
LV	79.7	11.6	8.7	100	95.1	2.6	2.4	100
MT	98.5	0.4	1.1	100	99.6	0.1	0.3	100
NL	98.3	0.5	1.3	100	99.6	0.1	0.3	100
PL	87.4	8.8	3.8	100	92.8	2.8	4.4	100
PT	94.2	4.0	1.9	100	97.6	1.1	1.4	100
RO	77.3	16.2	6.5	100	98.7	0.8	0.5	100
SE	90.5	3.6	5.9	100	96.9	1.2	1.9	100
SI	93.3	5.9	0.8	100	97.7	1.9	0.5	100
SK	89.0	5.9	5.1	100	96.2	1.1	2.8	100
EU	**93.9**	**4.0**	**2.0**	**100**	**97.8**	**1.0**	**1.2**	**100**
UK	85.4	7.6	7.0	100	94.4	3.2	2.4	100

Note: The first question (PH040) concerns 'unmet need for medical examination or treatment during the last 12 months': 1. Yes, there was at least one occasion when the person really needed examination or treatment but did not receive it; 2. No, there was no occasion when the person really needed examination or treatment but did not receive it.
If the answer is '1', the second question (PH050) asks the 'main reason for unmet need for medical examination or treatment: 1 Could not afford to (too expensive); 2 Waiting list; 3 Could not take time because of work, care for children or for others; 4 Too far to travel/no means of transportation; 5 Fear of doctor/hospitals/examination/ treatment; 6 Wanted to wait and see if problem got better on its own; 7 Didn't know any good doctor or specialist; 8 Other reasons.
Data source: EU-SILC UDB 2018 Release 2020, Version 1.

2.4 Professional home care

Table 11: Presence in the household of people who need help due to long-term physical or mental ill-health, infirmity or because of old age (household respondents only), 2016

	Persons with disabilities			Persons without disabilities		
	Yes	No	Total	Yes	No	Total
AT	15.2	84.8	100	2.6	97.4	100
BE	25.5	74.5	100	4.6	95.4	100
BG	22.5	77.5	100	5.9	94.1	100
CY	18.1	81.9	100	2.6	97.5	100
CZ	11.2	88.8	100	2.2	97.8	100
DE	9.0	91.0	100	1.7	98.3	100
DK	13.3	86.7	100	2.6	97.4	100
EE	30.4	69.6	100	6.9	93.1	100
EL	36.0	64.1	100	6.1	93.9	100
ES	36.6	63.4	100	9.1	90.9	100
FI	19.6	80.4	100	4.2	95.8	100
FR	19.4	80.6	100	2.4	97.6	100
HR	13.6	86.4	100	4.4	95.6	100
HU	9.1	90.9	100	2.7	97.3	100
IE	25.3	74.7	100	6.4	93.6	100
IT	25.4	74.7	100	4.5	95.6	100
LT	11.9	88.1	100	5.2	94.8	100
LU	18.8	81.2	100	6.1	94.0	100
LV	17.3	82.7	100	3.9	96.1	100
MT	21.9	78.1	100	4.5	95.5	100
NL	33.7	66.3	100	4.8	95.2	100
PL	22.8	77.2	100	7.9	92.1	100
PT	18.3	81.7	100	5.8	94.2	100
RO	4.9	95.2	100	1.3	98.8	100
SE	38.1	61.9	100	7.0	93.0	100
SI	11.2	88.8	100	3.1	96.9	100
SK	12.4	87.7	100	4.3	95.7	100
EU	**20.3**	**79.7**	**100**	**4.3**	**95.8**	**100**
UK	34,7	65,3	100	5,4	94,6	100

Note: Household respondents only.
Data source: EU-SILC UDB 2016 – version 20 March 2018.

Table 12: Presence in the household of people who need help due to long-term physical or mental ill-health, infirmity or because of old age (All persons in the sample), 2016

	Persons with disabilities			Persons without disabilities		
	Yes	No	Total	Yes	No	Total
AT	17,0	83,1	100	3,2	96,8	100
BE	27,0	73,0	100	5,5	94,5	100
BG	27,7	72,3	100	6,3	93,7	100
CY	18,3	81,7	100	3,6	96,4	100
CZ	12,1	87,9	100	2,1	97,9	100
DE	12,2	87,8	100	1,9	98,1	100
DK	13,2	86,8	100	3,0	97,0	100
EE	33,7	66,3	100	7,7	92,4	100
EL	39,5	60,5	100	8,2	91,8	100
ES	42,5	57,5	100	10,6	89,4	100
FI	21,2	78,8	100	4,3	95,7	100
FR	18,8	81,2	100	2,6	97,4	100
HR	17,3	82,7	100	5,5	94,5	100
HU	13,7	86,3	100	3,0	97,0	100
IE	33,2	66,8	100	7,0	93,0	100
IT	26,1	73,9	100	5,2	94,8	100
LT	17,5	82,6	100	5,9	94,1	100
LU	20,0	80,0	100	7,5	92,5	100
LV	18,6	81,4	100	4,6	95,4	100
MT	27,4	72,6	100	5,0	95,0	100
NL	31,6	68,4	100	4,5	95,5	100
PL	28,3	71,8	100	8,8	91,2	100
PT	22,0	78,0	100	6,6	93,4	100
RO	5,9	94,1	100	1,8	98,3	100
SE	38,1	61,9	100	7,0	93,0	100
SI	12,9	87,1	100	3,4	96,6	100
SK	15,8	84,2	100	5,5	94,5	100
EU	**22,5**	**77,5**	**100**	**4,9**	**95,1**	**100**
UK	36,6	63,4	100	6,9	93,1	100

Note: The value provided by the household respondent is attributed to all members of the household.
Data source: EU-SILC UDB 2016 – version 20 March 2018.

Table 13: Persons receiving professional home care (only those needing help), 2016

	Persons with disabilities			Persons without disabilities		
	Yes	No	Total	Yes	No	Total
AT	52.6	47.4	100	35.8	64.2	100
BE	46.9	53.1	100	38.5	61.5	100
BG	7.4	92.6	100	4.6	95.4	100
CY	49.9	50.1	100	43.9	56.2	100
CZ	64.6	35.4	100	54.0	46.0	100
DE	35.8	64.3	100	28.5	71.5	100
DK	60.5	39.5	100	47.2	52.8	100
EE	8.9	91.1	100	2.8	97.2	100
EL	12.7	87.3	100	10.7	89.3	100
ES	15.0	85.0	100	12.1	88.0	100
FI	34.8	65.2	100	26.1	73.9	100
FR	57.1	42.9	100	49.9	50.1	100
HR	17.3	82.7	100	12.2	87.8	100
HU	29.7	70.3	100	15.1	84.9	100
IE	34.3	65.7	100	22.3	77.7	100
IT	16.0	84.0	100	9.9	90.1	100
LT	15.8	84.2	100	7.2	92.8	100
LU	92.1	7.9	100	82.9	17.2	100
LV	17.2	82.8	100	7.2	92.8	100
MT	19.6	80.4	100	21.0	79.1	100
NL	52.8	47.2	100	40.2	59.8	100
PL	8.0	92.0	100	6.4	93.6	100
PT	20.8	79.2	100	19.8	80.2	100
RO	10.4	89.6	100	5.7	94.3	100
SE	28.8	71.2	100	17.9	82.1	100
SI	28.9	71.1	100	28.0	72.0	100
SK	18.6	81.4	100	15.7	84.3	100
EU	**30.8**	**69.2**	**100**	**19.9**	**80.1**	**100**
UK	25.4	74.6	100	15.3	84.7	100

Note: Household respondents only.
Data source: EU-SILC UDB 2016 – version 20 March 2018.

Table 14: Persons receiving professional home care (only those needing help), 2016. All persons in the sample

	Persons with disabilities			Persons without disabilities		
	Yes	No	Total	Yes	No	Total
AT	45,6	54,4	100	33,6	66,4	100
BE	44,9	55,1	100	32,3	67,7	100
BG	5,8	94,2	100	4,1	95,9	100
CY	41,8	58,2	100	52,6	47,4	100
CZ	63,2	36,8	100	55,9	44,1	100
DE	32,2	67,9	100	25,6	74,4	100
DK	59,7	40,3	100	52,4	47,6	100
EE	6,7	93,3	100	3,1	96,9	100
EL	11,2	88,8	100	8,7	91,3	100
ES	15,1	84,9	100	9,3	90,7	100
FI	36,5	63,5	100	22,9	77,1	100
FR	55,4	44,6	100	41,5	58,5	100
HR	15,7	84,3	100	12,2	87,8	100
HU	23,7	76,3	100	17,6	82,4	100
IE	32,9	67,1	100	21,8	78,2	100
IT	14,5	85,5	100	9,8	90,2	100
LT	10,3	89,7	100	6,0	94,0	100
LU	91,9	8,1	100	85,1	14,9	100
LV	13,7	86,3	100	9,4	90,6	100
MT	19,4	80,6	100	17,2	82,8	100
NL	51,9	48,1	100	39,7	60,3	100
PL	7,3	92,7	100	4,9	95,1	100
PT	19,9	80,1	100	17,3	82,7	100
RO	9,0	91,0	100	4,3	95,7	100
SE	28,8	71,2	100	17,9	82,1	100
SI	27,8	72,2	100	22,9	77,1	100
SK	16,1	84,0	100	14,1	85,9	100
EU	26,6	73,5	100	15,9	84,1	100
UK	21,1	78,9	100	13,7	86,3	100

Note: The value provided by the household respondent is attributed to all household members.
Data source: EU-SILC UDB 2016 – version 20 March 2018.

2.5 The cost of professional home care

Table 15: Payment and affordability of professional home care, 2016

	Persons who paid professional home care Only respondents needing help and having received help			Affordability of professional home care services Only respondents who paid			
	Yes	**No**	**Total**	**Difficult**	**Fair**	**Easily**	**Total**
AT	91.9	8.1	100	29.1	51.6	19.4	100
BE	72.2	27.8	100	26.4	49.9	23.7	100
BG	64.3	35.7	100	(46.5)	(53.5)	(0.0)	100
CY	82.7	17.3	100	78.2	19.7	2.1	100
CZ	41.7	58.4	100	44.1	51.0	4.9	100
DE	46.0	54.0	100	11.7	69.7	18.6	100
DK	47.7	52.3	100	23.8	31.4	44.8	100
EE	31.3	68.7	100	(11.4)	(79.3)	(9.3)	100
EL	84.9	15.1	100	88.6	11.1	0.3	100
ES	80.2	19.8	100	46.5	44.7	8.8	100
FI	80.8	19.2	100	8.8	57.0	34.2	100
FR	68.8	31.2	100	18.8	56.5	24.7	100
HR	17.5	82.5	100	(47.8)	(49.7)	(2.5)	100
HU	41.9	58.1	100	(41.5)	(58.5)	(0.0)	100
IE	14.8	85.2	100	(35.6)	(28.4)	(36.0)	100
IT	45.3	54.8	100	54.8	38.6	6.6	100
LT	46.9	53.1	100	(35.5)	(59.9)	(4.6)	100
LU	43.2	56.8	100	(14.7)	(68.2)	(17.0)	100
LV	14.5	85.5	100	…	…	…	…
MT	47.0	53.0	100	(25.9)	(48.4)	(25.6)	100
NL	80.3	19.7	100	21.2	34.1	44.6	100
PL	71.8	28.2	100	45.7	49.1	5.3	100
PT	67.4	32.6	100	50.4	44.9	4.7	100
RO	30.4	69.6	100	…	…	…	…
SE	100.0	0.0	100	12.5	44.9	42.6	100
SI	33.8	66.2	100	46.5	46.9	6.6	100
SK	40.9	59.1	100	48.0	51.5	0.6	100
							100
EU	**67.3**	**32.7**	**100**	**28.0**	**47.5**	**24.5**	**100**
							100
UK	37.1	62.9	100	16.8	52.9	30.3	100

Note: Household respondents only. With difficulty: 1 With great difficulty or 2 With difficulty; Fair: 3 With some difficulty or 4 Fairly easily; Easily: 5 Easily or 6 Very easily.
Data in parenthesis (): Indicative estimates (observations between 20 and less than 50)
Data source: EU-SILC UDB 2016 – version 20 March 2018.

Table 16: Payment and affordability of professional home care, 2016

	Persons who paid professional home care Only respondents needing help and having received help			Affordability of professional home care services Only respondents who paid			
	Yes	**No**	**Total**	**Difficult**	**Fair**	**Easily**	**Total**
AT	93.2	6.8	100	30.2	47.6	22.1	100
BE	68.9	31.1	100	26.6	49.8	23.7	100
BG	57.5	42.5	100	57.3	42.7	0.0	100
CY	85.4	14.6	100	75.3	22.8	2.0	100
CZ	38.8	61.2	100	41.9	54.4	3.8	100
DE	48.3	51.7	100	18.0	65.2	16.8	100
DK	50.2	49.8	100	22.3	34.3	43.4	100
EE	27.1	72.9	100	17.6	75.1	7.3	100
EL	82.2	17.8	100	87.6	12.0	0.3	100
ES	77.7	22.3	100	45.4	44.5	10.1	100
FI	80.0	20.0	100	8.0	55.8	36.3	100
FR	63.4	36.6	100	19.2	56.2	24.7	100
HR	14.9	85.1	100	45.5	52.0	2.5	100
HU	34.8	65.2	100	46.1	53.9	0.0	100
IE	12.9	87.1	100	36.5	31.6	31.9	100
IT	37.7	62.4	100	51.4	41.0	7.6	100
LT	40.9	59.1	100	38.7	54.7	6.6	100
LU	37.5	62.5	100	17.3	69.7	13.1	100
LV	14.6	85.4	100	62.6	37.4	0.0	100
MT	41.9	58.1	100	32.9	47.4	19.7	100
NL	80.0	20.1	100	20.4	33.7	45.9	100
PL	69.4	30.6	100	40.2	49.8	10.1	100
PT	62.8	37.2	100	51.4	43.6	5.1	100
RO	20.1	80.0	100	61.3	38.7	0.0	100
SE	100.0	0.0	100	12.5	44.9	42.6	100
SI	32.5	67.5	100	43.7	44.8	11.4	100
SK	34.9	65.1	100	38.7	61.1	0.3	100
EU	**62.8**	**37.2**	**100**	**29.9**	**47.7**	**22.4**	**100**
UK	31.0	69.0	100	16.9	53.7	29.5	100

Note: The value provided by the household respondent is attributed to all household members.
With difficulty: 1 With great difficulty or 2 With difficulty; Fair:3 With some difficulty or 4 Fairly easily; Easily: 5 Easily or 6 Very easily.
Data source: EU-SILC UDB 2016 – version 20 March 2018.

2.6 Unmet needs for professional home care

Table 17: Persons with unmet needs for professional home care, 2016
Only households with a presence in the household of people who need help
Only household respondents

	Persons with disabilities			Persons without disabilities		
	Yes	No	Total	Yes	No	Total
AT	26.8	73.3	100	15.6	84.4	100
BE	22.6	77.4	100	10.9	89.1	100
BG	51.3	48.7	100	37.7	62.3	100
CY	50.6	49.4	100	38.6	61.4	100
CZ	31.0	69.0	100	19.8	80.2	100
DE	13.7	86.3	100	8.1	91.9	100
EE	16.1	84.0	100	8.3	91.7	100
EL	64.8	35.2	100	48.7	51.3	100
ES	35.6	64.4	100	23.4	76.6	100
FI	29.3	70.7	100	11.2	88.8	100
FR	32.5	67.5	100	14.6	85.5	100
HR	17.9	82.1	100	14.7	85.4	100
HU	24.0	76.0	100	20.3	79.7	100
IE	33.3	66.7	100	31.2	68.8	100
IT	39.8	60.2	100	25.1	74.9	100
LT	50.6	49.4	100	28.4	71.6	100
LU	17.2	82.8	100	11.5	88.5	100
LV	43.8	56.2	100	22.5	77.5	100
MT	23.4	76.6	100	17.8	82.2	100
NL	45.7	54.3	100	39.8	60.2	100
PL	19.0	81.0	100	13.0	87.0	100
PT	87.3	12.7	100	83.0	17.1	100
RO	40.7	59.4	100	37.9	62.1	100
SE	19.9	80.1	100	6.1	93.9	100
SI	22.8	77.2	100	13.5	86.5	100
SK	26.0	74.0	100	18.5	81.5	100
EU	**35.0**	**65.0**	**100**	**21.9**	**78.1**	**100**
UK	22.2	77.8	100	17.0	83.0	100

Note: Household respondents only.
Data source: EU-SILC UDB 2016 – version 20 March 2018.

Table 18: Persons with unmet needs for professional home care, 2016
Only households with a presence in the household of people who need help
All persons in the sample.

	Persons with disabilities			Persons without disabilities		
	Yes	No	Total	Yes	No	Total
AT	24,9	75,1	100	19,5	80,5	100
BE	20,0	80,0	100	14,6	85,5	100
BG	48,3	51,7	100	34,8	65,2	100
CY	54,9	45,1	100	35,6	64,4	100
CZ	28,4	71,6	100	18,5	81,5	100
DE	13,8	86,2	100	10,2	89,8	100
EE	14,7	85,3	100	8,6	91,4	100
EL	62,2	37,8	100	47,2	52,8	100
ES	35,9	64,1	100	22,2	77,8	100
FI	28,2	71,8	100	9,7	90,3	100
FR	30,7	69,3	100	15,3	84,7	100
HR	18,2	81,8	100	16,6	83,4	100
HU	23,3	76,7	100	19,8	80,2	100
IE	37,5	62,5	100	30,1	69,9	100
IT	39,2	60,8	100	26,6	73,5	100
LT	39,1	60,9	100	30,8	69,2	100
LU	19,0	81,0	100	5,9	94,1	100
LV	38,2	61,8	100	25,1	74,9	100
MT	24,3	75,7	100	15,2	84,8	100
NL	46,2	53,8	100	42,5	57,6	100
PL	16,6	83,4	100	12,9	87,1	100
PT	87,4	12,6	100	86,7	13,3	100
RO	42,9	57,1	100	32,0	68,0	100
SE	19,9	80,1	100	6,1	93,9	100
SI	21,1	78,9	100	13,5	86,6	100
SK	23,4	76,6	100	16,0	84,0	100
EU	**33,9**	**66,1**	**100**	**23,1**	**76,9**	**100**
UK	22,1	78,0	100	17,5	82,5	100

Note: The value provided by the household respondent is attributed to all household members.
Data source: EU-SILC UDB 2016 – version 20 March 2018.

3. Isolation and social distancing

3.1 Social networking (Getting together with friends or relatives)

Table 19: Get-together with friends/family (relatives) for a drink/meal at least once a month, 2018

	Persons with disabilities				Persons without disabilities			
	1 Yes	2 No - cannot afford it	3 No - other reason	Total	1 Yes	2 No - cannot afford it	3 No - other reason	Total
AT	83.1	5.6	11.3	100	93.6	1.8	4.7	100
BE	69.3	19.8	11.0	100	89.5	6.3	4.3	100
BG	45.3	32.1	22.6	100	74.3	18.9	6.8	100
CY	95.3	1.5	3.1	100	98.0	0.6	1.5	100
CZ	87.4	3.7	8.9	100	95.8	1.2	3.0	100
DE	67.2	13.9	19.0	100	84.0	4.7	11.2	100
DK	78.2	6.1	15.7	100	90.8	1.7	7.6	100
EE	71.0	10.3	18.7	100	89.3	2.2	8.5	100
EL	44.0	27.4	28.6	100	75.4	19.3	5.3	100
ES	64.9	19.9	15.2	100	89.0	7.6	3.5	100
FI	82.7	1.5	15.8	100	89.0	0.7	10.3	100
FR	80.7	9.4	10.0	100	92.0	3.9	4.1	100
HR	67.7	9.3	23.0	100	92.6	3.2	4.2	100
HU	49.0	31.0	20.0	100	68.0	19.0	13.0	100
IE	62.9	19.2	17.9	100	81.4	8.2	10.4	100
IT	63.3	7.8	28.9	100	82.0	5.9	12.1	100
LT	49.4	25.1	25.6	100	77.5	12.5	10.0	100
LU	83.2	7.0	9.8	100	94.5	2.1	3.4	100
LV	69.4	12.5	18.2	100	89.0	4.5	6.6	100
MT	62.0	14.6	23.4	100	87.1	5.9	7.0	100
NL	78.0	7.3	14.7	100	89.3	5.0	5.7	100
PL	65.0	10.4	24.6	100	83.8	5.3	10.9	100
PT	74.6	14.0	11.4	100	93.0	5.2	1.8	100
RO	56.8	31.4	11.8	100	75.5	20.0	4.5	100
SE	76.4	3.9	19.8	100	89.3	1.0	9.8	100
SI	85.8	5.8	8.4	100	94.8	1.7	3.6	100
SK	95.7	2.9	1.5	100	98.0	1.8	0.2	100
EU	**69.3**	**13.2**	**17.5**	**100**	**85.7**	**6.6**	**7.7**	**100**
UK	59.9	9.7	30.5	100	74.4	3.9	21.8	100

Data source: EU-SILC UDB 2018 Release 2020, Version 1.

3.2 Satisfaction with personal relationships

Table 20: Satisfaction with personal relationships, 2018
From 0 (Not at all satisfied) to 10 (Completely satisfied)

	Persons with disabilities	Persons without disabilities
AT	8.3	8.7
BE	7.5	8.1
BG	5.8	6.7
CY	8.4	8.6
CZ	8.1	8.4
DE	7.3	8.1
DK	7.7	8.5
EE	7.5	8.2
EL	6.7	7.2
ES	7.8	8.4
FI	8.1	8.5
FR	7.6	8.1
HR	7.0	7.8
HU	7.1	7.8
IE	8.3	8.7
IT	7.2	7.6
LT	7.4	8.1
LU	7.6	7.9
LV	7.5	7.9
MT	8.4	8.6
NL	7.6	8.1
PL	7.7	8.2
PT	7.9	8.4
RO	7.0	7.8
SE	8.1	8.6
SI	8.3	8.7
SK	8.0	8.4
EU	**7.5**	**8.1**
UK	8.2	8.6

Data source: EU-SILC UDB 2018 Release 2020, Version 1.

3.3 Feeling lonely

Table 21: Feeling lonely, 2018

1: All of the time or Most of the time, 2: Some of the time, 3: A little of the time or None of the time

	Persons with disabilities				Persons without disabilities			
	1	2	3	Total	1	2	3	Total
AT	6.6	15.6	77.8	100	1.9	8.0	90.1	100
BE	14.5	27.2	58.3	100	3.9	15.6	80.5	100
BG	22.0	23.0	55.1	100	6.0	15.8	78.3	100
CY	10.3	10.9	78.8	100	2.6	6.2	91.2	100
CZ	12.0	19.6	68.4	100	2.9	11.1	86.0	100
DE	14.0	22.0	63.9	100	4.9	15.7	79.4	100
DK	10.9	15.3	73.8	100	2.8	9.6	87.7	100
EE	10.7	26.0	63.3	100	2.2	15.7	82.2	100
EL	14.7	19.9	65.4	100	3.7	8.4	87.9	100
ES	11.0	18.1	70.9	100	2.9	8.8	88.3	100
FI	7.6	22.9	69.5	100	2.4	15.5	82.2	100
FR	13.2	26.3	60.6	100	4.9	18.2	76.9	100
HR	16.6	29.8	53.6	100	4.1	16.8	79.1	100
HU	19.5	21.5	59.0	100	5.8	12.1	82.1	100
IE	8.6	23.3	68.1	100	2.9	11.7	85.5	100
IT	12.0	27.3	60.7	100	3.4	11.5	85.1	100
LT	18.7	24.1	57.2	100	5.1	15.6	79.3	100
LU	10.3	20.0	69.6	100	2.9	13.2	83.8	100
LV	10.0	15.4	74.6	100	3.0	7.2	89.8	100
MT	16.8	18.4	64.8	100	4.6	9.8	85.6	100
NL	11.5	22.3	66.1	100	2.8	13.9	83.3	100
PL	14.0	17.7	68.3	100	4.7	10.0	85.3	100
PT	16.3	18.6	65.1	100	4.5	8.8	86.7	100
RO	16.2	30.3	53.5	100	6.8	21.2	72.0	100
SE	14.9	23.6	61.6	100	4.3	15.7	80.0	100
SI	9.6	18.5	71.8	100	1.7	9.1	89.3	100
SK	8.1	22.5	69.4	100	2.5	11.6	85.9	100
EU	13.1	22.8	64.2	100	4.2	13.6	82.2	100
UK	11.9	22.2	65.9	100	2.9	12.3	84.8	100

Data source: EU-SILC UDB 2018 Release 2020, Version 1.

3.4 Material help

Table 22: Material help, 2018

	Persons with disabilities			Persons without disabilities		
	Yes	No	Total	Yes	No	Total
AT	71.7	28.3	100	82.1	17.9	100
BE	85.7	14.3	100	92.4	7.6	100
BG	68.7	31.3	100	73.7	26.3	100
CY	81.7	18.3	100	86.0	14.0	100
CZ	88.6	11.4	100	92.9	7.1	100
DE	64.3	35.7	100	78.0	22.0	100
DK	69.9	30.1	100	84.9	15.1	100
EE	75.1	24.9	100	89.2	10.9	100
EL	69.3	30.7	100	75.7	24.3	100
ES	83.3	16.7	100	91.1	8.9	100
FI	80.2	19.8	100	88.9	11.1	100
FR	72.7	27.3	100	83.0	17.0	100
HR	73.0	27.0	100	83.9	16.1	100
HU	74.1	25.9	100	81.4	18.6	100
IE	80.2	19.8	100	87.6	12.4	100
IT	68.3	31.7	100	79.1	20.9	100
LT	71.1	28.9	100	83.2	16.8	100
LU	73.4	26.6	100	83.0	17.0	100
LV	69.9	30.1	100	83.6	16.4	100
MT	68.1	31.9	100	78.4	21.6	100
NL	73.8	26.2	100	83.1	16.9	100
PL	86.4	13.6	100	93.7	6.4	100
PT	81.7	18.3	100	89.9	10.1	100
RO	70.8	29.2	100	76.2	23.8	100
SE	85.1	14.9	100	92.4	7.7	100
SI	74.1	25.9	100	84.9	15.1	100
SK	77.0	23.0	100	84.6	15.4	100
EU	**73.5**	**26.5**	**100**	**83.3**	**16.7**	**100**
UK	78.1	21.9	100	86.6	13.4	100

Data source: EU-SILC UDB 2018 Release 2020, Version 1.

3.5 Non-material help

Table 23: Non-material help, 2018

	Persons with disabilities			Persons without disabilities		
	Yes	No	Total	Yes	No	Total
AT	90.0	10.0	100	94.7	5.3	100
BE	85.5	14.5	100	91.9	8.1	100
BG	78.0	22.0	100	81.2	18.8	100
CY	93.3	6.7	100	94.9	5.1	100
CZ	94.4	5.7	100	96.5	3.5	100
DE	87.4	12.6	100	92.8	7.2	100
DK	88.4	11.6	100	95.0	5.0	100
EE	87.6	12.4	100	95.7	4.3	100
EL	81.4	18.6	100	86.5	13.5	100
ES	90.6	9.4	100	95.5	4.5	100
FI	94.0	6.0	100	97.8	2.2	100
FR	91.8	8.2	100	95.6	4.4	100
HR	89.1	11.0	100	95.2	4.8	100
HU	89.3	10.7	100	92.9	7.1	100
IE	90.9	9.1	100	95.1	4.9	100
IT	75.7	24.3	100	86.5	13.5	100
LT	87.0	13.0	100	94.4	5.6	100
LU	91.0	9.0	100	95.4	4.6	100
LV	86.0	14.0	100	93.4	6.6	100
MT	83.6	16.4	100	88.8	11.2	100
NL	84.4	15.7	100	89.9	10.1	100
PL	92.5	7.5	100	96.7	3.3	100
PT	91.6	8.4	100	96.0	4.0	100
RO	79.0	21.0	100	81.1	18.9	100
SE	94.4	5.6	100	97.3	2.7	100
SI	88.8	11.2	100	94.3	5.7	100
SK	91.3	8.7	100	94.2	5.8	100
EU	87.0	13.0	100	92.3	7.7	100
UK	90.7	9.3	100	94.7	5.3	100

Data source: EU-SILC UDB 2018 Release 2020, Version 1.

4. Access to online services

4.1 Possession of a telephone (including mobile phone)

Table 24: Persons who cannot afford a telephone, 2018

	Persons with disabilities	Persons without disabilities
AT	0.2	0.0
BE	0.2	0.2
BG	3.9	2.0
CY	0.1	0.1
CZ	0.3	0.0
DE	0.2	0.1
DK	0.0	0.0
EE	0.3	0.0
EL	0.6	0.2
ES	0.2	0.1
FI	0.0	0.0
FR	0.1	0.0
HR	1.2	0.2
HU	1.9	0.8
IE	0.2	0.2
IT	0.4	0.3
LT	1.1	0.5
LU	0.1	0.1
LV	0.5	0.1
MT	0.5	0.3
NL	0.0	0.0
PL	1.1	1.0
PT	0.7	0.1
RO	1.9	1.0
SE	0.0	0.0
SI	0.3	0.0
SK	0.6	0.6
EU	**0.5**	**0.3**
UK	0.0	0.0

Data source: Data extracted on 18/12/2020 from ESTAT.

4.2 Possession of a computer

Table 25: Persons who have a computer, 2018

	Persons with disabilities				Persons without disabilities			
	Yes	No – cannot afford	No – other reason	Total	Yes	No – cannot afford	No – other reason	Total
AT	76.0	4.1	19.9	100	91.5	1.2	7.3	100
BE	74.8	5.0	20.3	100	91.2	1.8	7.0	100
BG	41.2	17.0	41.8	100	73.9	11.7	14.5	100
CY	53.5	5.2	41.3	100	86.3	3.2	10.5	100
CZ	61.9	5.3	32.8	100	87.8	2.0	10.3	100
DE	83.0	6.0	11.0	100	93.4	1.6	5.0	100
DK	89.8	2.3	7.9	100	93.7	1.3	5.0	100
EE	70.4	5.8	23.8	100	92.5	0.9	6.6	100
EL	56.9	5.9	37.2	100	91.0	3.7	5.2	100
ES	55.6	6.2	38.3	100	81.3	4.8	14.0	100
FI	84.2	3.1	12.7	100	94.5	0.9	4.7	100
FR	74.0	3.7	22.3	100	90.8	2.1	7.1	100
HR	55.4	6.8	37.8	100	87.1	2.6	10.3	100
HU	57.6	10.7	31.8	100	84.0	5.6	10.4	100
IE	69.8	6.4	23.9	100	87.8	2.3	9.9	100
IT	48.1	2.9	48.9	100	77.1	4.2	18.7	100
LT	55.4	10.5	34.2	100	86.6	4.1	9.4	100
LU	80.3	3.2	16.6	100	94.1	1.1	4.8	100
LV	64.6	10.8	24.7	100	88.9	3.3	7.8	100
MT	67.3	3.8	29.0	100	88.7	1.6	9.8	100
NL	93.0	2.5	4.5	100	98.1	0.5	1.4	100
PL	65.7	5.2	29.1	100	88.7	2.1	9.2	100
PT	55.9	8.2	36.0	100	83.7	4.0	12.4	100
RO	44.8	13.1	42.1	100	73.1	12.2	14.7	100
SE	79.7	2.9	17.4	100	92.1	1.3	6.6	100
SI	75.6	5.7	18.7	100	91.9	1.6	6.5	100
SK	70.4	7.5	22.1	100	90.1	3.4	6.5	100
EU	**67.2**	**5.5**	**27.3**	**100**	**86.9**	**3.3**	**9.8**	**100**
UK	86.9	2.7	10.4	100	95.7	0.8	3.5	100

Data source: EU-SILC UDB 2018 Release 2020, Version 1.

4.3 Internet connection for personal use at home

Table 26: Persons with an internet connection for personal use at home, 2018

	Persons with disabilities				Persons without disabilities			
	Yes	No – cannot afford	No – other reason	Total	Yes	No – cannot afford	No – other reason	Total
AT	84.5	0.9	14.6	100	95.2	0.2	4.6	100
BE	78.4	3.6	18.0	100	93.7	1.7	4.6	100
BG	26.7	13.8	59.6	100	68.2	10.6	21.3	100
CY	44.3	3.3	52.4	100	85.6	1.3	13.0	100
CZ	62.1	4.6	33.3	100	87.9	1.7	10.4	100
DE	77.3	6.9	15.9	100	91.9	1.7	6.4	100
DK	92.8	1.2	6.0	100	97.5	0.2	2.4	100
EE	68.1	5.7	26.3	100	92.5	0.8	6.7	100
EL	40.2	5.0	54.8	100	87.0	5.1	7.9	100
ES	60.1	13.2	26.8	100	89.4	3.6	7.0	100
FI	81.8	1.2	17.0	100	94.8	0.3	5.0	100
FR	75.3	3.2	21.5	100	92.3	1.3	6.4	100
HR	42.4	5.5	52.1	100	84.9	1.4	13.7	100
HU	51.4	11.3	37.3	100	83.0	5.5	11.5	100
IE	69.9	8.6	21.5	100	89.7	2.1	8.2	100
IT	42.5	5.8	51.7	100	80.2	4.0	15.7	100
LT	50.1	8.3	41.5	100	85.6	3.9	10.5	100
LU	85.2	2.1	12.7	100	96.0	0.4	3.7	100
LV	58.4	8.4	33.2	100	89.4	2.5	8.2	100
MT	68.8	6.3	24.9	100	90.9	1.3	7.8	100
NL	93.9	3.2	2.9	100	98.4	1.1	0.5	100
PL	60.1	4.0	35.9	100	88.3	1.4	10.3	100
PT	56.4	7.5	36.1	100	85.4	3.0	11.6	100
RO	30.1	26.7	43.2	100	65.6	19.3	15.1	100
SE	89.7	1.1	9.2	100	95.9	0.3	3.8	100
SI	68.8	3.0	28.2	100	90.8	0.8	8.4	100
SK	64.6	6.4	29.0	100	88.7	3.6	7.7	100
EU	**64.3**	**6.9**	**28.8**	**100**	**87.9**	**3.2**	**8.8**	**100**
UK	**84.63**	**2.4**	**12.97**	**100**	**95.67**	**0.85**	**3.48**	**100**

Data source: EU-SILC UDB 2018 Release 2020, Version 1.

B. The impact of COVID-19 pandemic on the affordability of health care services. Case study: Cyprus and Greece

The current pandemic and the associated measures are expected to hit hard the employment in all countries. However, in some countries, this might be hardest due to the productive structure of the economy and the small size of their business.

Hotel and restaurants, arts and leisure, food, retail sales and certain service activities are the most affected sectors.[57] This means that certain countries will be affected more than others by the economic crisis following the pandemic.

Analysis of the productive structure of Member States indicates that this might be the case in Greece and Cyprus. In fact, the hardest hit sectors are overrepresented in these two countries. Accommodation - food - beverage service activities represent 9.3 % of employment (persons aged 66 or less) in Greece and 9.1 % in Cyprus, when the EU 27 average is 4.4 %. Similarly, wholesale and retail sales represent 18.1 % and 17.7 % in these Member States, when the EU 27 average is 13.9 %.[58]

Or, we have noted above that the highest rates of persons declaring difficulty to afford the cost of health care services can be found in Greece and Cyprus. Consequently, we expect an overall stronger deterioration of the employment situation in these two Member States compared to other countries.

Furthermore, the situation of persons with disabilities is expected to deteriorate in relation to other groups. In fact, small companies are more vulnerable to economic shocks. The analysis of employment by economic sector and size of companies indicates that persons with disabilities are overrepresented in very small business in the most hit economic sectors.

For example, in Greece, in the accommodation sector (Accommodation - food - beverage service activities), about 62.2 % of disabled people working in this sector are employed in very small business, occupying less than 5 persons. Small family business is the characteristic in this case. In the EU 27, the equivalent rate is 22.5 %.

This ought to lead to a general health pauperisation of persons with disabilities, notably in Greece, where the percentage of persons declaring difficulty to afford the cost of health care services was 76 % in 2016.

Fana et al.[59] consider that in the mid-term, the economic sectors most affected now will remain problematic until the pandemic is under control, because they involve an important degree of social interaction. They consider that these sectors will continue to be either forcefully closed or suffer from very weak demand because of continuing consumers´ concern.

[57] Fana, M., Tolan, S., Torrejón, S., Urzi Brancati, C., Fernández-Macías, E. (2020) “The COVID confinement measures and EU labour markets”; COVID & Empl Working Group. Joint Research Centre, European Union.

[58] EU-SILC UDB 2016.

[59] Fana, M., Tolan, S., Torrejón, S., Urzi Brancati, C., Fernández-Macías, E. (2020) “The COVID confinement measures and EU labour markets”; COVID & Empl Working Group. Joint Research Centre, European Union.

In order to dampen this deterioration, the special needs of small business ought to be taken into account, notably policies helping them to survive during the crisis or reorient their activities.

In this framework, job retention schemes have played a critical role in helping employers keep workers in jobs (through short-time work schemes and wage subsidies).[60] Such schemes ought to be accessible to very small business.

Improving access to health care of workers (and their families) in these very small businesses ought to be reinforced.

In the case of wholesale and retail services, support for adapting to ecommerce in businesses, ought to take into account the special needs of persons with disabilities. This might include both software and hardware as well adaptation of workplaces.

An important number of those included in the very small business (one to 5 workers) concern self-employed persons. Persons with disabilities are overrepresented in this case. Support schemes, like job retention and income support schemes, could be adapted to their specific needs.[61] For example, this ought to take into account equipment, software and adaptations aiming to overcome barriers in case of reorientation to ecommerce.

Finally, measures to protect workers from COVID-19 ought not to create new barriers for persons with disabilities. Reasonable adaptations of such measures and sanitation facilities for persons with disabilities ought to be taken into account in the different employment schemes.

Table 27: Distribution of employment in selected sectors in Greece and Cyprus by size of local production unit. Age: 16-66, 2016

Number of workers	EU 27		Greece (EL)				Cyprus (CY)			
	All sectors		Accommo-dation		Trade		Accommo-dation		Trade	
	Disability		Disability		Disability		Disability		Disability	
	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes
	%	%	%	%	%	%	%	%	%	%
1-5	22.1	22.5	40.3	51.1	54.3	62.2	25.7	28.8	45.3	56.2
6-10	7.9	7.4	14.7	16.6	6.9	7.5	17.3	17.1	15.1	9.5
11-19	11.3	10.2	16.4	6.5	12.7	3.5	11.5	24.8	12.8	7.7
20-49	13.5	13.1	9.4	11.6	8.1	9.9	12.8	0.0	14.3	12.6
50+	45.2	46.8	19.2	14.2	18.1	17.0	32.7	29.2	12.6	14.1
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Accommodation: It includes Accommodation - food - beverage service activities.
Trade: It includes wholesale, retail sales and repair.
Data source: EU-SILC UDB 2016– version 20 March 2018.

[60] ILO: "*National employment policies for an inclusive, job-rich recovery from the COVID-19 crisis*"; Policy Brief, International labour Organisation, September 2020; https://www.ilo.org/wcmsp5/groups/public/---ed_emp/documents/publication/wcms_756676.pdf.

[61] For example, in Denmark, self-employed people who are not registered in the Central Business Register may also apply for a compensation of 75 per cent of lost income, with the maximum capped at DKK 23 000. Cited in: ILO (2020) "*A quick reference guide to common COVID-19 policy responses*"; © International Labour Organization. https://www.ilo.org/wcmsp5/groups/public/---ed_dialogue/---act_emp/documents/publication/wcms_754728.pdf.

C. List of tables

D. Classification of countries

BE Belgique/Belgïe
BG Bulgaria
CZ Czech Republic
DK Denmark
DE Deutschland
EE Estonia
IE Ireland
EL Elláda
ES España
FR France
HR Croatia
IT Italia
CY Cyprus
LV Latvia
LT Lithuania
LU Luxembourg
HU Hungary
MT Malta
NL Nederland
AT Österreich
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SI Slovenia
SK Slovak republic
FI Suomi
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UK United Kingdom

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