



ACCESS TO HEALTHCARE AND LONG-TERM CARE

Equal for women and men?



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ACCESS TO HEALTHCARE AND LONG-TERM CARE:

Equal for women and men?

Final Synthesis Report

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Contents

Executive summary	5
Zusammenfassung	11
Résumé	17
Introduction	23
1. Main characteristics and recent trends in the health status of women and men	25
1.1. Gender differences in life expectancy and healthy life years	25
1.2. Self-perceived health and disability	25
1.3. Gender differences in health risks and death by typology of diseases	28
1.4. Gender differences in mortality rates	32
1.5. The impact of income and social inequalities on gender differences in health status.....	35
2. Gender differences in access to healthcare	41
2.1. Existing service provisions: an overview of gender differences	41
2.1.1. Health promotion	43
2.1.2. Health prevention	50
2.1.3. General treatment	67
2.1.4. Gender mainstreaming in healthcare: recent trends	84
2.2. Barriers to accessing service provisions	87
2.2.1. Financial barriers: insurance coverage and individual costs	89
2.2.2. Cultural barriers	100
2.2.3. Geographical and physical barriers	106
3. Gender differences in access to long-term care (LTC)	111
3.1. Overview of existing LTC service provisions	111
3.2. Overview of existing service provisions for LTC from a gender perspective	115
3.3. Gender barriers to access LTC	118
3.3.1. Gender and financial barriers	118
3.3.2. Gender and geographical barriers	119
3.3.3. Gender and bureaucratic and administrative barriers	120
3.3.4. Gender and cultural barriers	120
3.4. Programmes aimed at overcoming barriers to LTC.....	122
3.5. Overall conclusions about gender barriers to access LTC.....	124
4. Conclusions	125
5. Annex – Statistical tables.....	129
References.....	133

Executive summary

While healthcare systems have contributed to significant improvements in health in Europe, access to healthcare remains uneven across countries and social groups, according to socioeconomic status, place of residence, ethnic group, and gender.

Gender plays a specific role both in the incidence and prevalence of specific pathologies and also in their treatment and impact in terms of well-being and recovery. This is due to the interrelations between sex-related biological differences and socioeconomic and cultural factors which affect the behaviour of women and men and their access to services.

This comparative report presents the main differences in the health status of women and men in European countries and examines how healthcare and long-term care systems respond to the specific needs of women and men in ensuring equal access. It considers the main financial, cultural and physical barriers to access and provides good practice examples of healthcare promotion, prevention and general treatment programmes, as well as of long-term care.

The information in this report is mainly provided by the national experts of the EGGSI network of experts in gender equality, social inclusion, healthcare and long-term care and covers 30 European countries (EU-27 and EEA/EFTA) ⁽¹⁾. Available comparative statistical data from Eurostat and OECD sources have also been considered.

Gender differences in health status

Gender differences in health status and health needs are largely explained by biological and genetic factors, as well as by differences in social norms and health behaviour.

On the one hand, women and men are susceptible to sex-specific diseases related to their reproductive health, such as breast cancer and cancer of the cervix for women and cancer of the prostate for men. On the other hand, women and men also present different symptoms and consequences of common

diseases, such as for cardiovascular and many sexually transmitted diseases.

Besides biological factors, social norms also affect the health status of women and men differently: women are less likely to engage in risky health behaviour and consequently face fewer of the related illnesses and disabilities than men. However, they are more likely than men to present 'invisible' illnesses and disabilities which are often not adequately recognised by the healthcare system. Examples include depression, eating disorders, disabilities related to home accidents and sexual violence, as well as diseases and disabilities related to old age. Women, especially very young women, are more vulnerable to sexually transmitted diseases compared to men, and the consequences are more serious for them. Sexual abuse and domestic violence particularly affect women and girls in all countries and in all social classes.

The comparison of the population's health status in European countries also shows that eastern European countries tend to present worse health conditions for women and men than western countries.

Overall, it can be noted that women are more aware of their health status and are greater users of healthcare services than men. There are several reasons for this, such as their reproductive role, their role as caregivers for dependants (children, the elderly, the disabled), their higher share among the older population and also gender stereotypes, since men usually do not consider it normal to complain about their health and to visit physicians.

Gender differences in healthcare provisions

Little is known about gender differences in accessing healthcare and long-term care, and if and how healthcare and long-term care systems take these into account in service delivery. For example, while it has been suggested that women are more likely than men to engage in health-seeking behaviour and thus to practise health prevention and promotion, there also seems to be evidence that especially poor women ⁽²⁾ may have more difficulties accessing healthcare services than men.

⁽¹⁾ EGGSI is the European Commission's network of 30 national experts (EU and EEA countries) in the fields of gender equality and social inclusion, health and long-term care issues. The network is coordinated by the Istituto Ricerca Sociale and Fondazione Giacomo Brodolini, and undertakes an annual programme of policy-oriented research and reports to the Directorate-General for Employment, Social Affairs and Equal Opportunities.

⁽²⁾ European Institute of Women's Health Report, Gender Equity Conference, Conference of September 2000.
<http://www.eurohealth.ie/gender/index.htm>

In some European countries (like Austria, Bulgaria, Germany, Iceland, Ireland, Italy, Norway, Spain, the Netherlands, the UK, Slovenia), there is increasing awareness regarding the need to acknowledge gender differences in access to healthcare among governmental institutions, universities, and especially NGOs, which have traditionally been very active in providing specialist services to women, ethnic minorities and other disadvantaged groups. In these countries, gender-sensitive strategies have recently been introduced within healthcare and medical research: resource-centres and research institutes with special knowledge regarding women and health have been created, observatories on women's health have been set up to support the development of sex-disaggregated data and gendered medical research. In addition, these countries have implemented specific training projects aimed at general practitioners and healthcare providers, as well as pilot programmes for the treatment of disadvantaged women, such as homeless women, immigrant women, disabled women and single mothers.

The comparative analysis presented in this report has, however, shown that in most countries, besides reproductive care, there are still few gendered healthcare strategies and services addressing the specificities of gender-related behaviours and diseases in a more structured way.

Health promotion strategies appear to be largely gender neutral except for reproductive health. The promotion of breastfeeding is the most widespread promotion programme across Europe. It is supported by common guidelines and accompanied in many countries by more general programmes supporting mothers and their newborn babies. Also, programmes promoting healthy behaviour addressed to adults or adolescents are often gender oriented, being either targeted at women or men. The report presents programmes aiming at reducing the consumption of alcohol and smoking and promoting diet and physical activity, programmes promoting mental health and occupational health, health-promotion programmes and campaigns specifically targeted at more vulnerable groups. In those countries where national health promotion activities are less developed, NGOs usually have a relevant role as substitutes for public action and are a stimulus in raising awareness of certain issues.

Screening programmes are important preventive measures, since many diseases can be avoided through early detection. The EGGSI national reports have evidenced that gendered prevention programmes are mainly targeted at women. The most important and widespread gendered prevention programme implemented in Europe is cancer screening. This is related to a Council recommendation which invites

Member States to take common action to implement national cancer screening programmes with a population-based approach and with appropriate quality assurance at all levels. Although much progress has been made, more is still required to ensure that programmes are available in all Member States.

Across Europe, many prevention programmes address maternity: prenatal tests, support for the mothers with newborn children and family development, support for groups of children and mothers with special needs. Other widespread prevention programmes across Europe concern sexual and reproductive health. The health sector can also play a vital role in preventing domestic violence against women, by helping to identify abuse early, providing victims with the necessary treatment, and referring women to appropriate care. A general lack of attention among the population and awareness among health professionals has been described in some EGGSI national reports, together with some examples of good practice of support services for victims.

On the other hand, few programmes presented in the EGGSI national reports aimed at children and adolescents are gender sensitive. The most widespread programme across Europe (even if there are differences in access) and targeted at young girls is the Human Papilloma Virus (HPV) vaccination programme. Another area where young girls are the main targets of preventive programmes is education regarding healthy sexual behaviour and abortion prevention. Abortion in adolescence is still a problem in Europe even though a clear trend of reduction is detectable all over Europe.

Although gender-specific health-related risk behaviour is starting to be documented and knowledge about the necessity to provide gender-specific health treatment is increasingly diffused, gender differences in most healthcare treatments are often neglected. The exceptions are reproductive care (basic service provision for pregnant women and childbirth) and the treatment of specifically female diseases, such as, for example, breast and cervical cancer.

Age, income, education and residency are important determinants of access to healthcare treatment for women and men. For similar levels of health needs, individuals with lower income and education are more likely to use primary healthcare more intensively, whereas specialised assistance tends to be underutilised. In most countries, immigrants and non-residents usually only have access to emergency care. As long as there are gender differences in income levels, these different patterns are also relevant in terms of gender.

The physical, psychological and social barriers that prevent many women from making healthy decisions

are often not visible or addressed by healthcare treatment programmes and regulations. There is usually little recognition of gender specificities in the treatment of some pathologies such as heart diseases, sexually transmitted diseases, mental disorders, or work-related illnesses, and of the long-term consequences of violence and abuse on women's health. In many cases, as for example in heart diseases, the knowledge utilised is based on studies conducted on men, which results in treatment that may, in some cases, not address the needs of women. Other examples are the repercussions on mental health of the role overload of working women with care responsibilities, or of the anxiety and social isolation often experienced by female single parents and older single women. Domestic abuse, in particular, results in high rates of depression and anxiety for women. As for work-related health risks, regulations on health and safety at the workplace mainly cover the risks that men are more commonly exposed to, while little consideration is given to the health risks of women in female-intensive occupations and sectors.

It has also been noticed that sometimes women and men are treated differently, not because their specific needs are recognised, but because of prejudiced and stereotyped attitudes by health practitioners. For example, therapeutic support aimed at return to work after work accidents is more frequent among men than women. This is also due to the attitudes of occupational health physicians and of employers, who feel that rehabilitation is more important for men than for women.

The issue of health service provisions targeted specifically at men is less recognised, even if in some countries there is an increasing attention to these issues. Some male-related diseases (such as prostate or testicular cancers or benign prostatic diseases among the elderly) are not paid special attention in many European countries. Also, the health programmes and treatment of some diseases related to gendered behaviours, such as alcohol addiction and alcohol-related diseases, which present different patterns and consequences among women and men, do not consider gender differences sufficiently.

Barriers to access and gender differences

Even if universal or nearly universal rights to care are basic principles in all the Member States and most of the European population is covered by public health insurance, these basic principles do not always translate into equal access to and use of healthcare. Residency, socioeconomic and geographical factors can affect the accessibility to healthcare for specific groups. These

include the lack of insurance coverage (especially affecting those without residency or citizenship, the long-term unemployed and the homeless in countries based on social security contribution systems), the direct financial costs of care (affecting low-income groups), the lack of mobility (affecting disabled and elderly persons), the lack of language competence (affecting migrants and ethnic minorities), the lack of information access (affecting the poorly educated and migrants/ethnic minorities), as well as time constraints (affecting especially single mothers). In all of these factors there are specific gender issues to consider.

Financial barriers are particularly relevant for low-income groups and for women. Income inequalities are especially related to the lack of insurance coverage, the cost of certain (specialised) types of care (such as dental, ophthalmic and ear care) which are often not covered by public insurance systems, and the incidence of private insurance systems. Out-of-pocket costs and the persistence of informal payments in many eastern and southern European countries are also significant.

The increasing role of private health insurance and out-of-pocket payments may increase gender inequalities, since men are more likely to be covered by private insurance than women, although women are greater consumers of healthcare services and medicines. Women usually have a lower income and do not benefit from the same kind of firm-based private insurance coverage as men do. Women also present lower employment rates in the regular economy (many are either inactive or work at home or in the informal sector) and, when employed, they are more likely to be employed in the public sector and small firms (which are not likely to provide supplementary private insurance schemes) with part-time and/or temporary contracts in low-paying jobs. In addition, private insurance schemes are less attractive to women since they usually consider age and gender-specific risks in defining contributions. Women from ethnic minorities and poor households may be especially penalised by the privatisation of health services and the increase in out-of-pocket spending on healthcare. There are no sex-differentiated comparative data on insurance coverage by type of insurance in European countries, however it is likely that financial barriers are particularly relevant for women living in those countries where the incidence of cost-sharing is higher and the extension of public insurance coverage is lower.

Cultural barriers are also particularly relevant for women, especially for immigrant women and women of ethnic origin. The distinct roles and behaviours of men and women in a given culture, resulting from gender norms and values, give rise to gender differences and inequalities in access to healthcare as well as in risk behaviours and in health status. Cultural

barriers can be expressed in terms of prejudices and lack of knowledge among healthcare professionals concerning gender specificities in needs and types of care to be provided. Language barriers, as well as traditions and cultural practices also play a role, as certain groups of immigrant women and women of ethnic origin have more difficult access to health facilities and information on sexual health. On the other hand, men also have to face stereotypes in accessing healthcare and prevention programmes. Osteoporosis, for instance, is perceived as a female disease, and it might be less obvious that men should be treated for osteoporosis as well. Education and health prevention programmes are also targeted mostly at women and only occasionally address men. The report shows that it is important to take into consideration a variety of elements while analysing cultural barriers in accessing healthcare. These are prejudices and gender stereotypes, social status and level of education, cultural differences inherent in ethnicity and migration issues (that involve not only language skills but also traditions and norms of hygiene), religious practices, prejudices concerning sexual orientation, and working culture.

Geographical variations in coverage and provision are another relevant barrier to access healthcare. The supply of healthcare services is typically greater in bigger cities and more densely populated areas, whilst there is a lack of General Practitioners or family doctors and of certain basic specialist services in small, rural and remote areas. Hospitals are also often unevenly distributed across the countries, with the explanation in some cases coming from geographical features (due to the presence of islands or mountains). In some countries, however, disparities are the result of decentralised decision-making processes, giving regional and local authorities policy discretion and permitting regional differences in funding. The distance from hospitals and healthcare centres and the lack of accessible transportation and facilities particularly affect women (especially those living in rural or mountainous areas, the disabled and the elderly), as they are less autonomous concerning mobility than men (they drive cars less frequently than men), and live more years in old age and ill health.

Gender differences in access to long-term care

All over Europe various provisions concerning long-term care (LTC) are present. The mix of benefit types — formal/informal, in cash/in kind, institutional/at home care — varies among European countries, reflecting more the organisational features of each system rather than population structure and demographic developments. In particular, the variations reflect the different national approaches to familial solidarity

(incidence of informal care and support for carers). In the last 15 years, European countries have experienced reforms aimed at removing inequalities in access to LTC and improving the quality of care.

The gender perspective is relevant when considering access to LTC services, as women are the main providers of LTC, especially informal care, and the main users of LTC services, because they live longer than men and are more likely to live alone in old age. Elderly women are also likely to be more negatively affected than men by the forms of co-payment for access to LTC which have been introduced in many countries, because their average income is lower than men's.

Addressing gender inequalities in access to healthcare and long-term care

The comparative analysis presented in this report has highlighted some important issues which have to be addressed in order to reduce gender inequalities in access to healthcare and long-term care and provide cost-effective and high-quality care.

The most important is the need to adopt a gender perspective in healthcare policies, considering the biological, economic, social and cultural factors which affect the health condition of women and men and their access to healthcare. A gender mainstreaming approach to healthcare policies, addressing gender-specific risk factors in medical research, in service delivery (considering promotion, prevention and treatment policies) and the design of financing systems enhances the effectiveness of the care provided for women and men and reduces inequalities in access, as shown in some of the good practices presented in the report.

Gender-based health research increases knowledge regarding the complex ways in which biological, social, cultural and environmental factors interact to affect the health of women and men. Gender-based medical research also improves the attention of health practitioners regarding gender differences and supports the provision of gender-differentiated treatment when necessary. For example, it is important that research in cardiovascular diseases considers gender differences in morbidity and mortality and in reaction to treatment; occupational health and safety research and practices should take gender-specific factors into account, such as the different health risks that women and men are exposed to, due to occupational gender segregation and the health risks resulting from precarious employment, domestic work and informal care work performed by women.

The implementation of gendered health information systems and analysis tools (such as Gender Impact Assessment), upgrading quality in data collection and analysis, is essential to support medical research and the systematic gender-specific monitoring and evaluation of healthcare systems.

The promotion of capacity building for gender sensitivity in healthcare systems and gender-specific training for healthcare professionals is likely to improve the attention paid to gender differences in service delivery and the effectiveness of healthcare services.

Recognition of women's role as healthcare users and providers both within the healthcare system and outside as informal and often unpaid carers, is important when evaluating the gender impact of recent trends in healthcare reforms, especially in relation to healthcare financing and delivery. Healthcare reform trends, especially increasing the incidence of cost-sharing through private insurance schemes and out-of-pocket payments, may adversely affect women more than men, since women are the majority among healthcare users and low-income groups. Recent trends in cost containment and the limitation in the basic care provisions included within primary care are also likely to increase gender and income inequalities if not adequately addressed. The rationalisation of healthcare services which, in many countries, has reduced local clinics and services in

rural or low-populated areas and reduced patient/staff ratios may have negative consequences for women more than for men, as women are the majority both among healthcare users and providers. These issues are particularly relevant for LTC, where gender plays an even more relevant role, women being the main care providers (formal and informal) and care users.

Measures supporting LTC systems have important gender impacts. Provisions to overcome barriers to accessing LTC can be found across European countries and are presented in the report. They are mainly related to: supporting low-income groups (such as in the Netherlands); improving the quality of care (such as in Germany, Romania and Norway); and supporting informal care providers (such as in Finland and Sweden).

To conclude, the evidence emerging from this comparative report underlines the need to adopt a gender mainstreaming approach to healthcare policies in order to improve their effectiveness. This is even more relevant as the current financial and economic crisis may reduce the available resources for improving the quality and coverage of healthcare and LTC provisions, with pilot gender-based programmes at great risk of budget cuts. Eastern European countries, in the process of improving the quality and extension of their healthcare systems, especially present such a risk.

Zusammenfassung

Obwohl das Gesundheitssystem zu bedeutenden Verbesserungen der Gesundheit in Europa beigetragen hat, bleibt der Zugang zum Gesundheitswesen in den Ländern und Bevölkerungsgruppen unterschiedlich, je nach sozioökonomischem Status, Wohnort, ethnischer Gruppe und Geschlecht.

Das Geschlecht spielt eine wesentliche Rolle sowohl beim Auftreten und der Verbreitung spezifischer Krankheiten, als auch in ihrer Behandlung und ihren Auswirkungen auf das Wohlbefinden und die Genesung. Dies ist bedingt durch die Wechselbeziehungen zwischen geschlechtsspezifischen biologischen Unterschieden und sozioökonomischen sowie kulturellen Faktoren, die sich auf das Verhalten von Frauen und Männern und deren Zugang zu Gesundheitsdiensten auswirken.

Dieser vergleichende Bericht stellt die Hauptunterschiede des Gesundheitszustands von Frauen und Männern in den europäischen Ländern dar und untersucht, wie Gesundheits- und Pflegeversicherungssysteme die speziellen Bedürfnisse von Frauen und Männern bei der Gewährleistung eines gleichberechtigten Zugangs berücksichtigen. Dabei werden die wesentlichen finanziellen, kulturellen und physischen Zugangsbarrieren betrachtet und Beispiele bewährter Methoden für die Förderung von Gesundheitsbehandlungen, Präventions- und allgemeinen Behandlungsprogrammen sowie der Pflegeversicherung vorgestellt.

Die in dieser Studie verwendeten Informationen stammen von der Expertengruppe des EGGSI *Netzwerkes für Geschlechtergleichstellung, soziale Integration, Gesundheitsversorgung und Langzeitpflege* und beziehen sich auf die 30 europäischen Länder (EU-27 und EEA/EFTA) ⁽³⁾. Verfügbare vergleichende statistische Daten von Eurostat- und OECD-Quellen wurden ebenfalls herangezogen.

⁽³⁾ EGGSI ist ein Netzwerk der Europäischen Kommission, das sich aus 30 nationalen Experten (EU und EEA-Länder) aus den Bereichen Geschlechtergleichstellung, soziale Integration, Gesundheit und Langzeitpflege zusammensetzt. Das Netzwerk wird vom Istituto per la Ricerca Sociale und der Stiftung Giacomo Brodolini koordiniert. Es führt jährlich ein strategisch ausgerichtetes Forschungsprogramm durch und untersteht der Generaldirektion Beschäftigung, soziale Angelegenheiten und Chancengleichheit.

Geschlechterunterschiede hinsichtlich des Gesundheitszustands

Geschlechterunterschiede hinsichtlich des Gesundheitszustands und der Gesundheitsbedürfnisse werden größtenteils durch biologische und genetische Faktoren sowie durch Unterschiede in gesellschaftlichen Normen und Gesundheitsverhalten erklärt.

Einerseits sind Frauen und Männer anfällig für geschlechtsspezifische Krankheiten, die in Zusammenhang mit ihrer Reproduktionsgesundheit stehen, wie zum Beispiel Brust- und Gebärmutterhalskrebs bei Frauen und Prostatakrebs bei Männern. Andererseits weisen Frauen und Männer auch unterschiedliche Symptome und Folgeerscheinungen bei allgemeinen Krankheiten auf, wie zum Beispiel bei kardiovaskulären und bei vielen sexuell übertragbaren Krankheiten.

Abgesehen von biologischen Faktoren wirken sich auch gesellschaftliche Normen unterschiedlich auf den Gesundheitszustand von Frauen und Männern aus: Frauen lassen sich seltener auf riskantes Gesundheitsverhalten ein und sind demzufolge nicht so häufig von den damit verbundenen Krankheiten und Behinderungen betroffen wie Männer. Allerdings weisen sie eher als Männer „unsichtbare“ Krankheiten und Behinderungen auf, die oftmals nicht angemessen vom Gesundheitssystem anerkannt werden. Beispiele hierfür sind Depressionen, Essstörungen und Behinderungen, die durch Haushaltsunfälle und durch sexuelle Gewalt verursacht wurden, sowie altersbedingte Krankheiten und Behinderungen. Frauen, vor allem sehr junge Frauen, sind anfälliger als Männer für sexuell übertragbare Krankheiten, und die Folgen sind für sie schwerwiegender. Sexuelle Misshandlung und häusliche Gewalt treffen Frauen und Mädchen in allen Ländern und in allen sozialen Klassen.

Der Vergleich des Gesundheitszustands der Bevölkerung in den europäischen Ländern zeigt auch, dass Frauen und Männer osteuropäischer Länder tendenziell schlechtere Gesundheitsbedingungen aufweisen als Frauen aus westlichen Ländern.

Insgesamt kann beobachtet werden, dass Frauen ihren Gesundheitszustand bewusster wahrnehmen und häufiger Gesundheitsbehandlungen in Anspruch nehmen als Männer. Dies ist durch ihre Reproduktionsrolle, ihre Rolle als Pflegerinnen von Angehörigen (Kinder, Ältere,

Behinderte), ihren größeren Anteil an der älteren Bevölkerung und auch durch Geschlechterstereotype bedingt, da Männer es im Allgemeinen nicht als normal betrachten, sich über ihre Gesundheit zu beschweren und einen Arzt aufzusuchen.

Geschlechterunterschiede bei Maßnahmen der Gesundheitspflege

Man weiß nur wenig über Geschlechterunterschiede beim Zugang zur Gesundheits- und Langzeitpflege und darüber, ob und wie Gesundheits- und Langzeitpflegesysteme diese Unterschiede bei den Versorgungsdiensten berücksichtigen. Während Frauen zum Beispiel ein in stärkerem Maße gesundheitsbewusstes Verhalten als Männer aufweisen und daher auch mehr für Gesundheitsprävention und -förderung tun, scheint es auch bewiesen zu sein, dass insbesondere arme Frauen⁽⁴⁾ größere Schwierigkeiten haben, auf Gesundheitsdienste zuzugreifen, als Männer.

In einigen europäischen Ländern (wie in Österreich, Bulgarien, Deutschland, Island, Italien, Norwegen, Spanien, den Niederlanden, Großbritannien und Slowenien) steigt das Bewusstsein in staatlichen Einrichtungen, Universitäten und vor allem bei NRO, die seit Langem aktiv an der Bereitstellung von speziellen Diensten für Frauen, ethnische Minderheiten und andere benachteiligte Gruppen beteiligt sind, Geschlechterunterschiede beim Zugang zu Gesundheitsdiensten anzuerkennen. In diesen Ländern wurden vor Kurzem geschlechtsspezifische Strategien in die Gesundheitsbehandlungen und in der medizinischen Forschung eingeführt: Es wurden Zentren für Ressourcen und Forschungsinstitute mit speziellem Fachwissen in Bezug auf Frauen und Gesundheit geschaffen sowie Observatorien für Frauengesundheit eingerichtet, um die Erhebung geschlechtsspezifischer Daten und die Entwicklung entsprechender medizinischer Forschung zu unterstützen. Überdies haben diese Länder spezielle Schulungsprojekte für Allgemeinmediziner und Gesundheitsdienste eingeführt sowie Pilotprogramme für die Behandlung von benachteiligten Frauen, wie beispielsweise Obdachlose, Immigrantinnen, behinderte Frauen und alleinstehende Mütter.

Die in diesem Bericht dargestellte vergleichende Analyse hat gezeigt, dass es in den meisten Ländern abgesehen von der Reproduktionsmedizin noch immer wenige geschlechtsspezifische Gesundheitsstrategien und -dienste gibt, die die Besonderheiten von

geschlechterspezifischem Verhalten und Krankheiten in strukturierter Weise ansprechen.

Gesundheitsförderungsstrategien scheinen weitgehend geschlechtsneutral zu sein, mit Ausnahme der Reproduktionsgesundheit. Die Förderung des Stillens ist das in Europa am weitesten verbreitete Förderungsprogramm. Es wird durch gemeinsame Richtlinien unterstützt und geht in vielen Ländern mit allgemeinen Programmen einher, die Mütter und ihre neugeborenen Babys unterstützen. Auch Programme zur Förderung von gesundheitsbewusstem Verhalten für Erwachsene oder Jugendliche sind oftmals geschlechtsbezogen und speziell auf Frauen oder Männer ausgerichtet. Der Bericht stellt Programme vor, die auf die Reduzierung des Alkoholkonsums und des Rauchens abzielen und gesunde Ernährungsweisen sowie körperliche Bewegung fördern, Programme zur Förderung der psychischen und beruflichen Gesundheit, Gesundheitsförderungsprogramme und Kampagnen, die besonders auf gefährdete Gruppen abzielen. In denjenigen Ländern, in denen nationale Gesundheitsförderungsmaßnahmen weniger entwickelt sind, spielen NRO eine maßgebliche Rolle beim Ersatz öffentlicher Maßnahmen und bieten einen Anreiz zur Steigerung des Bewusstseins in bestimmten Bereichen.

Screening-Programme sind wichtige *Präventionsmaßnahmen*, da viele Krankheiten durch Früherkennung vermieden werden können. Die nationalen EGGSI-Berichte haben hervorgehoben, dass geschlechterbezogene Präventionsprogramme hauptsächlich auf Frauen abzielen. Das wichtigste und am weitesten verbreitete geschlechterbezogene Präventionsprogramm, das in Europa implementiert wurde, ist das Krebs-Screening. Dieses steht in Zusammenhang mit einer Empfehlung des Rates, der alle Mitgliedstaaten dazu auffordert, gemeinsame Maßnahmen zu ergreifen, um nationale Krebs-Screening Programme mit einem bevölkerungsbasierten Ansatz und mit geeigneter Qualitätssicherung auf allen Ebenen zu implementieren. Obwohl viele Fortschritte gemacht wurden, muss jedoch noch mehr getan werden, um sicherzustellen, dass Programme in allen Mitgliedstaaten zur Verfügung stehen.

In Europa beziehen sich viele Präventionsprogramme auf die *Mutterschaft*: Pränatal-Tests, Unterstützung für Mütter mit neugeborenen Kindern und Familienentwicklung, Unterstützung von Kindergruppen und Müttern mit besonderen Bedürfnissen. Andere weitverbreitete Präventionsprogramme in Europa betreffen die *sexuelle Gesundheit und die Reproduktionsgesundheit*. Der Gesundheitssektor kann auch eine entscheidende Rolle dabei spielen, *häuslicher Gewalt gegen Frauen vorzubeugen*, indem er dazu beiträgt, Missbrauch früh zu erkennen, den Opfern die notwendige Behandlung zukommen zu lassen und den Frauen die geeignete

⁽⁴⁾ Bericht des Instituts für Frauengesundheit (European Institute of Women's Health), Konferenz zur Geschlechtergleichheit, Konferenz vom September 2000, <http://www.eurohealth.ie/gender/index.htm>

Hilfe zur Verfügung zu stellen. Ein allgemeiner Mangel an Aufmerksamkeit unter der Bevölkerung und bei der Wahrnehmung durch das Gesundheitspersonal wurde in einigen nationalen EGGSI-Berichten beschrieben, zusammen mit einigen Musterbeispielen im Zusammenhang mit Unterstützungsdiensten für die Opfer.

Einerseits sind nur wenige der in den nationalen EGGSI-Berichten vorgestellten Programme, die auf Kinder und Jugendliche abzielen, geschlechterbezogen. Das in Europa am weitesten verbreitete auf junge Mädchen abzielende Programm (wenn auch mit Zugangsunterschieden), ist das *Impfprogramm gegen humane Papillomviren (HPV)*. Ein anderer Bereich, in dem junge Mädchen die Hauptzielgruppe bei Präventivprogrammen sind, ist die *Erziehung zum gesunden Sexualverhalten und Abtreibungsprävention*. Abtreibung bei Jugendlichen stellt noch immer ein Problem in Europa dar, obwohl sich ein deutlicher Rückgang abzeichnet.

Obwohl begonnen wurde, geschlechtsspezifisches gesundheitsbezogenes Risikoverhalten zu dokumentieren und das Wissen über die Notwendigkeit geschlechtsspezifischer Gesundheitsbehandlung immer weiter verbreitet ist, werden die Geschlechterunterschiede bei den meisten *Gesundheitsbehandlungen* noch immer vernachlässigt. Ausnahmen stellen die Behandlung im Bereich der Reproduktion (Versorgung mit dem grundlegenden Diensten für schwangere Frauen und für die Entbindung) sowie die Behandlung von besonderen weiblichen Krankheiten, wie zum Beispiel Brust- und Gebärmutterhalskrebs, dar.

Alter, Einkommen, Bildung und Wohnsitz sind wichtige Zugangsfaktoren für die Gesundheitsbehandlungen von Frauen und Männern. Bei ähnlichen Gesundheitsbedürfnissen machen Personen mit niedrigerem Einkommen und Bildungsstand öfter und intensiver Gebrauch von den Diensten der medizinischen Grundversorgung, wohingegen Fachbehandlungen nicht ausreichend genutzt werden. In den meisten Ländern haben Immigranten und Personen ohne Aufenthaltsstatus im Allgemeinen nur Zugang zur medizinischen Notfallversorgung. Solange es Geschlechterunterschiede beim Einkommensniveau gibt, sind diese unterschiedlichen Muster auch in Bezug auf das Geschlechterverhältnis relevant.

Die physischen, psychologischen und sozialen Barrieren, die viele Frauen davon abhalten, gesundheitsbewusste Entscheidungen zu treffen, sind oft nicht sichtbar oder werden durch Gesundheitsbehandlungsprogramme und -bestimmungen nicht angesprochen. Es besteht normalerweise wenig Anerkennung der geschlechtsspezifischen Besonderheiten bei der Behandlung einiger Krankheiten, wie zum Beispiel bei Herzkrankheiten, sexuell übertragbaren Krankheiten, psychischen oder arbeitsbedingten Krankheiten sowie

den Langzeitauswirkungen von Gewalt und Misshandlungen auf die Frauengesundheit. In vielen Fällen, wie zum Beispiel bei Herzkrankheiten, basieren die verwendeten Kenntnisse auf Studien, die an Männern durchgeführt wurden, woraus sich Behandlungen ergeben, die in einigen Fällen nicht auf die Bedürfnisse der Frauen zugeschnitten sind. Andere Beispiele betreffen die Auswirkungen auf die psychische Gesundheit durch die Rollenüberlastung von arbeitenden Frauen mit Pflegeverantwortung, oder der oftmals von alleinstehenden Müttern und alleinstehenden älteren Frauen erfahrenen Angst und sozialen Isolation. Insbesondere häuslicher Missbrauch hat oftmals hohe Depressions- und Angstquoten von Frauen zur Folge. Bezüglich der Gesundheitsrisiken am Arbeitsplatz decken die Gesundheits- und Sicherheitsbestimmungen hauptsächlich die Risiken ab, denen Männer im Allgemeinen ausgesetzt sind, während den Gesundheitsrisiken von Frauen in frauentypischen Anstellungen und Sektoren nur wenig Beachtung geschenkt wird.

Es wurde außerdem bemerkt, dass Frauen und Männer manchmal unterschiedlich behandelt werden, und dies nicht, weil ihre speziellen Bedürfnisse berücksichtigt werden, sondern durch Vorurteile und stereotypes Verhalten des Gesundheitspersonals. Zum Beispiel bekommen Männer bei der Rückkehr an ihren Arbeitsplatz nach Arbeitsunfällen häufiger therapeutische Unterstützung als Frauen. Dies ist auch bedingt durch das Verhalten von Arbeitsärzten und Arbeitgebern, die die Rehabilitation von Männern für wichtiger erachten als die von Frauen.

Der Bereich der *auf Männer ausgerichteten* Gesundheitsbehandlung ist weniger anerkannt, auch wenn diesem in einigen Ländern zunehmend Aufmerksamkeit geschenkt wird. Einigen männerspezifischen Krankheiten (wie Prostata- oder Hodenkrebs oder gutartige Prostataerkrankungen bei älteren Männern) wird in vielen europäischen Ländern hingegen keine besondere Beachtung geschenkt. Auch Gesundheitsprogramme und die Behandlung einiger Krankheiten, die in Bezug zu geschlechterbezogenem Verhalten stehen, wie beispielsweise Alkoholismus und alkoholbedingte Krankheiten, und die unterschiedliche Muster und Folgen bei Frauen und Männern aufweisen, gehen nicht ausreichend auf die Geschlechterunterschiede ein.

Zugangsbarrieren und Geschlechterunterschiede

Auch wenn ein allgemeines oder fast allgemeines Recht auf Gesundheitsversorgung ein Grundprinzip in allen Mitgliedstaaten darstellt und der größte Teil der europäischen Bevölkerung durch die öffentlichen Krankenkassen abgesichert ist, hat dieses Grundprinzip nicht immer den gleichen Zugang und die gleiche Nutzung

der Gesundheitsdienste zur Folge. Wohnsitz, sozio-ökonomische und geografische Faktoren können den Zugang bestimmter Gruppen zu Gesundheitsdiensten beeinflussen. Dies umfasst die fehlende Versicherung (was insbesondere diejenigen betrifft, die keine Aufenthaltsgenehmigung oder Staatsangehörigkeit haben sowie Langzeitarbeitslose und Obdachlose in Ländern mit beitragsbezogenen sozialen Sicherungssystemen), die direkten finanziellen Kosten der Behandlungen (betrifft Gruppen mit niedrigem Einkommen), fehlende Mobilität (betrifft Behinderte und Ältere), fehlende Sprachkompetenz (betrifft MigrantInnen und ethnische Minderheiten), den Mangel an Zugang zu Informationen (betrifft Personen mit geringer Bildung und MigrantInnen/ethnische Minderheiten), sowie Zeitmangel (betrifft insbesondere alleinstehende Mütter). Bei all diesen Faktoren müssen geschlechtsspezifische Belange berücksichtigt werden.

Finanzielle Barrieren sind besonders relevant für Gruppen mit geringem Einkommen und für Frauen. Ungleiche Einkommen stehen insbesondere im Zusammenhang mit fehlender Versicherung, den Kosten bestimmter (fachlicher) Pflegearten (wie Zahn-, Augen- und Ohrenbehandlungen), die oft nicht durch die öffentlichen Versicherungssysteme abgedeckt werden, und dem Vorhandensein privater Versicherungssysteme. Private Zusatzkosten sowie das Fortbestehen informeller Zahlungen in vielen ost- und südeuropäischen Ländern sind ebenfalls wichtig.

Die zunehmende Bedeutung privater Krankenversicherungen und privater Zusatzkosten könnte Geschlechterungleichheiten erhöhen, da Männer öfter durch private Krankenversicherungen abgesichert sind als Frauen, obwohl Frauen mehr Gesundheitsbehandlungen und Medizin in Anspruch nehmen. Frauen haben gewöhnlich ein niedrigeres Einkommen und profitieren nicht in derselben Weise von firmenbasierten privaten Absicherungen wie Männer. Frauen weisen überdies niedrigere Anstellungsraten in der geregelten Wirtschaft auf (viele sind entweder unbeschäftigt oder arbeiten zu Hause oder im informellen Sektor), und wenn sie beschäftigt sind, sind sie häufiger im öffentlichen Sektor und in kleinen Firmen (die keine zusätzlichen privaten Krankenversicherungen anbieten) sowie in Teilzeit- und/oder mit Zeitverträgen in Niedriglohnjobs beschäftigt. Überdies sind private Krankenversicherungen für Frauen weniger attraktiv, da diese im Allgemeinen Alter und geschlechtsspezifische Risiken bei der Beitragsberechnung mit einbeziehen. Frauen ethnischer Minderheiten und aus ärmeren Haushalten könnten besonders durch die Privatisierung von Gesundheitsdiensten und die zunehmenden privaten Zuzahlungen bei der Gesundheitsbehandlung benachteiligt werden. Es gibt keine geschlechterdifferenzierten und vergleichenden Daten des Versicherungsschut-

zes nach Versicherungsart in den europäischen Ländern. Allerdings ist es wahrscheinlich, dass finanzielle Barrieren besonders für Frauen relevant sind, die in Ländern leben, wo die Zuzahlungen höher sind und die Absicherung durch öffentliche Krankenversicherungen niedriger ist.

Kulturelle Barrieren sind ebenfalls besonders relevant für Frauen, insbesondere für Immigrantinnen und für Frauen bestimmter ethnischer Herkunft. Die unterschiedlichen Rollen und Verhaltensweisen von Männern und Frauen in einer bestimmten Kultur, die durch Geschlechternormen und -werte bedingt sind, erhöhen Geschlechterunterschiede und -ungleichheiten beim Zugang zu Gesundheitsdiensten sowie das Risikoverhalten und den Gesundheitszustand. Kulturelle Barrieren können durch Vorurteile und fehlende Kenntnisse bezüglich geschlechtsspezifischer Bedürfnisse und Behandlungsweisen beim Gesundheitspersonal zum Ausdruck kommen. Sprachbarrieren sowie Traditionen und kulturelle Praktiken spielen ebenfalls eine Rolle, da einige Immigrantinnen und Frauen bestimmter ethnischer Herkunft größere Schwierigkeiten beim Zugang zu Gesundheitsdiensten und zu Informationen zur sexuellen Gesundheit haben. Andererseits sind auch Männer beim Zugang zu Gesundheitsbehandlungen und Präventionsprogrammen mit Stereotypen konfrontiert. Osteoporose wird zum Beispiel als eine Frauenkrankheit wahrgenommen, obwohl es offensichtlich ist, dass auch Männer gegen Osteoporose behandelt werden sollten. Auch Bildungs- und Gesundheitspräventionsprogramme sind meistens auf Frauen ausgerichtet und sprechen nur gelegentlich Männer an. Der Bericht zeigt auch auf, dass es wichtig ist, verschiedene Elemente bei der Analyse der kulturellen Hindernisse beim Zugang zu Gesundheitsdiensten zu berücksichtigen.

Dies betrifft Vorurteile und Geschlechterstereotypen, sozialen Status und Bildungsniveau, kulturelle Unterschiede je nach ethnischer Zugehörigkeit und Migrationshintergrund (was nicht nur die Sprachfähigkeiten einschließt, sondern auch Traditionen und Hygienennormen), religiöse Praktiken, Vorurteile bezüglich sexueller Orientierung und der Arbeitskultur.

Geografische Unterschiede in der Versorgung und der Flächendeckung sind weitere relevante Barrieren beim Zugang zu Gesundheitsbehandlungen. Die Versorgung mit Gesundheitsdiensten ist üblicherweise besser in größeren Städten und in dichter besiedelten Gebieten, während ein Mangel an Allgemeinmedizinern oder Hausärzten sowie an bestimmten grundlegenden Facharzt-dienstleistungen in kleinen, ländlichen und abgelegenen Gebieten besteht. Krankenhäuser sind in den Ländern oft ungleich verteilt, was sich in einigen Fällen durch geografische Merkmale (wie auf Inseln oder in Berggebieten) erklären lässt. In

einigen Ländern sind Unterschiede jedoch das Ergebnis eines dezentralisierten Entscheidungsfindungsprozesses, bei dem regionale und lokale Behörden Richtlinienbefugnis haben und regionale Unterschiede bei der Finanzierung entstehen. Die Entfernung zu Krankenhäusern und Gesundheitszentren und der Mangel an erreichbaren Transportmitteln und Einrichtungen betreffen insbesondere Frauen in ländlichen oder bergigen Gebieten, Behinderte und ältere Frauen, da diese hinsichtlich der Mobilität weniger unabhängig sind als Männer (sie fahren seltener Auto als Männer) und eine höhere Lebenserwartung haben und somit mehr Krankheitsjahre aufweisen.

Geschlechterunterschiede beim Zugang zur Langzeitpflege

In ganz Europa gibt es zahlreiche Vorschriften für die Langzeitpflege. Die Mischung der Leistungsarten – formell/informell, in Barzahlungen/in Sachleistungen, institutionelle/häusliche Pflege – variiert in den verschiedenen europäischen Ländern und spiegelt stärker die organisatorischen Merkmale jedes Systems wider als die Bevölkerungsstruktur und die demografischen Entwicklungen. Insbesondere spiegeln die Unterschiede die verschiedenen nationalen Annäherungen an familiäre Solidarität wider (informelle Pflege und Unterstützung für Pfleger). In den vergangenen fünfzehn Jahren haben europäische Länder Reformen erfahren, die darauf abzielten, Ungleichheiten beim Zugang zur Langzeitpflege zu beseitigen und die Pflegequalität zu verbessern.

Die Geschlechterperspektive ist bei der Berücksichtigung des Zugangs zu Langzeitpflegediensten relevant, da Frauen die hauptsächlichen Anbieter von Langzeitpflege sind, insbesondere der informellen Pflegedienste, und die Hauptnutzer, da sie länger als Männer leben und häufiger im Alter alleinstehend sind. Auch sind ältere Frauen häufiger als Männer negativ von den in vielen Ländern eingeführten Zuzahlungen für den Zugang zu Langzeitpflegediensten betroffen, da ihr durchschnittliches Einkommen niedriger ist als das der Männer.

Geschlechterungleichheiten beim Zugang zu Gesundheitsfürsorge und Langzeitpflegediensten

Die in diesem Bericht vorgestellte vergleichende Analyse hat einige wichtige Probleme herausgearbeitet, die angegangen werden müssen, um Geschlechterunterschiede beim Zugang zu Gesundheitspflege und Langzeitpflege zu verringern und kostenwirksame sowie qualitativ hochwertige Pflege zu liefern.

Das Wichtigste ist die Notwendigkeit, eine Geschlechterperspektive in Gesundheitsfürsorge Richtlinien zu übernehmen, unter Berücksichtigung der biologischen, ökonomischen, sozialen und kulturellen Faktoren, die den Gesundheitszustand von Männern und Frauen und deren Zugang zu Gesundheitsdiensten beeinflussen. Der Ansatz einer geschlechterorientierten Gesundheitspolitik, der geschlechterspezifische Risikofaktoren in der medizinischen Forschung, in der Versorgung (unter Berücksichtigung der Förderung, Prävention und der Behandlungsrichtlinien) sowie der Entwicklung von Finanzierungssystemen berücksichtigt, verbessert die Wirksamkeit der Pflege für Frauen und Männer und verringert Ungleichheiten beim Zugang, wie in einigen der Beispiele im Bericht gezeigt wurde.

Geschlechterbasierte Gesundheitsforschung erhöht das Wissen in Bezug auf die komplexe Art, in der biologische, soziale, kulturelle und Umweltfaktoren zusammenwirken und auf die Gesundheit von Frauen und Männern einwirken. Geschlechterbasierte medizinische Forschung verbessert auch die Aufmerksamkeit des Gesundheitspersonals in Bezug auf Geschlechterunterschiede und unterstützt, wenn notwendig, die Förderung geschlechterdifferenzierter Behandlung. Es ist zum Beispiel wichtig, dass bei der Erforschung kardiovaskulärer Krankheiten Geschlechterunterschiede bei der Krankheitsziffer und der Sterbewahrscheinlichkeit sowie als Folge auch in der Behandlung berücksichtigt werden; die Erforschung der Gesundheit am Arbeitsplatz und der Arbeitssicherheit sowie die Praktiken sollten geschlechtsspezifische Faktoren in Betracht ziehen, wie zum Beispiel die unterschiedlichen Gesundheitsrisiken, denen Frauen und Männer aufgrund beruflicher geschlechterspezifischer Segregation ausgesetzt sind, und die Gesundheitsrisiken, die sich aus prekären Anstellungen, bei der Hausarbeit und bei informeller Pflege durch Frauen ergeben.

Die Einführung *geschlechtsspezifischer Gesundheitsinformationssysteme und Analyseinstrumente* (wie zum Beispiel Gender Impact Assessment), die die Qualität bei der Erhebung und Analyse von Daten verbessern, ist grundlegend für die Unterstützung der medizinischen Forschung und für die systematische geschlechtsspezifische Überwachung und Evaluierung von Gesundheitspflegesystemen.

Die *Förderung von Handlungskapazitäten und Wissen* für eine geschlechterspezifische Sensibilität in den Gesundheitspflegesystemen und die *geschlechtsspezifische Schulung* des Gesundheitspflegepersonals werden voraussichtlich die Aufmerksamkeit gegenüber Geschlechterunterschieden bei der Bereitstellung und der Wirksamkeit von Gesundheitspflegediensten erhöhen.

Die Anerkennung der Rolle der Frauen als Nutzer und Anbieter der Gesundheitspflegedienste, sowohl innerhalb des Gesundheitspflegesystems als auch außerhalb in Form von informellen und oft auch unbezahlten Pflegediensten, ist bei der Evaluierung der Geschlechterauswirkung auf die derzeitigen Reformen des Gesundheitswesens wichtig, insbesondere in Bezug auf die Finanzierung und Bereitstellung der Gesundheitspflege. Die Reformen des Gesundheitswesens können sich wegen der Erhöhung der Kostenteilung durch private Versicherungssysteme und private Zuzahlungen nachteiliger auf Frauen auswirken als auf Männer, da Frauen die Mehrheit unter den Gesundheitspflegenutzern und den Niedriglohngruppen bilden. Die jüngsten Entwicklungen zur Kostenreduzierung tragen zur Erhöhung von Geschlechter- und Einkommensungleichheiten bei, wenn dies nicht angemessen berücksichtigt wird. Die Rationalisierung der Gesundheitspflegedienste, welche in vielen Ländern die Zahl der Kliniken und Dienstleistungen in ländlichen oder niedrig bevölkerten Gebieten sowie den Patienten-/Personalanteil verringert hat, könnte für Frauen negativere Folgen als für Männer mit sich bringen, da Frauen sowohl die Mehrheit unter den Nutzern als auch unter den Anbietern der Gesundheitspflege bilden. Diese Probleme sind besonders relevant bei der Langzeitpflege, bei der das Geschlecht eine noch relevantere Rolle spielt, da Frauen die hauptsächlichen Anbieter

(formell und informell) und Nutzer von Pflegeleistungen sind.

Maßnahmen, die Langzeitpflegesysteme unterstützen, wirken sich auf das Geschlechterverhältnis aus. Vorkehrungen zur Überwindung von Barrieren für Langzeitpflegedienste gibt es in einigen Mitgliedstaaten; sie werden im Bericht vorgestellt. Sie beziehen sich hauptsächlich auf die Unterstützung von niedrigen Einkommensgruppen (wie in den Niederlanden), die Verbesserung der Pflegequalität (wie in Deutschland, Rumänien und Norwegen) sowie die Unterstützung informeller Pflegeanbieter (wie in Finnland und Schweden).

Abschließend zeigen die Ergebnisse aus diesem vergleichenden Bericht, dass die Notwendigkeit besteht, einen gleichstellungsorientierten Ansatz bei den Gesundheitspflegerichtlinien anzuwenden, um deren Wirksamkeit zu verbessern. Dies ist insofern bedeutsam, da die derzeitige Finanz- und Wirtschaftskrise die verfügbaren Ressourcen zur Verbesserung der Qualität und der Deckung der Gesundheitspflege- und Langzeitpflegemaßnahmen verringern könnte und geschlechterbasierte Pilotprogramme unter großem Budgetkürzungsrisiko stehen. Die osteuropäischen Länder, die dabei sind, die Qualität und Erweiterung ihrer Gesundheitspflegesysteme zu verbessern, sind einem solchen Risiko in besonderem Maße ausgesetzt.

Résumé

Alors que les systèmes de soins ont contribué à améliorer de manière significative le domaine de la santé en Europe, l'accès à ces derniers demeure inégal dans les pays et les groupes sociaux, en fonction du statut socio-économique, du lieu de résidence, du groupe ethnique et du sexe de la personne concernée.

Le sexe joue un rôle particulier dans l'incidence et dans la prédominance de pathologies spécifiques, mais aussi dans leur traitement et leur impact en termes de bien-être et de rétablissement. Cela en raison des corrélations qui existent entre les différences biologiques liées au sexe et les facteurs culturels et socio-économiques qui produisent des effets sur le comportement des hommes et femmes et sur leur accès aux services.

Le présent rapport comparatif expose les principales différences au niveau de l'état de santé des femmes et des hommes dans les pays européens et étudie la façon dont les systèmes de soins, et surtout ceux de longue durée, répondent aux besoins spécifiques des femmes et des hommes en leur assurant une égalité d'accès aux soins. Il tient compte des principales barrières financières, culturelles et physiques à cet accès et donne des exemples de bonnes pratiques de promotion des soins, de prévention et de programmes de traitement général, ainsi que de soins de longue durée (SLD).

Les informations contenues dans le présent rapport sont fournies essentiellement par les experts nationaux du EGGSI (réseau d'experts en égalité des sexes, insertion sociale, soins de santé et soins de longue durée) et couvre trente pays européens (EU-27 et Espace économique européen/Association européenne de libre-échange) ⁽⁵⁾. Des données statistiques comparatives disponibles auprès d'Eurostat et de l'Organisation de coopération et de développement économiques (OCDE) ont également été prises en compte.

⁽⁵⁾ EGGSI est le réseau de la Commission européenne réunissant trente experts nationaux (pays de l'Union européenne et de l'Espace économique européen) dans les domaines de l'égalité des sexes et de l'insertion sociale ainsi que des questions de santé et de soins de longue durée. Ce réseau est coordonné par l'Istituto per la ricerca sociale et la Fondazione Giacomo Brodolini; il met en œuvre un programme annuel de recherche à caractère stratégique et en rend compte à la direction générale de l'emploi, des affaires sociales et de l'égalité des chances.

Différences de l'état de santé selon le sexe

Les différences de l'état de santé et des besoins en matière de santé selon le sexe s'expliquent largement par des facteurs biologiques et génétiques ainsi que par des différences de normes sociales et de comportement en matière de santé.

D'une part, les femmes et les hommes sont prédisposés à des maladies spécifiques liées à leur santé reproductive; par exemple les cancers du sein et de l'utérus chez les femmes et le cancer de la prostate chez les hommes. D'autre part, les femmes et les hommes présentent des symptômes et des effets différents lors de maladies courantes, telles que les maladies cardiovasculaires et de nombreuses maladies sexuellement transmissibles.

Tout comme les facteurs biologiques, les normes sociales produisent également des effets différents sur l'état de santé des femmes et des hommes: les femmes sont moins confrontées que les hommes aux maladies et handicaps dus à des comportements à risque pour la santé, mais elles sont plus susceptibles de présenter des maladies et handicaps «invisibles» qui souvent ne sont pas reconnus de manière adéquate par le système de soins (par exemple la dépression, les troubles du comportement alimentaire, les actes de violence sexuelle, les handicaps liés à des accidents domestiques et au grand âge). Les femmes, et plus particulièrement les très jeunes femmes, sont plus vulnérables que les hommes aux maladies sexuellement transmissibles, et les conséquences en sont plus sérieuses pour elles. Les abus sexuels et les violences domestiques affectent particulièrement le sexe féminin dans l'ensemble des pays et dans toutes les classes sociales.

La comparaison de l'état de santé des populations des pays européens montre également que les pays d'Europe de l'Est tendent à présenter des conditions de santé moins bonnes en général que les pays occidentaux.

Les femmes, en général, sont plus conscientes de leur état de santé et utilisent plus les services de soins que les hommes. Et ce, pour plusieurs raisons: leur rôle dans la reproduction, leur rôle d'aidantes vis-à-vis des personnes dépendantes (enfants, personnes âgées, handicapées), leur plus grande proportion au sein de la population âgée et aussi les stéréotypes liés à leur sexe, puisqu'en général les hommes n'estiment pas normal de se plaindre de leur santé et de consulter un médecin.

Différences selon le sexe dans la prestation des soins

On sait peu de chose sur les disparités entre les sexes en ce qui concerne l'accès aux soins et plus particulièrement aux soins de longue durée, et on ne sait pas davantage si ni comment ces disparités sont prises en compte dans la prestation des services de santé. Par exemple, il semble que les femmes ont plus un comportement qui favorise leur santé et pratiquent donc plus la prévention et la promotion de la santé par rapport aux hommes, mais il est également prouvé que les femmes pauvres ⁽⁶⁾, en particulier, peuvent rencontrer plus de difficultés que les hommes à accéder aux services de santé.

Dans certains pays d'Europe (comme l'Allemagne, l'Autriche, la Bulgarie, l'Espagne, l'Irlande, l'Islande, l'Italie, la Norvège, les Pays-Bas, le Royaume-Uni et la Slovaquie), on assiste à une prise de conscience croissante du besoin de reconnaissance des différences entre les sexes pour l'accès aux soins au sein des institutions gouvernementales, des universités, et en particulier des organisations non gouvernementales (ONG), traditionnellement très actives dans la fourniture de services de spécialistes aux femmes, aux minorités ethniques et autres groupes défavorisés. Dans ces pays, des stratégies tenant compte des besoins spécifiques des hommes et des femmes ont été récemment mises en œuvre dans le domaine des soins et de la recherche médicale: des centres de ressources et des instituts de recherche spécialisés dans le domaine des femmes et de la santé ont été créés, des observatoires sur la santé des femmes ont été mis en place pour aider au développement de données ventilées par sexe et la recherche médicale sexuée. De plus, ces pays ont mis en œuvre des projets de formation particuliers pour les praticiens généralistes et les prestataires de santé, ainsi que des programmes pilotes pour le traitement des femmes défavorisées, telles que les sans domicile fixe, les immigrées, les handicapées et les mères célibataires.

L'analyse comparative exposée dans le présent rapport montre toutefois que, dans la plupart des pays, en dehors des soins en matière de reproduction, il existe encore peu de stratégies de soins intégrant le facteur sexe et de services abordant les spécificités d'attitudes et de maladies liées au sexe d'une manière plus structurée.

Les *stratégies de promotion de la santé* apparaissent comme largement neutres en matière de sexe, sauf en ce qui concerne la santé liée à la reproduction. La promotion de l'allaitement maternel est le programme le plus répandu à travers l'Europe. Il est soutenu par les lignes directrices classiques et s'accompagne, dans de nombreux pays, de programmes plus généraux d'aide aux mères et aux nouveau-nés. De plus, certains programmes de promotion de comportements sains s'adressant aux adultes ou aux adolescents sont souvent orientés selon le sexe et ont pour cible soit les hommes, soit les femmes: programmes visant à réduire la consommation d'alcool et de cigarettes, programmes soutenant les régimes et l'activité physique, programmes promouvant la santé mentale et la santé au travail, programmes de promotion de la santé et campagnes ciblées tout particulièrement sur les groupes les plus vulnérables. Dans les pays où les activités de promotion nationale de la santé sont moins développées, les ONG jouent habituellement un rôle important en se substituant aux pouvoirs publics et en lançant des campagnes de sensibilisation sur des questions spécifiques.

Les programmes de dépistage constituent d'importantes *mesures de prévention*, puisque de nombreuses maladies peuvent être évitées grâce à une détection précoce. Les rapports nationaux de l'EGGSI ont mis en évidence que les programmes de prévention intégrant le facteur sexe sont principalement ciblés sur les femmes. En Europe, le programme de prévention le plus important et le plus répandu intégrant le facteur sexe est le dépistage du cancer. Cela est dû à une recommandation du Conseil invitant les États membres à engager une action de mise en œuvre de programmes nationaux de dépistage du cancer selon une approche basée sur la population et avec l'assurance d'une qualité appropriée à tous les niveaux. En dépit des grands progrès réalisés, il est nécessaire d'en faire davantage pour s'assurer que les programmes sont disponibles dans l'ensemble des États membres.

En Europe, de nombreux programmes de prévention concernent la *maternité*: tests prénataux, aide aux mères ayant des nouveau-nés et au développement de la famille, aide aux groupes d'enfants et de mères ayant des besoins spécifiques. Mais il existe aussi d'autres programmes de prévention importants concernant la *santé sexuelle et reproductive*. Le secteur de la santé peut également jouer un rôle essentiel dans la *prévention de la violence domestique contre les femmes*, en aidant à la détection précoce des abus, en fournissant aux victimes les traitements nécessaires et en renvoyant les femmes aux soins appropriés. Certains rapports nationaux de l'EGGSI ont fait état d'un manque général d'attention de la population et de conscience parmi les professionnels de la santé, mais ont également mis en avant des exemples de bonnes pratiques de services d'aide aux victimes.

⁽⁶⁾ Rapport du European Institute of Women's Health, conférence sur l'égalité des sexes, septembre 2000, <http://www.eurohealth.ie/gender/index.htm>

En revanche, peu de programmes présentés dans les rapports nationaux de l'EGGSI destinés aux enfants et aux adolescents sont ciblés selon le sexe. Le programme le plus répandu à travers l'Europe (même s'il existe des différences quant à son accès) et ciblé sur les jeunes filles est le *programme de vaccination contre les papillomavirus humains (PVH)*. L'éducation sexuelle et la prévention de l'avortement constituent un autre domaine où les jeunes filles sont la cible principale de programmes de prévention. En Europe, l'avortement chez les adolescentes est encore un problème, même si une tendance à la réduction transparait clairement.

Bien que le comportement à risque pour la santé en fonction du sexe commence à être documenté et que les connaissances sur la nécessité de fournir un traitement adapté au sexe soient diffusées de façon croissante, les disparités entre les sexes dans la plupart des *traitements de soins* sont souvent négligées. Les seules exceptions concernent les soins en matière de reproduction (prestation de services de base pour les femmes enceintes et la naissance) et le traitement de maladies spécifiquement féminines telle que le cancer du sein et le cancer du col de l'utérus.

L'âge, les revenus, l'éducation et le lieu de résidence constituent des critères d'accès importants aux traitements de soins pour les hommes et les femmes. À des niveaux similaires de besoins de soins, les individus ayant de plus faibles revenus et une moins bonne éducation utilisent majoritairement les soins primaires et tendent à sous-utiliser une assistance spécialisée. Dans la plupart des pays, les immigrés et les non-résidents n'ont habituellement accès qu'aux soins d'urgence. Tant qu'il existera des différences dans les niveaux de revenus selon le sexe, ces différents modèles seront également applicables en termes d'inégalité de genre.

Les barrières physiques, psychologiques et sociales qui empêchent de nombreuses femmes de prendre des décisions relatives à leur santé sont souvent non visibles ou abordées par les programmes et les réglementations de traitement de soins. Les spécificités féminines sont peu reconnues dans le traitement de certaines pathologies telles que les maladies cardiaques, les maladies sexuellement transmissibles, les troubles mentaux ou les maladies liées au travail, et dans celui des conséquences à long terme d'actes de violence ou d'abus sexuels. En effet, dans de nombreux cas, par exemple celui des maladies cardiaques, le savoir utilisé est fondé sur des études menées sur des hommes, ce qui aboutit à un traitement qui ne répond pas toujours aux besoins d'une femme. Les autres exemples sont les répercussions sur la santé mentale de la surcharge de tâches pour des femmes actives et ayant des responsabilités de soins, mais aussi de l'anxiété et de l'isolement social souvent rencontrés

par les mères célibataires et les femmes âgées vivant seules. Les actes de violence domestique, en particulier, entraînent habituellement des taux élevés de dépression et d'anxiété chez les femmes. Quant aux risques pour la santé liés au travail, les réglementations sur la santé et la sécurité sur le lieu de travail couvrent principalement les risques auxquels les hommes sont plus généralement exposés, tandis qu'il est fait peu de cas des risques pour la santé des femmes dans des domaines et des activités féminines intensives.

Il a également été relevé que les femmes et les hommes sont parfois traités différemment, non parce que leurs besoins spécifiques sont reconnus, mais en raison des attitudes préconçues et stéréotypées des praticiens de la santé. Par exemple, une aide thérapeutique pour le retour au travail après un accident du travail est plus fréquente chez les hommes que chez les femmes, car médecins du travail et les employeurs estiment que la réintégration est plus importante pour un homme que pour une femme.

La prestation de services de santé *ciblée spécifiquement sur les hommes* est moins reconnue, même si, dans certains pays, ces questions font l'objet d'une attention croissante. Certaines maladies spécifiques aux hommes (cancers de la prostate ou des testicules ou maladies bénignes de la prostate chez les hommes d'un certain âge) ne font pas l'objet d'une attention particulière dans de nombreux pays d'Europe. Par ailleurs, les programmes de santé et le traitement de certaines maladies liées aux comportements sexuels, telles l'addiction à l'alcool et les maladies liées à l'alcool, qui présentent des formes et des effets différents chez les femmes et les hommes, ne prennent pas suffisamment en compte les différences liées au sexe.

Barrières à l'accès aux soins et différences selon le sexe

Même si les droits universels ou quasi universels aux soins sont des principes de base dans l'ensemble des États membres et si la majorité des populations européennes sont couvertes par l'assurance de santé publique, ces principes de base ne se traduisent pas toujours en un accès et une utilisation identiques des soins de santé. Le lieu de résidence et certains facteurs socio-économiques et géographiques peuvent influencer l'accessibilité aux soins de certains groupes particuliers: l'absence de couverture par une assurance (touchant en particulier les personnes sans résidence ou nationalité, les chômeurs de longue durée et les sans domicile fixe dans des pays fondés sur des systèmes de contribution de sécurité sociale), les coûts financiers directs des soins (touchant les personnes percevant de faibles revenus), l'absence de mobilité (touchant les

personnes âgées et les handicapés), l'absence de compétence linguistique (touchant les migrants et les minorités ethniques), l'absence d'accès à l'information (touchant les personnes ayant reçu peu d'éducation et les migrants/minorités ethniques) et les contraintes de temps (touchant en particulier les mères célibataires). Tous ces facteurs contiennent aussi des éléments spécifiques liés au sexe qui doivent être pris en considération.

Les *barrières financières* sont particulièrement significatives pour les groupes disposant de faibles revenus et pour les femmes. Les inégalités de revenus sont principalement liées à l'absence de couverture par une assurance, au coût de certains types de soins spécialisés (tels que ceux concernant la dentition, la vue et l'audition) qui souvent ne sont pas couverts par les systèmes d'assurance publics et à l'incidence des systèmes d'assurance privés. Les coûts non remboursés et la persistance de paiements informels dans de nombreux pays d'Europe de l'Est et du Sud ont également un impact significatif.

Le rôle croissant de l'assurance maladie privée et des dépenses non remboursées peut accroître les inégalités entre les sexes, puisque les hommes sont plus susceptibles d'être couverts par une assurance privée que les femmes, bien que celles-ci soient de plus grandes consommatrices de services de soins et de médicaments. Habituellement, les femmes ont un revenu inférieur et ne profitent pas du même type de couverture d'assurance privée reposant sur une base professionnelle que les hommes. Les femmes présentent également des taux d'emploi plus faibles dans l'économie régulière (de nombreuses femmes sont inactives ou travaillent à la maison ou dans le secteur informel) et, lorsqu'elles ont un emploi, elles sont plus susceptibles d'être employées dans le secteur public et les petites entreprises (qui ne sont pas obligées de fournir un système d'assurance privée complémentaire) avec des contrats de travail à temps partiel et/ou temporaire pour un emploi mal payé. En outre, les systèmes d'assurance privée sont moins attrayants pour les femmes puisqu'ils prennent habituellement en considération les risques liés à l'âge et au sexe de la personne concernée pour fixer les cotisations. Les femmes issues de minorités ethniques et de ménages pauvres peuvent être particulièrement pénalisées par la privatisation des services de santé et l'augmentation des dépenses de santé non remboursées. Il n'existe pas de données comparatives selon le sexe relatives à la couverture d'assurance par type d'assurance dans les pays européens, cependant, il est vraisemblable que les barrières financières sont particulièrement significatives pour les femmes vivant dans les pays où l'incidence du partage des coûts est plus forte et où l'extension de la couverture de l'assurance publique est plus faible.

Les *barrières culturelles* sont aussi particulièrement significatives pour les femmes, spécialement pour les immigrées et les femmes d'origine ethnique. Les rôles et comportements distincts des hommes et des femmes dans une culture donnée, résultant des normes et des valeurs liées au sexe, donnent lieu à des différences et à des inégalités entre les sexes dans l'accès aux soins ainsi qu'au niveau des comportements à risque et de l'état de santé. Les barrières culturelles peuvent être exprimées en termes de préjugés et de manque de connaissance parmi les professionnels de la santé en ce qui concerne les spécificités liées au sexe pour les besoins et les types de soins à fournir. Les questions de langue ainsi que les traditions et les pratiques culturelles jouent également un rôle. Certains groupes de femmes immigrées et d'origine ethnique ont de grandes difficultés d'accès aux équipements de santé et à l'information sur la santé sexuelle. D'un autre côté, les hommes sont également confrontés à des stéréotypes lors de l'accès aux soins et aux programmes de prévention. L'ostéoporose, par exemple, est perçue comme une maladie féminine, et il ne semble pas évident que certains hommes doivent eux aussi être traités pour l'ostéoporose. Les programmes d'éducation et de prévention de la santé sont également ciblés principalement sur les femmes et ne s'adressent aux hommes que de manière occasionnelle. Ce rapport montre à quel point il est important de prendre en considération une variété d'éléments dans l'analyse des barrières culturelles à l'accès aux soins. Ces éléments sont notamment les préjugés et les stéréotypes sexuels, le statut social et le niveau d'éducation, les différences culturelles inhérentes à l'ethnie et les questions de migration (qui impliquent non seulement des aptitudes linguistiques, mais également des traditions et des règles d'hygiène), les pratiques religieuses, les préjugés concernant l'orientation sexuelle, la culture du travail.

Les *variations géographiques* dans la couverture du territoire et la fourniture de services sont une autre barrière significative à l'accès aux soins. La prestation de services de soins est généralement plus importante dans les grandes villes et les zones à forte densité de population, alors qu'il manque des praticiens généralistes ou des médecins de famille et certains services spécialisés de base dans des petites zones rurales et reculées. Par ailleurs, dans certains cas, les hôpitaux sont souvent répartis de manière inégale à travers les pays à cause de caractéristiques géographiques (en raison de la présence d'îles ou de montagnes). Toutefois, dans certains pays, les disparités sont le résultat de la décentralisation du processus de prise de décision, permettant aux autorités régionales et locales de mener une politique discrétionnaire et autorisant des différences régionales dans le financement. La distance jusqu'aux hôpitaux et aux centres de soins et l'absence de moyens de transport et d'équipements accessibles touchent en

particulier les femmes (surtout celles vivant dans des zones rurales ou montagneuses, les handicapées et les femmes âgées), qui sont moins autonomes que les hommes sur le plan de la mobilité (il est moins fréquent que les femmes conduisent) et vivent un plus grand nombre d'années à un âge avancé et en mauvaise santé.

Les différences selon le sexe pour l'accès aux soins de longue durée

Partout en Europe, il existe différentes dispositions relatives aux SLD. Le mélange des types de prestation — formelle/informelle, en espèces/en nature, soins en institution/à domicile — varie selon les pays européens, reflétant davantage les caractéristiques de l'organisation propres à chaque système plutôt qu'une structure de population et des développements démographiques. En particulier, ces variations reflètent les différentes approches nationales en matière de solidarité familiale (incidence des soins informels et aide aux soignants). Au cours des quinze dernières années, les pays européens ont connu des réformes visant à effacer les inégalités d'accès aux SLD et à améliorer la qualité des soins.

La question du sexe est significative si l'on considère l'accès aux services de soins de longue durée, puisque les femmes sont les principales fournisseuses de SLD, en particulier des soins informels, et les principales utilisatrices des services SLD, parce qu'elles vivent plus longtemps que les hommes et sont donc plus susceptibles de vivre seules à un âge avancé. Les femmes les plus âgées sont souvent plus touchées négativement que les hommes par la cotisation pour l'accès aux SLD, introduite dans de nombreux pays, car leur revenu moyen est inférieur à celui des hommes.

Aborder les inégalités entre les sexes au niveau de l'accès aux soins et aux soins de longue durée

L'analyse comparative exposée dans le présent rapport a mis en lumière des questions importantes qui doivent être abordées pour réduire les inégalités entre les sexes au niveau de l'accès aux soins, et en particulier aux soins de longue durée, et pour fournir des soins rentables et de haute qualité.

Le plus important est la nécessité d'adopter une perspective spécifique au sexe dans les politiques de soins, en prenant en considération les facteurs biologiques, économiques, sociaux et culturels qui affectent l'état de santé des hommes et des femmes et leur accès aux soins. Une *approche* des politiques de soins *fondée sur une analyse selon le sexe*, abordant

des facteurs de risques liés au sexe dans la recherche médicale, la fourniture de services (prenant en considération les politiques de promotion, de prévention et de traitement) et la conception de systèmes de financement, accroît l'efficacité des soins fournis aux femmes et aux hommes et réduit les inégalités d'accès, comme cela est montré dans certaines bonnes pratiques présentées dans ce rapport.

La *recherche en matière de santé basée sur le sexe* augmente les connaissances sur le fait que les facteurs biologiques, sociaux, culturels et environnementaux interagissent pour affecter la santé des femmes et des hommes. La recherche médicale basée sur le sexe accroît également l'attention des praticiens de la santé sur les différences entre les sexes et aide à la fourniture d'un traitement différencié selon le sexe, si nécessaire. Par exemple, il est important que la recherche dans le domaine des maladies cardiovasculaires prenne en considération les différences en fonction du sexe dans la morbidité et la mortalité et au niveau des réactions au traitement. Les recherches et les pratiques en matière de santé et de sécurité professionnelle devraient prendre en compte les facteurs spécifiques au sexe, tels que les différents risques auxquels les femmes et les hommes s'exposent en raison d'une ségrégation professionnelle selon le sexe et les risques pour la santé résultant de l'emploi précaire, du travail à domicile et des travaux de soins informels accomplis par les femmes.

La mise en œuvre de *systèmes d'information sur la santé sexuée et d'instruments d'analyse* (tels que l'étude d'impact de genre), améliorant la qualité de la collecte et de l'analyse des données, est essentielle pour le soutien de la recherche médicale et pour l'évaluation et le contrôle systématique lié au sexe des systèmes de soins.

La *promotion du renforcement des capacités* pour tenir compte des besoins spécifiques des femmes et des hommes dans les systèmes de soins et de la *formation spécifique au sexe* pour les professionnels de la santé est susceptible d'accroître l'attention accordée aux différences entre les sexes dans la fourniture des services et l'efficacité des services de soins.

La *reconnaissance du rôle des femmes en tant qu'utilisatrices et fournisseuses de soins* à la fois à l'intérieur et à l'extérieur du système de soins, en tant que soignantes informelles et souvent non payées, est importante lors de l'évaluation de l'*impact sur le genre des tendances récentes dans les réformes de soins*, en particulier en rapport avec le financement et la fourniture de soins. Les tendances de la réforme des soins, augmentant notamment l'incidence du partage des coûts par des systèmes d'assurance privée et de dépenses non remboursées, peuvent affecter défavorablement les femmes plus que les hommes,

puisqu'elles constituent la majorité des utilisateurs des soins et des groupes à faibles revenus. Les dernières tendances en matière de limitation des coûts et de limitation dans la fourniture des soins de base inclus dans les soins primaires sont également susceptibles d'augmenter les inégalités de revenus et celles entre les sexes si elles ne sont pas abordées de manière adéquate. La rationalisation des services de soins de santé qui, dans de nombreux pays, a réduit les cliniques et les services locaux dans les zones rurales ou moins peuplées et a réduit les ratios patient/personnel médical peut avoir des effets négatifs sur les femmes plus que sur les hommes, car les femmes constituent la majorité des utilisateurs et fournisseurs de soins de santé. Ces questions sont particulièrement importantes en matière de soins de longue durée, où le sexe joue un rôle encore plus important, puisque les femmes sont les principales fournisseuses de soins (formels et informels) et utilisatrices de ces soins.

Les mesures soutenant les systèmes de SLD ont des effets importants sur le sexe. Des textes permettant de

dépasser les barrières pour l'accès aux SLD peuvent être trouvés dans les États membres et sont présentés dans ce rapport. Ils visent principalement: l'aide aux groupes ayant de faibles revenus (aux Pays-Bas), l'amélioration de la qualité des soins (en Allemagne, en Norvège et en Roumanie) et l'aide aux fournisseurs informels de soins (en Finlande et en Suède).

En conclusion, les éléments se dégageant de ce rapport comparatif soulignent le besoin d'adopter une approche intégrant le facteur sexe dans les politiques de soins en vue d'améliorer leur efficacité. Cela est d'autant plus important que la crise financière et économique actuelle peut réduire les ressources disponibles pour l'amélioration de la qualité et de la couverture dans la prestation des soins, et en particulier des SLD, avec des programmes pilotes basés sur le sexe qui font face à de grands risques de coupes budgétaires. Les pays d'Europe de l'Est, qui sont dans un processus d'amélioration de la qualité et de l'extension de leurs systèmes de soins, présentent ce genre de risque.

Introduction

The 2007 Joint Report on Social Protection and Social Inclusion underlined that while universal or near universal rights⁽⁷⁾ giving access to care can be found in all Member States, this does not necessarily translate into universal access and significant sources of inequality remain⁽⁸⁾. These include, amongst others, lack of insurance coverage, lack of coverage/provision of certain types of care, as well as high individual financial care costs⁽⁹⁾. The 2008 Joint Report stressed that important steps are to increase population coverage, address financial barriers to care, emphasise promotion and prevention regarding curative care, and address cultural barriers to the use of services⁽¹⁰⁾.

Little is known about gender differences in accessing healthcare and long-term care, and if and how healthcare and long-term care systems take these into account in service delivery. For example, while it has been suggested that women are more likely than men to engage in health-seeking behaviour and thus to practise health prevention and promotion, there also seems to be evidence that especially poor women⁽¹¹⁾ may have more difficulties in accessing healthcare services than men.

This comparative report examines how healthcare and long-term care systems respond to the specific

needs of women and men in ensuring equal access, by assessing the main financial, cultural and physical barriers to access and providing good-practice examples of healthcare promotion, prevention and general treatment programmes as well as of long-term care. The information in this report has mainly been provided by the national experts of the EGGSI network of experts in gender equality, social inclusion, healthcare and long-term care and covers 30 European countries (EU and EEA/EFTA)⁽¹²⁾. Available comparative statistical data from Eurostat and OECD sources have also been considered.

The report is organised into four chapters: the first summarises the main characteristics and trends in the health status of women and men across Europe. The second chapter addresses gender differences in access to healthcare, first considering service provisions in health promotion, prevention and treatment, and, second analysing how financial, cultural and geographical barriers may affect women and men. The third chapter gives an overview of existing service provisions for long-term care and gender differences in access, together with a discussion of the main barriers to access long-term care services. The final chapter presents some overall conclusions.

⁽⁷⁾ Universal rights ensure that access does not depend on one's ability to pay, income or wealth and that the need for care does not lead to poverty and financial dependency.

⁽⁸⁾ European Commission (2007), Joint Report on Social Protection and Social Inclusion, Supporting document, SEC(2007) 329, Brussels.

http://ec.europa.eu/employment_social/spsi/docs/social_inclusion/2007/joint_report/sec_2007_329_en.pdf

⁽⁹⁾ European Commission (2007), Joint Report on Social Protection and Social Inclusion, Supporting document, SEC(2007) 329, Brussels.

http://ec.europa.eu/employment_social/spsi/docs/social_inclusion/2007/joint_report/sec_2007_329_en.pdf

⁽¹⁰⁾ Council of the European Union (2008), Joint Report on Social Protection and Social Inclusion, Directorate-General for Employment, Social Policy, Health and Consumer Affairs, Brussels.

<http://register.consilium.europa.eu/pdf/en/08/st07/st07274.en08.pdf>

⁽¹¹⁾ European Institute of Women's Health Report, Gender Equity Conference, Conference of September 2000.

<http://www.eurohealth.ie/gender/index.htm>

⁽¹²⁾ EGGSI is the European Commission's network of 30 national experts (EU and EEA countries) in the fields of gender equality and social inclusion, health and long-term care issues. The network is coordinated by the Istituto per la Ricerca Sociale and Fondazione Giacomo Brodolini, and undertakes an annual programme of policy-oriented research and reports to the Directorate-General for Employment, Social Affairs and Equal Opportunities. <http://eggssi.irs-online.it/>

1. Main characteristics and recent trends in the health status of women and men

This chapter presents the main country specificities in relation to gender differences in the health status of the population in 30 European countries. The analysis is mainly based on gender-relevant Eurostat indicators in the field of health and long-term care, and on national data provided by the EGGSI national reports.

1.1. Gender differences in life expectancy and healthy life years

In all European Member States, women live longer than men. The longer life expectancy of women is mainly explained by biological and genetic factors, as well as by differences in health behaviour: men take more health risks and are less conscious about health than women⁽¹³⁾.

Life expectancy at birth in the EU-27 has increased over the past two decades with a gain in longevity of about 4–5 years. According to Eurostat, in 2006 the average life expectancy was 82 years for women and 76 for men. The increase in longevity, however, is not the same among the EU countries: the highest life expectancies are in Italy, Spain, Sweden, Norway,

Austria and Iceland, while the lowest life expectancies (about 2–4 years below the EU-27 average) are in Romania, Bulgaria, Hungary, Latvia and Lithuania.

Since women live longer than men, they are more likely to experience more years of poor health: in all EU countries, the percentage of healthy life years without disability is lower for women than for men (Table 1-1).

Regarding the elderly, more women than men suffer from long-standing illnesses or health problems. Women experience more chronic ill health, distress and disability, especially in old age, also due to their longer life expectancy⁽¹⁴⁾.

1.2. Self-perceived health and disability

In all EU-25 countries and Iceland and Norway, men's self-perceived health is generally better than women's (very good and good), while more women consider their health to be fair or in a bad/very bad condition (Table 1-2).

EU-SILC was first launched in 2006 for Bulgaria and Romania. However, data on self-perceived health for Bulgaria and Romania are not available for the year 2006.

⁽¹³⁾ European Parliament (2007), Discrimination against women and young girls in the health sector, Directorate-General Internal Policies, by the European Institute of Women's Health, Brussels. <http://www.europarl.europa.eu/sides/getDoc.do?sessionid=42D62CA22BDD5134ABE684A2B6C616BC.node1?pubRef=-//EP//TEXT+TA+P6-TA-2007-0021+0+DOC+XML+V0//EN>

⁽¹⁴⁾ Eurostat (2008), The life of women and men in Europe — A statistical portrait, Luxembourg. http://epp.eurostat.ec.europa.eu/portal/page?_pageid=1073,46587259&_dad=portal&_schema=PORTAL&product_code=KS-80-07-135

Table 1-1 — Life expectancy and healthy life years for EU-27, and Iceland and Norway, 2006

	Life expectancy		Healthy life years		% of healthy life years	
	female	male	female	male	female	male
Austria	82.8	77.2	60.8	58.4	73.4	75.6
Belgium	82.3	76.6	62.8	62.8	76.3	82.0
Bulgaria	76.3	69.2	:	:	:	:
Cyprus	82.4	78.8	63.2	64.3	76.7	81.6
Czech Republic	79.9	73.5	59.8	57.8	74.8	78.6
Denmark	80.7	76.1	67.1	67.7	83.1	89.0
Estonia	78.6	67.4	53.7	49.4	68.3	73.3
Finland	83.1	75.9	52.7	52.9	63.4	69.7
France	84.4	77.3	64.1	62.7	75.9	81.1
Germany	82.4	77.2	58.0	58.5	70.4	75.8
Greece	81.9	77.2	67.9	66.3	82.9	85.9
Hungary	77.8	69.2	57.0	54.2	73.3	78.3
Ireland	82.1	77.3	65.0	63.3	79.2	81.9
Italy (*)	83.8	77.9	70.2	67.9	83.8	87.2
Latvia	76.3	65.4	52.1	50.5	68.3	77.2
Lithuania	77.0	65.3	56.1	52.4	72.9	80.2
Luxembourg	81.9	76.8	61.8	61.0	75.5	79.4
Malta	81.9	77.0	69.2	68.1	84.5	88.4
Netherlands	82.0	77.7	63.2	65.0	77.1	83.7
Poland	79.7	70.9	62.5	58.2	78.4	82.1
Portugal	82.3	75.5	57.6	59.6	70.0	78.9
Romania	76.2	69.2	:	:	:	:
Slovakia	78.4	70.4	54.4	54.3	69.4	77.1
Slovenia	82.0	74.5	61.0	57.6	74.4	77.3
Spain	84.4	77.7	63.3	63.7	75.0	82.0
Sweden	83.1	78.8	67.0	67.1	80.6	85.2
United Kingdom (*)	81.1	77.1	65.0	63.2	80.1	82.0
Iceland	82.9	79.5	65.3	68.3	78.8	85.9
Norway	82.9	78.2	63.4	65.7	76.5	84.0

Note: ':' data not available.

(*) Data for Italy: 2004; Data for UK: 2005.

Source: European Commission, New common indicators from 2006 for the Open Method of Coordination

http://epp.eurostat.ec.europa.eu/portal/page/portal/health/public_health/main_tables

Indicator HC-P4a on Life Expectancy and HC-P5a on Healthy Life years, based on Eurostat data (EU-SILC)

EU-SILC was first launched in 2006 for Bulgaria and Romania. However, data on healthy life years for Bulgaria and Romania are not available for the year 2006.

Explanatory note: life expectancy: Eurostat data on the mean number of years that a newborn child can expect to live if subject throughout life to the current mortality conditions (age-specific probability of death). Healthy life years (HLY) is a health-expectancy indicator which combines information on mortality and morbidity. The data considered are the age-specific prevalence (proportions) of the population in healthy and unhealthy conditions and age-specific mortality information. A healthy condition is defined by the absence of limitations in functioning/disability. The indicator is also called disability-free life expectancy (DFLE).

**Table 1-2 — Self-perceived health status of men and women,
for EU-25 and Iceland and Norway, 2006**

	Men			Women		
	Very good/ good	Fair	Very bad/ bad	Very good/ good	Fair	Very bad/ bad
EU-25	67.8	23.1	9.1	61.7	26.2	12.1
Austria	73.1	19.9	7.1	70.9	20.5	8.6
Belgium	77.9	15.2	6.9	70.9	19.4	9.7
Cyprus	79.1	13.0	7.8	73.3	15.8	10.8
Czech Republic	62.8	25.6	11.7	56.3	28.9	14.9
Denmark	77.6	15.9	6.5	72.6	18.4	9.0
Estonia	56.5	30.0	13.5	50.8	32.8	16.4
Finland	69.1	21.7	9.2	68.3	21.1	10.6
France	72.3	19.6	8.2	66.8	22.5	10.7
Germany	63.5	27.9	8.6	57.8	32.3	10.1
Greece	79.9	12.1	8.1	74.0	15.9	10.2
Hungary	52.2	30.8	17.1	44.9	32.0	23.1
Ireland	84.4	12.4	3.2	81.9	14.9	3.1
Italy	60.8	30.6	8.6	53.2	34.4	12.4
Latvia	47.5	37.2	15.4	36.1	41.1	22.8
Lithuania	48.8	36.9	14.3	38.9	39.7	21.4
Luxembourg	76.2	17.6	6.1	76.2	17.6	6.1
Malta	77.3	18.8	4.0	72.8	22.4	4.8
Netherlands	80.0	16.0	4.0	74.0	19.7	6.4
Poland	58.7	26.0	15.3	51.0	30.0	19.1
Portugal	53.3	30.8	15.8	43.4	32.8	23.8
Slovakia	56.8	28.8	14.3	48.2	30.6	21.2
Slovenia	59.6	26.3	14.1	53.3	29.4	17.3
Spain	71.3	18.5	10.2	64.8	21.1	14.2
Sweden	78.6	16.7	4.7	78.6	16.7	4.7
UK	78.1	16.2	5.8	75.3	17.5	7.2
Iceland	83.1	13.9	3.0	80.3	13.7	6.0
Norway	76.4	15.8	7.8	72.6	16.5	10.9

Source: Eurostat data on health status based on EU-SILC Survey, 2006.

EU-SILC was first launched in 2006 for Bulgaria and Romania. However, data on self-perceived health for Bulgaria and Romania are not available for the year 2006.

Slightly more women than men all over the EU-25 countries suffer from limitations in their everyday activities because of chronic (long-standing) illnesses or health problems ⁽¹⁵⁾. This difference may be the result of different attitudes by women compared with men, and is also influenced by a different self-perception on the health status between women and men. Psychological (such as self-esteem, social isolation, and work overload due to family responsibilities) and social determinants (such as the educational or income level) are generally more important factors influencing the health status of women, while behavioural determinants (such as nutrition, exercise and substance abuse) are more important for men. Higher rates of accidents (traffic accidents, work-related accidents) and violence-related mortality in men seem to be due to differences in gender norms regarding risk-taking.

According to Eurostat data on long-standing illness or health problems (EU-SILC survey, 2006), it is estimated that about 29.7% of men and 34.2% of women in the EU-25 have a long-standing health problem or disability (Figure 1-1).

Bulgaria and Romania launched SILC in 2006. However, data on long-standing illness or health problem for Bulgaria and Romania were not available for the year 2006.

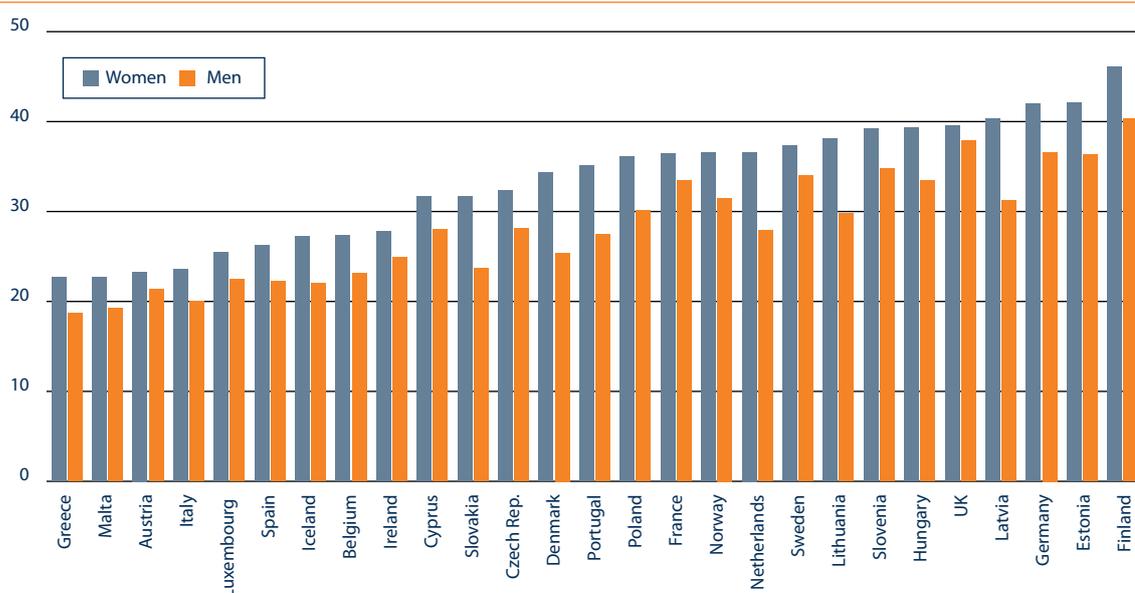
Explanatory note: The data on chronic (long-standing) illnesses or conditions refer to the self-declaration by the respondents regarding whether they have a chronic (long-standing) illness or condition or not.

Differences among countries vary widely, but these data may be also affected by social differences in the self-perception of one's health and disability status. Notably, the income of people who experience considerable limitations (e.g. long-standing illness) was 22% lower than those of people without limitations. The wage gap between men and women is also apparent here: earnings of men who experience strong limitations are 12% lower, while of those women who experience considerable limitations are 28% lower than those of people (both sexes) with no limitations ⁽¹⁶⁾.

1.3. Gender differences in health risks and death by typology of diseases

Differences in health risks behaviour exist between men and women, starting from childhood. The literature shows that in childhood and adolescence boys present a higher mortality rate due to behaviour-generated causes (suicide, drug abuse, traffic accidents, etc.) and more physical and mental problems than girls ⁽¹⁷⁾.

Figure 1-1 — Long-standing illness or health problem by sex (%), 2006



Source: Eurostat data based on EU-SILC survey.

Explanatory note: Bulgaria and Romania launched SILC in 2006, and are not included in the table. The data on chronic (long-standing) illnesses or conditions refer to the self-declaration by the respondents regarding whether they have a chronic (long-standing) illness or condition or not.

⁽¹⁵⁾ Based on Eurostat SILC survey.

⁽¹⁶⁾ According to Eurostat data based on EU-SILC survey (2006).

⁽¹⁷⁾ WHO (1999), Gender and Health in Adolescence, Health policy for children and adolescents (HEPCA), series No 1. by Kolip, P. and Schmidt, B., Copenhagen.

Overall, the main health problems of males are injuries caused by traffic accidents⁽¹⁸⁾. Young women suffer especially from invisible health risks (such as excessive medication use and dieting), sexual violence and socioeconomic deprivation (since their economic situation is generally less favourable than that of men), with serious effects on their health status⁽¹⁹⁾.

In the European countries, men tend to die earlier than women, yet women tend to report higher levels of ill health at all ages than men. The following analysis will show the main differences in terms of mortality, incidence, prevalence, and in some case severity among women and men for the major diseases and conditions.

Cardiovascular diseases

Overall in the European Union Member States, more men than women die of cardiovascular diseases (CVD), still the main natural cause of death for both women and men. Although Member States register declining mortality rates due to CVD, there is an increasing number of people who live with CVD. This paradox is due to increased life expectancy and improved CVD patient survival. More people die from CVD than from (all forms of) cancer, with a higher percentage of women (54% of all causes of mortality during 2000–05) than men (43% of all causes of mortality during 2000–05), and there is a higher mortality rate in lower socioeconomic income groups⁽²⁰⁾.

Among cardiovascular diseases, coronary heart disease (CHD)⁽²¹⁾ is the leading cause of mortality in the EU, accounting for over 741 000 deaths every year (one in six men and over one in seven women)⁽²²⁾. A stroke is the second leading cause of death in the EU, accounting

for 508 000 deaths each year: around one in 10 men and one in eight women die from this disease; many more suffer from non-fatal events⁽²³⁾.

In the 35–74 age group, CVD accounts for 34% of total mortality and ischaemic heart disease (IHD) for 15% in 2000–05⁽²⁴⁾. Mortality rates are higher for men than for women, which increases in the older age groups. IHD patterns showed a clear East–West gradient with the highest mortality rates in the Baltic and eastern European member countries. The rates vary from 42.7 deaths per 100 000 in France (72 male and 16 female) to 327 deaths per 100 000 in Latvia (555 men and 167 women)⁽²⁵⁾.

Cancer

The most frequent types of cancer and causes of cancer-related mortality for women are breast cancer, colon and lung cancer, and for men prostate cancer⁽²⁶⁾. The increase of the incidence of lung cancer and mortality in women, compared to the decrease in men, is due to the growing number of smokers among women.

In 2006, 3.2 million new cases and 1.7 million deaths were estimated for all types of cancer all around Europe. The highest incidence rates in 2006 were in western European countries for men (482 new cases per 100 000) and in northern European countries for women (351 new cases per 100 000), while the highest mortality rates were reported in the eastern European Member States for men (287 deaths per 100 000) and in the northern European Member States for women (155 deaths per 100 000)⁽²⁷⁾. The countries with the highest mortality rates for men were Hungary (337.1 deaths per 100 000), Estonia (302.1), Lithuania and Latvia (299.4 and 299.3), and for women Hungary (172.9 deaths per 100 000), Czech Republic (163.1), Ireland (15.89), Poland (154.8) and the Netherlands (145.3)⁽²⁸⁾.

⁽¹⁸⁾ WHO (1999), *Gender and Health in Adolescence*, Health policy for children and adolescents (HEPCA), series No 1. by Kolip, P. and Schmidt, B., Copenhagen, p. 13.

⁽¹⁹⁾ See for instance on health behaviour: European Parliament (2007), *Discrimination against women and young girls in the health sector*, Directorate-General Internal Policies, by the European Institute of Women's Health, Brussels.
<http://www.europarl.europa.eu/sides/getDoc.do?jsessionid=42D62CA22BDD5134ABE684A2B6C616BC.node1?pubRef=-//EP//TEXT+TA+P6-TA-2007-0021+0+DOC+XML+V0//EN>

⁽²⁰⁾ Allender S., Scarborough, P., Peto, V., Rayner, M. (2008), *European cardiovascular disease statistics*, British Heart Foundation Health Promotion Research Group, Oxford.
<http://www.ehnheart.org/files/statistics%202008%20web-161229A.pdf>

⁽²¹⁾ Coronary heart disease (CHD) is a narrowing of the small blood vessels that supply blood and oxygen to the heart. CHD is also called coronary artery disease. Ischaemic heart disease is related to a reduced coronary blood flow, often related to artery diseases, which causes a lack of oxygen. Risk factors are related to smoking, high cholesterol levels, or high blood pressure.

⁽²²⁾ Allender, S., Scarborough, P., Peto, V., Rayner, M. (2008), *European cardiovascular disease statistics*, British Heart Foundation Health Promotion Research Group, Oxford.

⁽²³⁾ The main forms of CVD are coronary heart disease (CHD) and stroke. Just under half of all deaths from CVD are from CHD and nearly a third are from stroke. European Heart Network, *European cardiovascular disease statistics*, 2008 edition, Brussels.

⁽²⁴⁾ Allender, S., Scarborough, P., Peto, V., Rayner, M. (2008), *European cardiovascular disease statistics*, British Heart Foundation Health Promotion Research Group, Oxford.

⁽²⁵⁾ Allender, S., Scarborough, P., Peto, V., Rayner, M. (2008), *European cardiovascular disease statistics*, British Heart Foundation Health Promotion Research Group, Oxford.

⁽²⁶⁾ Curado, M.P. et al. (2008), *Cancer Incidence in Five Continents*, Vol. IX, IARC Scientific Publications No 160, Lyon.

⁽²⁷⁾ Eugloreh (2009), *The Status of Health in the European Union: Towards a healthier Europe, 2009*, EU Public Health Programme project, Global Report on the health status in the European Union.
http://www.intratext.com/ixt/_EXT-rep/_INDEX.HTM#-.1

⁽²⁸⁾ Eurostat data based on national information derived from the medical certificate of cause of death.

Incidence rates are increasing both in men and in women in all the European macro-areas (northern, western, eastern and southern Europe). On the contrary, mortality is decreasing for men (with the exception of the eastern EU countries) and is decreasing or constant for women. The countries with the highest incidence rates were Hungary for men (599 new cases per 100 000) and Denmark for women (414 new cases per 100 000) ⁽²⁹⁾.

Women generally have a better survival rate than men. Countries with 5-year relative survival higher than 40% for men and 55% for women were the northern countries (Finland, Sweden, Iceland and Norway), Austria, France, Germany, the Netherlands, Italy and Spain. Denmark and the UK have lower survival rates than other EU countries with similar GDP, both for men and women. Lower levels of survival were also reported in the eastern European Member States ⁽³⁰⁾.

The prognosis for breast cancer is relatively good, with 5-year relative survival rate exceeding 75% in most countries of western Europe. In Finland, Sweden, France and Italy survival was $\geq 80\%$. England, Scotland, Wales, Denmark, Malta and Portugal had 5-year age-standardised survival of just above 70%. On the contrary, low breast cancer survival was seen in eastern Europe (Estonia, Poland, Slovakia and Slovenia), with 5-year relative survival rate between 60 and 67% ⁽³¹⁾.

Survival after breast cancer has improved steadily in all European countries since the nineties, but at different rates. Improvements were more marked for western Europe than in the Nordic countries (Denmark, Finland, Iceland, Norway and Sweden) where survival rates were already high for patients diagnosed in the 1980s. As a result, the gap between breast cancer survival rates in the Nordic countries and western Europe has greatly narrowed. There is some evidence of a more rapid improvement in survival in the UK, with a gradual reduction of the survival deficit relative to other western European countries. Conversely, improvements in survival were less evident in eastern European countries; actually, the gap between eastern and western European countries has increased.

⁽²⁹⁾ Eugloreh (2009), The Status of Health in the European Union: Towards a healthier Europe, 2009.

⁽³⁰⁾ Eugloreh (2009), The Status of Health in the European Union: Towards a healthier Europe, 2009.

⁽³¹⁾ Eugloreh (2009), The Status of Health in the European Union: Towards a healthier Europe, 2009.

Mental diseases and disorders

The incidence of mental illness, depression and anxiety disorders is higher for women, while alcohol and addiction disorders are more common for men ⁽³²⁾.

There are gender-specific risk factors for some common mental disorders. Women are at much greater risk of experiencing domestic abuse than men; this can lead to high rates of anxiety and depression, symptoms of post-traumatic stress, and subsequent difficulty in establishing and maintaining relationships. Women living in poverty and women from minority groups are at a higher risk for victimisation by violence. Similarly, women living on a low income for an extended period can experience stress, difficulty in personal and family relationships and be left feeling isolated and depressed. Individuals most at risk for social isolation and anxiety are single mothers and retired women living alone ⁽³³⁾. Women's social roles as primary carers for children and/or other dependants can result in 'role overload', where women assume both professional and household/child-bearing responsibilities. This contributes to social isolation and further impacts on mental health. Moreover, women are more likely to approach their primary care physician for help. Men are more likely to seek specialist mental healthcare and are the main users of inpatient care ⁽³⁴⁾.

Women are also more likely to be prescribed mood-altering psychotropic drugs than men ⁽³⁵⁾. This is probably because physicians are more likely to diagnose depression in women than in men, even when they have similar scores on standardised measures of depression, or present identical symptoms ⁽³⁶⁾. There may also be differences in accessing specific treatments such as psychotherapy or anti-depressant ⁽³⁷⁾.

Only cardiovascular disease has a greater toll on morbidity and mortality than depression.

The mortality rate for suicide and intentional self-harm varies considerably between the EU Member States (EU-25 average in 2006 is 16.3 for men and 4.6 for women per 100 000) ⁽³⁸⁾. Eurostat data indicates that

⁽³²⁾ Eugloreh (2009), The Status of Health in the European Union: Towards a healthier Europe, 2009.

⁽³³⁾ Eugloreh (2009), The Status of Health in the European Union: Towards a healthier Europe, 2009.

⁽³⁴⁾ WHO website on Gender and women's mental health.
http://www.who.int/mental_health/prevention/genderwomen/en/

⁽³⁵⁾ WHO (2000), Women's Mental Health — an evidence based review, Geneva.
http://whqlibdoc.who.int/hq/2000/WHO_MSD_MDP_00.1.pdf

⁽³⁶⁾ Eugloreh (2009), The Status of Health in the European Union: Towards a healthier Europe, 2009.

⁽³⁷⁾ WHO website on Gender and women's mental health.
http://www.who.int/mental_health/prevention/genderwomen/en/

⁽³⁸⁾ Eurostat data based on information derived from the medical certificate of cause of death of each country.

the highest mortality rates for suicide and intentional self-harm among the Member States is found in Lithuania (men 52.7 and women 9.3), Hungary (men 36.5 and women 9.3), Latvia (men 36.6 and women 5.1), Slovenia (men 38.2 and women 9.2) and Finland (29.4 and 8.9). Respectively, the lowest rates were observed in Cyprus (3.1 and 1.8), Greece (5.1 and 1.1), Malta (10 and 2.2), Italy (8.3 and 2.3) and Spain (10 and 2.8), and for women also in Slovakia (2.3)⁽³⁹⁾. As regards gender, in both the 15–64 and 65+ age groups, women in all countries have much lower suicide mortality rates compared to men⁽⁴⁰⁾.

Sexually transmitted diseases and HIV infection

Women (especially very young women) are more vulnerable to sexually transmitted diseases compared to men and the consequences are more serious for them⁽⁴¹⁾. Since many sexually transmitted diseases are asymptomatic in women, they often go untreated and the presence of untreated sexually transmitted diseases is a risk factor for HIV.

In Europe every year there are about 25 000 newly diagnosed cases of HIV and heterosexual transmission is responsible for 50% of the cases⁽⁴²⁾. Over a third of the cases (36%) of HIV infection were registered in women (2005)⁽⁴³⁾. Some 13% of the cases were in young people between 15–24 years of age. Women are more likely to be at risk of HIV infections due to biological reasons⁽⁴⁴⁾ than men, but in some countries also due to their unequal economic, social or cultural

status⁽⁴⁵⁾. Women are often more unaware of the risks of HIV infection, do not have information on the ways to protect themselves (and methods of contraception), and might lack access to methods of contraception, prevention and care services. In Europe, over 41% of the population still does not take precautions during sexual intercourse⁽⁴⁶⁾. The groups with the highest risk are people with limited social standing or economic security, or those who are involved in coercive or abusive relationships⁽⁴⁷⁾.

Smoking and alcohol consumption

Smoking and alcohol consumption are widely dispersed in European countries and are among the major causes of death. Smoking is the single largest cause of avoidable death, and every year about 650 000 people die from it. Nearly 25% of cancer deaths and 15% of all deaths are related to tobacco-related diseases, such as lung cancer and other specific diseases. Approximately one third of EU citizens smoke, and one fifth of people aged 15–25 smoke every day⁽⁴⁸⁾.

The number of smokers has decreased over the last five years (by nearly 10%), but gender differences persist: it has decreased among men, but increased among women; however, women still smoke less frequently than men, starting in adolescence.

In some countries, prevalence rates among girls are higher than for boys (Denmark, Germany, and Spain)⁽⁴⁹⁾. Girls are more likely than boys to start and continue smoking because they think that it might control weight gain. Smoking may have particularly adverse effects on girls' future health, as it may interact with oral contraceptives and this is thought to increase the risk of cardiovascular disease and affect reproductive health.

⁽³⁹⁾ Eurostat data based on national information derived from the medical certificate of cause of death.

⁽⁴⁰⁾ Eugloreh (2009), The Status of Health in the European Union: Towards a healthier Europe, 2009, EU Public Health Programme project, Global Report on the health status in the European Union.

⁽⁴¹⁾ European Parliament (2007), Discrimination against women and young girls in the health sector, Directorate-General Internal Policies, by the European Institute of Women's Health, Brussels. <http://www.europarl.europa.eu/sides/getDoc.do?jsessionid=42D62CA22BDD5134ABE684A2B6C616BC.node1?pubRef=-//EP//TEXT+TA+P6-TA-2007-0021+0+DOC+XML+V0//EN>

⁽⁴²⁾ European Commission (2007), Healthier together in the European Union, Luxembourg.

⁽⁴³⁾ EuroHIV (2006), HIV/AIDS Surveillance in Europe, End-Year report 2005, No 73, European Centre for the Epidemiological Monitoring of HIV/AIDS WHO and UN AIDS Collaborating Centre on HIV/AIDS, Saint-Maurice. http://www.eurohiv.org/reports/report_72/pdf/report_eurohiv_72.pdf

⁽⁴⁴⁾ Women are more likely to get HIV during vaginal intercourse for several biological reasons: 1. the lining of the vagina provides a large area, which can be exposed to HIV-infected semen; 2. semen has higher levels of HIV than vaginal fluids do; 3. more semen is exchanged during sexual intercourse than vaginal fluids; 4. having untreated sexually transmitted infections (STIs) makes it more likely for women to get HIV. <http://www.womenshealth.gov>

⁽⁴⁵⁾ European Parliament (2007), Discrimination against women and young girls in the health sector, Directorate-General Internal Policies, by the European Institute of Women's Health, Brussels. <http://www.europarl.europa.eu/sides/getDoc.do?jsessionid=42D62CA22BDD5134ABE684A2B6C616BC.node1?pubRef=-//EP//TEXT+TA+P6-TA-2007-0021+0+DOC+XML+V0//EN>

⁽⁴⁶⁾ European Commission (2007), Healthier together in the European Union, Luxembourg.

⁽⁴⁷⁾ Eugloreh (2009), The Status of Health in the European Union: Towards a healthier Europe, 2009, EU Public Health Programme project, Global Report on the health status in the European Union.

⁽⁴⁸⁾ European Commission (2007), Healthier together in the European Union, Luxembourg.

⁽⁴⁹⁾ European Parliament (2007), Discrimination against women and young girls in the health sector, Directorate-General Internal Policies, by the European Institute of Women's Health, Brussels. <http://www.europarl.europa.eu/sides/getDoc.do?jsessionid=42D62CA22BDD5134ABE684A2B6C616BC.node1?pubRef=-//EP//TEXT+TA+P6-TA-2007-0021+0+DOC+XML+V0//EN>

There is a strong association between educational level and rate of decline in the prevalence of smoking: smoking is declining only among more highly educated women, and increasing among lower-educated women, who also tend to be more addicted⁽⁵⁰⁾. This trend is likely to create (in southern Europe) or further widen (in northern Europe) the gap in smoking between higher and lower-educated women. In the EU-10 countries, the number of regular smokers is higher than the EU-15 level⁽⁵¹⁾.

Alcohol consumption is a more complex health-risk factor. It is estimated that more than 55 million adults drink at harmful levels. Younger population groups are at high risk, also due to social reasons (such as acceptance by peers). Harmful consumption of alcohol is responsible for approximately 195 000 deaths in the EU, related to liver damage, heart disease, mouth and throat cancer, as well as traffic accidents. This is especially the case in younger age groups, usually prevalent in (young) men: among men aged 15–29, more than one death in four is caused by alcohol, while this figure is one in 10 for women⁽⁵²⁾. It is possible, however, that women are under-represented in the statistics on alcohol abuse, because they feel more stigmatised by alcohol-related problems and do not respond to survey questions.

The consumption pattern also shows differences according to income groups. Eurobarometer data suggests that in lower income groups, excessive alcohol consumption is more frequent in men in all countries, while for women it may vary according to the country. Excessive alcohol consumption is also a problem in some Nordic countries (such as Denmark and Finland) and Ireland, the UK and Austria, and in several eastern European countries (such as Lithuania, Latvia) and Greece⁽⁵³⁾.

Work-related diseases and work accidents

There is very little research and awareness of gender differences in work-related diseases. The still strong occupational gender segregation in the European labour market, however, means that women and men are exposed to different work-related health risks, and this is still little recognised in the European and national approaches to occupational safety and health.

Eurostat data indicates that serious accidents and fatal accidents at work have decreased in most of the European countries⁽⁵⁴⁾. In general, men are more exposed to work-related (serious) accidents and injuries than women, because men predominate in sectors where job-related risks/hazards are higher and do more full-time work. In addition, in all countries, men are much more prone to fatal accidents than women⁽⁵⁵⁾.

Work-related diseases more common in women are asthma and allergies. Women also suffer more skin diseases and are more exposed to infectious diseases, particularly in the care and education sectors⁽⁵⁶⁾. Given the prevalence of women working at home, more women are affected by accidents at home than men.

1.4. Gender differences in mortality rates

Differences in mortality rates exist between men and women not only with respect to different diseases (as it is shown in paragraph 1.3.), but also with respect to infant mortality, maternal mortality and deaths due to external causes and accidents.

⁽⁵⁰⁾ European Parliament (2007), Discrimination against women and young girls in the health sector, Directorate-General Internal Policies, by the European Institute of Women's Health, Brussels. <http://www.europarl.europa.eu/sides/getDoc.do?sessionId=42D62CA22BDD5134ABE684A2B6C616BC.node1?pubRef=-//EP//TEXT+TA+P6-TA-2007-0021+0+DOC+XML+V0//EN>

⁽⁵¹⁾ Mackenbach, J.P., et al. (2008), Socioeconomic Inequalities in Health in 22 European Countries, Special Article for the European Union Working Group on Socioeconomic Inequalities in Health, New England Journal of Medicine, June 5, 2008. <http://content.nejm.org/cgi/reprint/358/23/2468.pdf>

⁽⁵²⁾ European Commission (2007), Healthier together in the European Union, Luxembourg European Commission (2007), Healthier together in the European Union, Luxembourg.

⁽⁵³⁾ European Commission (2007), Health and long-term care in the European Union, Special Eurobarometer, 283. http://ec.europa.eu/public_opinion/archives/ebs/ebs_283_en.pdf

⁽⁵⁴⁾ This refers to accidents resulting in more than 3 days of absence and fatal accidents at work. Available data from Eurostat refers to 1994–2002. Source: Eurostat (2004), Serious and fatal accidents at work decreasing in the EU.

http://epp.eurostat.ec.europa.eu/cache/ITY_PUBLIC/3-28042004-AP/EN/3-28042004-AP-EN.HTML

⁽⁵⁵⁾ Eurostat data for 2005 on the incidence rate per 100 000 workers of occupational disease indicates that 59.4 women and 94.2 men are affected (Data refer to the countries Belgium, Denmark, Spain, Italy, Luxembourg, the Netherlands, Austria, Portugal, Finland, Sweden and the United Kingdom, and includes occupational diseases and occupational death related to occupational disease). Source: Eurostat data based on the European Occupational Diseases Statistics (EODS).

http://epp.eurostat.ec.europa.eu/portal/page/portal/product_details/dataset?p_product_code=HSW_OD_NDSA

⁽⁵⁶⁾ European Agency for Safety and Health at Work (2003), Gender issues in safety and health at work, A review, Luxembourg, 2003. Fagan, C., Burchell, B. (2002), Gender, jobs and working conditions in the European Union, European Foundation for the Improvement of Living and Working Conditions, Dublin.

<http://www.eurofound.europa.eu/pubdocs/2002/49/en/1/ef0249en.pdf>

Infant and adolescent mortality

Gender differences in mortality rates occur from childhood onwards. The infant mortality rate is higher for boys in all EU countries apart from Ireland, Cyprus and Luxembourg. The proportion of deaths in the EU-27 among babies in their first year was 4.8 per 1 000 live births for boys and 3.9 per 1 000 live births for girls (2004)⁽⁵⁷⁾.

Deaths among boys aged 5–14 are slightly more frequent than among girls in most EU-27 Member States, with 14 deaths per 100 000 for boys relative to 11 per 100 000 for girls in the EU in 2005. Only in Cyprus, Iceland, Malta and Slovenia are the mortality rates for girls slightly higher than for boys. Apart from Bulgaria, Cyprus, Latvia, Lithuania and Romania, the mortality rate for boys was under 30 per 100 000 in the EU Member States⁽⁵⁸⁾.

Deaths among young men increase above the age of 20: the mortality rate of young men in the 20–24 age group is at least 2.5 times higher than the rate for women in all EU-25 countries, except the Netherlands and Sweden, and it is more than four times higher in Poland and Malta (in Poland because of a higher rate for men and in Malta because of a lower rate for women

than anywhere else) and five times higher in Lithuania (because of a higher rate for men)⁽⁵⁹⁾.

Maternal mortality

The average maternal mortality ratio in the EU has declined from about 20 maternal deaths per 100 000 live births in the early 1980s to 7 deaths per 100 000 in 2004⁽⁶⁰⁾.

The most significant decline has been observed in Romania, which had the highest ratio in Europe, between 140 and 160 per 100 000 in the 1980s. According to the EGGSI national report, after the liberalisation of abortion⁽⁶¹⁾, the ratio declined to 26 per 100 000 in the 2002–04 period, still the highest among the EU Member States. The three Baltic countries also had relatively high ratios in the 1990s, but their ratios have declined (especially in Latvia and Lithuania).

Data reported in Table 1-3 show an increasing trend towards higher rates of caesarean sections in EU-25 and Norway. Caesarean delivery is associated with increased morbidity among mothers and requires longer and more costly lengths of hospital stay⁽⁶²⁾. These data also illustrate the large variation between EU countries in the use of caesarean sections, which ranges from about 150 per 1 000 live births to 300 per 1 000 live births.

⁽⁵⁷⁾ Data presented in Euro-Peristat (2008), European Perinatal Health Report, Project coordinated by the Assistance Publique-Hôpitaux de Paris (AP-HP) and the Institut de la santé et de la recherche médicale (Inserm).
<http://www.europeristat.com/publications/european-perinatal-health-report.shtml>

⁽⁵⁸⁾ Eurostat (2008), The life of women and men in Europe — A statistical portrait, Luxembourg. http://epp.eurostat.ec.europa.eu/portal/page?_pageid=1073,46587259&_dad=portal&_schema=PORTAL&p_product_code=KS-80-07-135

⁽⁵⁹⁾ Eurostat (2009), Health statistics — Atlas on mortality in the European Union, Luxembourg.

http://epp.eurostat.ec.europa.eu/cache/ITY_OFFPUB/KS-30-08-357/EN/KS-30-08-357-EN.PDF

⁽⁶⁰⁾ Euro-Peristat (2008), European Perinatal Health Report, Project coordinated by the Assistance Publique-Hôpitaux de Paris (AP-HP) and the Institut de la santé et de la recherche médicale (Inserm).

⁽⁶¹⁾ European Observatory on Health Systems and Policies (2008), Healthcare systems in transition, Vol. 10, No 3, Romania Health System Review.

⁽⁶²⁾ Deneux-Tharoux, C., Carmona, E., Bouvier-Colle, M.-H., Bréart, G. (2006), Post partum mortality and Caesarean delivery, *Obstet Gynecol.* No 108, pp. 541–548.

Table 1-3 — Distribution of maternal deaths according to obstetric causes (in %) by country, in 2003–04

Country/Region	No of deaths	Amniotic fluid embolism	Other thromboembolism	Complications of hypertension	Haemorrhage	Sepsis chorioamnionitis	Ectopic abortion	Anaesthetic	Uterine rupture	Other direct obstetric causes	Other indirect obstetric causes	Unknown	Total
Belgium													
Flanders	5	0.0	0.0	20.0	0.0	20.0	0.0	0.0	0.0	0.0	20.0	40.0	100
Brussels	2	50.0	0.0	0.0	50.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100
Czech Republic	19	15.8	21.1	0.0	10.5	5.3	0.0	0.0	5.3	15.8	21.1	5.3	100
Denmark													
Germany	43	4.7	7.0	2.3	7.0	0.0	0.0	0.0	0.0	16.3	16.3	46.5	100
Estonia	8	12.5	12.5	0.0	25.0	12.5	0.0	0.0	0.0	37.5	0.0	0.0	100
Ireland													
Greece													
Spain													
Valencia	4	0.0	0.0	25.0	0.0	50.0	0.0	0.0	0.0	25.0	0.0	0.0	100
France	107	14.0	14.0	14.0	17.8	2.8	8.4	0.9	0.9	15.0	8.4	3.7	100
Italy	17	5.9	5.9	5.9	17.6	11.8	5.9	5.9	23.5	5.9	5.9	5.9	100
Cyprus													
Latvia	5	20.0	20.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	60.0	0.0	100
Lithuania	6	0.0	16.7	16.7	0.0	0.0	0.0	0.0	16.7	50.0	0.0	0.0	100
Luxembourg													
Hungary	14	0.0	14.3	0.0	14.3	35.7	0.0	0.0	0.0	0.0	28.6	7.1	100
Malta	0												
Netherlands	32	0.0	12.5	12.5	9.4	9.4	0.0	0.0	0.0	3.1	34.4	18.8	100
Austria	10	10.0	10.0	20.0	0.0	0.0	0.0	0.0	0.0	10.0	50.0	0.0	100
Poland	31	12.9	3.2	6.5	38.7	9.7	12.9	0.0	0.0	16.1	NA	0.0	100
Portugal													
Slovenia	4	0.0	25.0	0.0	50.0	0.0	0.0	0.0	0.0	0.0	25.0	0.0	100
Slovakia													
Finland	9	11.1	0.0	11.1	11.1	0.0	0.0	11.1	11.1	22.2	22.2	0.0	100
Sweden													
United Kingdom	108	13.9	8.3	9.3	5.6	5.6	9.3	0.9	0.0	25.0	22.2	0.0	100
Norway													
Total of data provided to Europeristat	425	10.6	10.4	9.2	13.2	6.4	5.6	0.9	1.9	16.7	16.9	8.2	100

Source: Euro-Peristat (2008), European Perinatal Health Report, Project coordinated by the Assistance Publique-Hôpitaux de Paris (AP-HP) and the Institut de la santé et de la recherche médicale (Inserm), p. 101.

Explanatory note: Countries were asked to report the number of deaths that corresponded to the ICD-10 codes for the following causes: amniotic fluid embolism, other thromboembolic causes, hypertension, haemorrhage, chorioamnionitis/sepsis, abortion/ectopic pregnancy, anaesthesia, uterine rupture, other direct causes, indirect causes, or unknown cause. The availability of the data generally depends on what information is written on death certificates and how this is coded by the national statistics office responsible for processing data from death certificates. A maternal death is usually the consequence of a series of unexpected obstetric complications and possibly also adverse social circumstances which in combination lead to the death of a woman who is generally young and in good health. As a result, the choice of the underlying cause and therefore its coding (attribution of the appropriate digit code of the ICD) is not easy and differs from one country to another.

N.B.: Data for Ireland, Denmark, Greece, Cyprus, Portugal, Luxembourg, Sweden, Norway are not available.

Deaths due to external causes and accidents

In the EU-27 external causes of death are relevant for 6.9% of men and 3.5% of women, of which two thirds are caused by unintentional injuries⁽⁶³⁾. Among deaths due to external causes versus illnesses/diseases, more men than women die from accidents (such as road or transport accidents) or non-illness related causes (such as suicide or self-inflicted injuries). This incidence, however, varies by country.

Table 1-4 — Death due to accidents and transport accidents by sex in some European countries and Iceland and Norway, 2006 (*)

	Accidents		Transport accidents	
	men	women	men	women
Bulgaria	48.5	13.0	19.7	6.6
Czech Republic	48.6	18.0	15.5	4.5
Germany	24.0	10.7	9.4	3.0
Estonia	130.8	28.8	28.2	7.1
Ireland	25.8	10.8	9.9	3.1
Greece	43.2	10.1	24.4	5.1
Spain	33.1	10.7	15.0	4.0
Italy	32.0	12.3	15.8	3.8
Cyprus	39.9	17.6	18.5	3.6
Latvia	162.3	39.4	30	8.1
Lithuania	169.6	41.5	40.1	12.6
Hungary	63.0	19.7	24.7	5.9
Malta	22.5	13.0	4.4	0.6
Netherlands	20.2	10.9	6.7	2.5
Austria	35.2	13.2	12.7	3.9
Poland	60.9	17.1	21.9	5.8
Portugal	29.9	8.3	15.8	3.8
Romania	64.4	18.9	23.8	7.1
Slovenia	57.1	18.5	23.0	4.4
Slovakia	63.7	14.3	23.5	5.7
Finland	70.7	23.4	12.4	3.3
Sweden	30.2	12.1	8.1	2.6
Iceland	39.8	19.0	17.5	8.2
Norway	39.7	18.2	8.7	2.7

(*) Standardised death rate by 100 000 inhabitants

Source: Eurostat data based on EU-SILC survey

Explanatory note: The (age-) standardised death rate is a weighted average of age-specific mortality rates. The weighting factor is the age distribution of a standard reference population. The standard reference population used is the European standard population as defined by the World Health Organisation (WHO). As method for standardisation, the direct method is applied. Standardised death rates are calculated for the age group 0–64 ('premature death') and for the total of ages. As most causes of death vary significantly with people's age and sex, the use of standardised death rates improves comparability over time and between countries.

⁽⁶³⁾ Eurostat (2009), Health statistics — Atlas on mortality in the European Union.
http://epp.eurostat.ec.europa.eu/cache/ITY_OFFPUB/KS-30-08-357/EN/KS-30-08-357-EN.PDF

Transport accidents, especially road traffic accidents, are the major cause of death of young people and especially young men. Young men in the 15–19 and 20–24 age groups have much higher mortality due to external causes than women of the same age groups in all European countries. This tendency also remains in the older age groups⁽⁶⁴⁾. When compared to women, well over twice as many men among those aged 65–74 die from external causes — around 92 per 100 000 against 37. In both cases, some 18% were killed in road or other transport accidents. Although these figures vary substantially between Member States, in all of them men in all ages were much more likely to be involved in fatal accidents than women.

1.5. The impact of income and social inequalities on gender differences in health status

Education and income levels are relevant factors in influencing a person's health status and access to healthcare. According to a study by Menvielle, men and women with less education have higher death rates from all types of cancer, except for breast cancer where a higher mortality is generally observed among more-educated women⁽⁶⁵⁾.

In all countries with available data, mortality due to cardiovascular disease is higher among men and women with lower socioeconomic positions⁽⁶⁶⁾. This does not, however, apply to all specific diseases of the cardiovascular system. Of these, ischaemic heart disease (myocardial infarction) and cerebro-vascular disease (stroke) are the most important. Whereas mortality from stroke is always higher in the lower socioeconomic groups, this is not the case for ischaemic heart disease.

Deaths caused by cancer also show inequalities among different socioeconomic groups, but the differences are less marked than for cardiovascular disease. Among men, lung, larynx, oropharyngeal, oesophageal, and stomach cancers occur more frequently in lower socioeconomic groups. Among women, this applies to oesophageal, stomach and cervical cancer⁽⁶⁷⁾.

⁽⁶⁴⁾ Eurostat (2008), The life of women and men in Europe, A statistical portrait, Luxembourg.

⁽⁶⁵⁾ See among others: Menvielle, G., et al. (2008), Educational differences in cancer mortality among women and men: a gender pattern that differs across Europe, *British Journal of Cancer* (2008) 98: 1012–1019.

⁽⁶⁶⁾ Cfr. among others Mackenbach, J.P., et al. (2008), Socioeconomic Inequalities in Health in 22 European Countries, Special Article for the European Union Working Group on Socioeconomic Inequalities in Health, *New England Journal of Medicine*, June 5, 2008.
<http://content.nejm.org/cgi/reprint/358/23/2468.pdf>

⁽⁶⁷⁾ Menvielle, G, et al. (2008), Educational differences in cancer mortality among women and men: a gender pattern that differs across Europe, *British Journal of Cancer*, 98(5): 1012–1019.

On the other hand, some cancers have a higher incidence in higher socioeconomic groups: colon and brain cancer and skin melanoma in men, and colon, breast and ovary cancer and skin melanoma in women⁽⁶⁸⁾. In terms of cancer prevalence, there are no differences among social classes. But lower socioeconomic classes present shorter survival rates. Actually there is extensive evidence for socioeconomic inequalities in cancer survival: most studies show a survival advantage in patients with a higher socioeconomic position.

Risk groups for suicide are above all people with mental disorders, including substance use disorders. 90% of suicides are associated with mental disorders, mostly with mood disorders like depression (60% of suicides) but also with alcohol-use disorders⁽⁶⁹⁾. Risk groups also include those persons with severe somatic illnesses, the socially disadvantaged, those suffering from recent loss (i.e. persons who lost a family member, or a job), and immigrants⁽⁷⁰⁾.

As a result of the higher frequency of physical and mental health problems in lower socioeconomic groups, the prevalence of limitations in functioning ('daily activities') and various forms of disability also tend to be higher.

Socioeconomic factors explain low-health status, with some disadvantages for men (accidents, disability rates) or for women (self-perceived health status). In Greece, Hungary, Lithuania, Poland and Cyprus, the probability of perceiving unmet medical needs because they are

'too expensive' is more than twice as high compared to the EU-27⁽⁷¹⁾.

Figure 1-2, taken from a recent comparative study, shows the relative inequalities in the death rate from all causes according to education level (which is strongly correlated with income level) in a study carried out in 22 Member States⁽⁷²⁾. The relative inequality index⁽⁷³⁾ is greater than 1 for both men and women in all countries, indicating that throughout Europe mortality is higher among those with less education. The magnitude of these inequalities varies substantially among countries. For example, in Sweden, the relative index of inequality for men is less than 2, indicating that mortality among those with a lower level of education is less than twice that among those with the highest education; on the other hand, in Hungary, the Czech Republic and Poland, the relative index of inequality for men is 4 or higher, indicating that mortality differs by a factor of more than 4 between the lower and upper ends of the education scale.

Figure 1-3 shows the relative inequalities in the prevalence of poorer, self-assessed health (weighted on the basis of the burden of chronic disease⁽⁷⁴⁾), according to education and income levels. The relative index of inequality is greater than 1 in all countries, indicating worse perceived health in groups of lower socioeconomic status in the countries studied. The variation of this measure among countries is considerably less than that of inequalities in the rate of death from all causes, and the international pattern also tends to be different from that of death from any cause.

⁽⁶⁸⁾ Mackenbach, J. (2006), *Health Inequalities: Europe in Profile*, Rotterdam.

http://ec.europa.eu/health/ph_determinants/socio_economics/documents/ev_060302_rd06_en.pdf

⁽⁶⁹⁾ Wahlbeck, K., Makinen, M. (eds.) (2008), *Prevention of depression and suicide*, Consensus paper, Luxembourg.

http://ec.europa.eu/health/ph_determinants/life_style_mental/docs/consensus_depression_en.pdf

⁽⁷⁰⁾ Several studies have shown, that immigrants have a higher risk in suicide relative to people of their countries of origin and relative to the native population of the host country. See for instance Hjern, A., Allebeck, P. (2002), *Suicide in first- and second-generation immigrants in Sweden — A comparative study*, In: *Soc Psychiatry Psychiatr Epidemiol* (2002) 37: 423–429. <http://www.springerlink.com/content/7w74l3xwtx7m3w8a/fulltext.pdf?page=1>

⁽⁷¹⁾ Eurostat (2009), *Perception of health and access to healthcare in the EU-25 in 2007*, by Baert, K. and de Norre, B., *Statistics in Focus*, No 24/2009, Luxembourg.

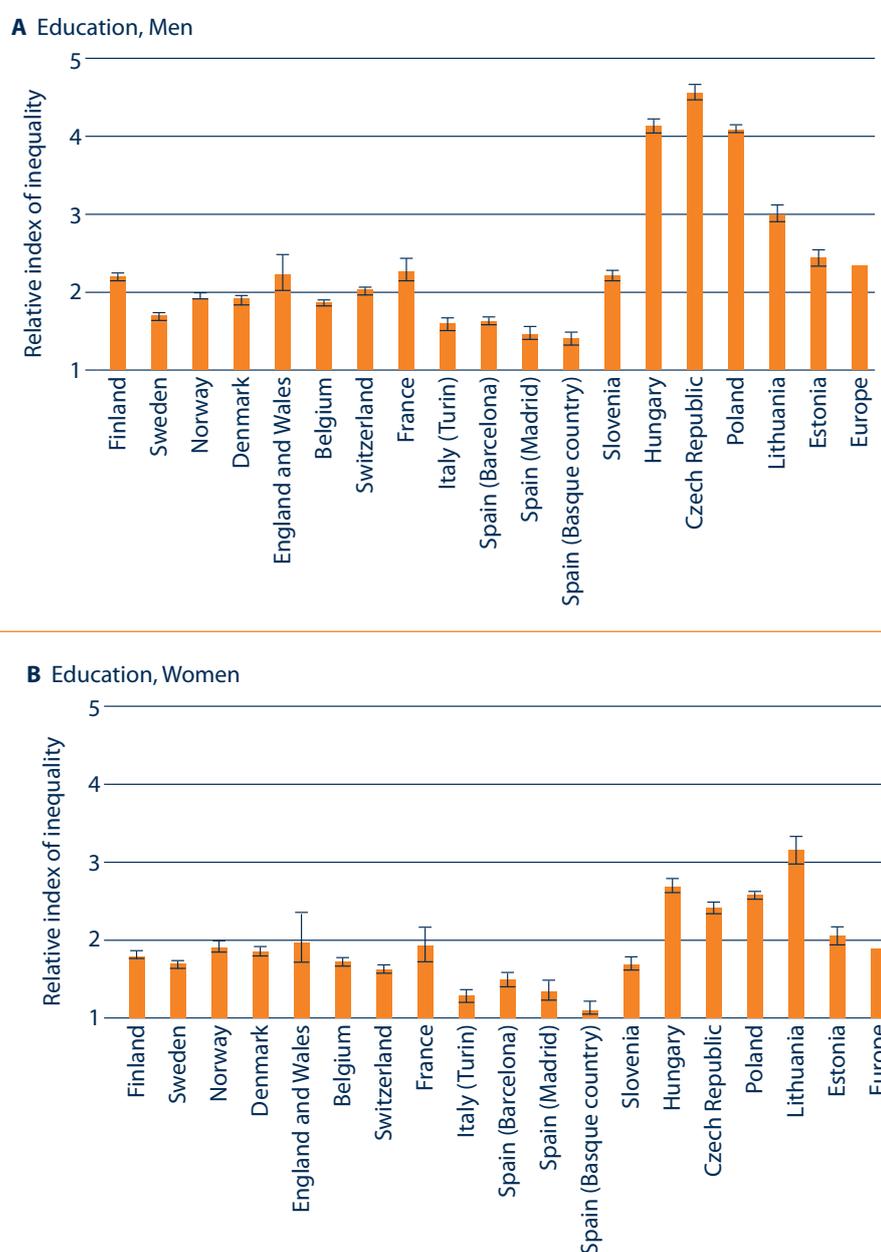
http://epp.eurostat.ec.europa.eu/cache/ITY_OFFPUB/KS-SF-09-024/EN/KS-SF-09-024-EN.PDF

⁽⁷²⁾ Mackenbach, J.P., et al. (2008), *Socioeconomic Inequalities in Health in 22 European Countries*, Special Article for the European Union Working Group on Socioeconomic Inequalities in Health, *New England Journal of Medicine*, June 5, 2008.

⁽⁷³⁾ The relative index of inequality is the ratio between the value (mortality, self-perceived health, obesity, etc.) among individuals at rank 1 (the lowest education or income level) and rank 0 (the highest level). Therefore an index equal to 1 means equality; while an index higher than 1 means inequality.

⁽⁷⁴⁾ e.g. all cancers, all cardiovascular, ischaemic heart and cerebrovascular diseases, chronic obstructive pulmonary disease.

Figure 1-2 — Relative inequalities in the rate of death from any cause for men and women, in 16 European countries⁽⁷⁵⁾

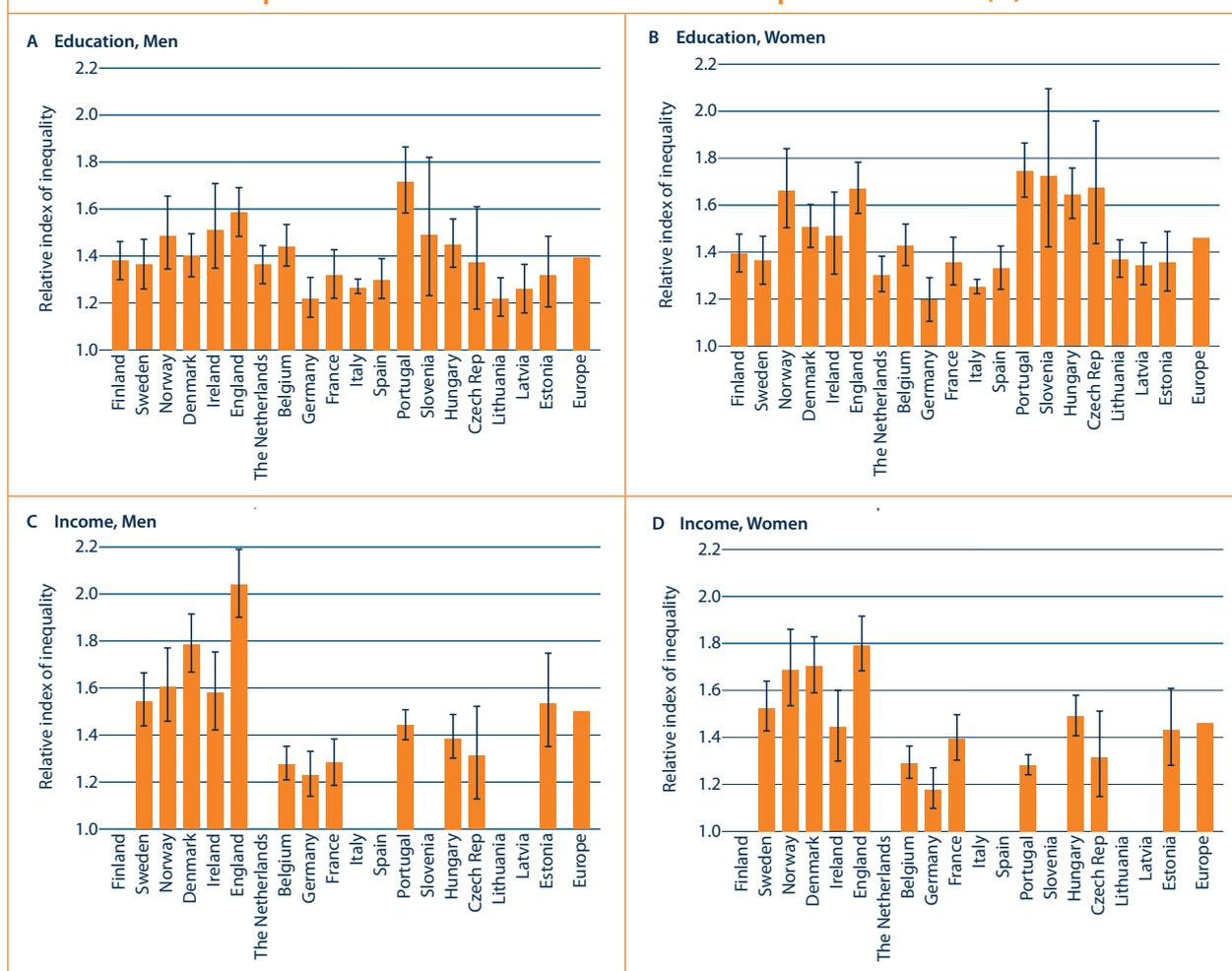


Source: Mackenbach, J.P., et al. (2008), *Socioeconomic Inequalities in Health in 22 European Countries*, Special Article for the European Union Working Group on Socioeconomic Inequalities in Health, *New England Journal of Medicine*, June 5, 2008, p. 2473.

Explanatory note: Panel A shows inequalities between men with the lowest level of education and those with the highest, and Panel B shows education-related inequalities for women. Economically inactive men whose last occupation was unknown were excluded from the analysis. Because exclusion of these men may lead to underestimation of mortality differences between occupational classes, an adjustment procedure was applied that was developed and tested in a previous European comparative study of inequalities in mortality; the procedure is based on national estimates of the proportion of economically inactive men in each occupational class and of the mortality rate ratio of inactive as compared with active men in each occupational class. 'Europe' refers to the 16 countries presented in the figure.

⁽⁷⁵⁾ The year of reference is different for the countries. See: Mackenbach, J.P., et al. (2008), *Socioeconomic Inequalities in Health in 22 European Countries*, Special Article for the European Union Working Group on Socioeconomic Inequalities in Health, *New England Journal of Medicine*, June 5, 2008, p. 247.

Figure 1-3 — Relative inequalities in the prevalence of poorer self-assessed health in 19 European countries⁽⁷⁶⁾



Source: Mackenbach, J.P., et al. (2008), Socioeconomic Inequalities in Health in 22 European Countries, Special Article for the European Union Working Group on Socioeconomic Inequalities in Health, New England Journal of Medicine, June 5.

Explanatory note: Panels A and B show inequalities between persons with the lowest and those with the highest level of education for men and women, respectively. Panels C and D show inequalities between persons with the lowest and those with the highest level of income for men and women, respectively. In order to make use of the full range of levels of self-assessed health, the burden of disease associated with each level was estimated on the basis of the number of chronic conditions reported by respondents to these surveys. Relative differences in self-reported chronic conditions between answer categories of the self-assessed health question were remarkably similar between countries and varied only marginally around a multiplicative factor of 1.85 (i.e. each step down on the self-assessed health scale was found to be associated with 1.85 times more chronic conditions). On the basis of this analysis, a weight for burden of disease was assigned to each category of answer to the question, 'How is your health in general?' 'Very good' was assigned a weight of $1.850 = 1$, 'good' a weight of $1.851 = 1.85$, 'fair' a weight of $1.852 = 3.42$, and 'poor' or 'very poor' a weight of $1.853 = 6.33$. Sensitivity analyses showed that the ranking of countries according to the magnitude of inequalities in self-assessed health did not change when these weights were varied within the range of observed values. 'Europe' refers to the 19 countries presented in the figure.

In Europe as a whole, both smoking and obesity are more common among people of lower education levels; education-related inequalities in smoking are greater among men, and education-related inequalities in obesity are greater among women (Figure 1-4). There are striking differences between countries in the magnitude and even the direction of these inequalities, however. Striking education-related inequalities in smoking are seen in the northern, western, and continental European

countries; small inequalities (among women even reverse inequalities, in which smoking rates are higher in groups with more education) are seen in the southern countries. In the eastern European countries, the pattern is unclear. Great education-related inequalities in obesity are seen in the southern region, particularly among women, for whom the relative indexes of inequality are above 4, indicating that the prevalence of obesity among those with the least education is more than four times higher

⁽⁷⁶⁾ The year of reference is different for the countries.

Figure 1-4 — Relative inequalities in the prevalence of current smoking (Panel A) and obesity (Panel B) between persons with the lowest and those with the highest level of education, according to sex, in 18 EU countries and Norway⁽⁷⁷⁾



Source: Mackenbach, J.P., et al. (2008), Socioeconomic Inequalities in Health in 22 European Countries, Special Article for the European Union Working Group on Socioeconomic Inequalities in Health, New England Journal of Medicine, June 5.

Explanatory note: Relative inequalities in the prevalence of current smoking (Panel A) and obesity (Panel B) between persons with the lowest and those with the highest level of education, according to sex. 'Europe' refers to the 19 countries presented in the figure.

than that among those with the most education. By contrast, education-related inequalities in obesity tend to be below average in the eastern European countries.

The correlation between the health status of the population and economic and social conditions is particularly evident when considering the eastern European countries. In general, living and health conditions in eastern European countries are below

the EU-25 average and have been worsening in the nineties (see Box 1.1), as they present lower levels of GDP and lower investments in the healthcare system. To improve access to and quality of health services, it is essential to improve accountability in healthcare, in these countries, which inherited a good network of health services, and where the erosion in access that had been observed during the 1990s has been only partially reversed⁽⁷⁸⁾.

⁽⁷⁷⁾ The year of reference is different for the countries. See: Mackenbach, J.P., et al. (2008), Socioeconomic Inequalities in Health in 22 European Countries, Special Article for the European Union Working Group on Socioeconomic Inequalities in Health, New England Journal of Medicine, June 5, 2008.

⁽⁷⁸⁾ Asad, A., Murthi, M., Yemtsov, R, et al. (2005), Growth, poverty, and inequality: eastern Europe and the former Soviet Union, The World Bank, Washington, DC.

Box 1-1 — Health status in eastern European countries

Eurostat data on health show that eastern Europe reports lower levels of health and substantial gender differences.

Indeed, the negative impact on life expectancy during the economic transition from a planned to a market economy is visible for some countries (e.g. Bulgaria, Estonia, Lithuania, Romania, and Latvia), where a temporary decline in life expectancy was seen between 1986 and 1996. In general, these countries now show important improvements with the exception of Latvia and Lithuania for men, where life expectancy is still below the 1986 level⁽⁷⁹⁾.

For instance, in Estonia, the life expectancy is far below the EU average, with a gender gap of over 11 years, and there has been no improvement since 1990. In the 5–19 and 20–44 age groups, men lose three times as many life years as women. As for the causes of death, the largest gender differences concern suicide, accidents and transport accidents, as over four times more men die due to these reasons as compared to women. Standardised death rates are also three times higher for men in case of pneumonia, alcohol abuse, AIDS and homicide compared to women⁽⁸⁰⁾.

Among eastern European countries, Poland is in the best position, with life expectancy very close to the EU average, with similar patterns of mortality and morbidity and rather low alcohol consumption and smoking rates.

Mortality rates are also high in these countries relative to the EU-27 average.

Data on socioeconomic inequalities in relation to mortality by cause of death are much more available for western than for eastern Europe. The few data for eastern EU countries that do exist, however, show that mortality due to cardiovascular disease is higher in the lower socioeconomic groups there as well. This has been shown for a range of countries including the Czech Republic, Hungary and Estonia. Cardiovascular disease is also one of the main causes for the increasing inequalities in the total mortality rates in many eastern European countries.

In Hungary the mortality rate caused by lung cancer in men is the highest in the world⁽⁸¹⁾.

In Bulgaria the mortality rate has increased over the last two decades (14.8 per 1 000, the highest value

in the EU-27)⁽⁸²⁾. Mortality is still higher among men (16.1 % than women (13.5 %), and is higher in rural areas (20.7 % than in towns (12.3 %). Maternal mortality at birth was four times higher than in the EU-15 in 2000 and has varied during the last 15 years. It is higher in villages (25.5 %) than in towns (16.5 %) due to the 'low level of care at pregnancy and the lack of qualified help at birth for particular groups of women from ethnic minorities'⁽⁸³⁾.

According to the EGGSI national report, in Romania maternal mortality was very high in the 1970s and 1980s, mainly due to the ban on abortions. Since abortion became legal, the maternal mortality rate has continuously decreased, but is still very high (15.5 per 100 000 live births in 2006)⁽⁸⁴⁾. This can be mainly attributed to abortions not performed in medical facilities and for obstetrical reasons. However there are significant ethnic and social class differences in both maternal and infant/child mortality rates and households headed by women are often at greatest risk.

Also, lifestyle appears to be less healthy in these countries. For example:

In Slovenia alcohol consumption is culturally accepted and very common: 87 % of people drank alcohol in the last 12 months (data for 2004)⁽⁸⁵⁾. Again, the share is higher among men (90 %) than among women (83 %). The share also somewhat increases with education, while there are no significant differences between age groups (only the youngest age group stands out with a somewhat higher consumption).

In Romania, smoking increased among both men and women after 1990, especially among young people. A survey by the Ministry of Health and Family from 1997 showed that 46 % of people (13 % of women) above the age of 18 were regular smokers, which is high compared to the EU, but similar to other central and east European countries⁽⁸⁶⁾.

Source: EGGSI network national reports 2009 and Eurostat data.

⁽⁷⁹⁾ European Commission (2007), Health and long-term care in the European Union, Special Eurobarometer, 283.
http://ec.europa.eu/public_opinion/archives/ebs/ebs_283_en.pdf

⁽⁸⁰⁾ EuroHIV (2006), HIV/AIDS Surveillance in Europe, End-year report 2005, No 73, European Centre for the Epidemiological Monitoring of HIV/AIDS WHO and UN AIDS Collaborating Centre on HIV/AIDS, Saint-Maurice.
http://www.eurohiv.org/reports/report_72/pdf/report_eurohiv_72.pdf

⁽⁸¹⁾ Curado, M.P., et al. (2008), Cancer Incidence in Five Continents, Vol. IX, IARC Scientific Publications No 160, Lyon.

⁽⁸²⁾ Ministry of Health (Bulgaria), Report on the Health Status of the Citizens — Priority Investment into the Future of the Nation (2005–07), Sofia.

⁽⁸³⁾ Ministry of Labour and Social Policy (2006), National Demographic Strategy of the Republic of Bulgaria (2006–20), Sofia, 2007, p. 14.
http://www.un-bg.bg/documents/unfpa_population_strategy06-20_en.pdf

⁽⁸⁴⁾ European Observatory on Health Systems and Policies (2008), Healthcare systems in transition, Vol. 10, No 3, Romania Health System Review, p. 12.

⁽⁸⁵⁾ European Commission (2007), Health and long-term care in the European Union. Special Eurobarometer, 283.
http://ec.europa.eu/public_opinion/archives/ebs/ebs_283_en.pdf

⁽⁸⁶⁾ Ministry of Public Health and Family (1997), Romanian health status survey, Bucharest, Computing Centre for Health Statistics and Medical Documentation.

2. Gender differences in access to healthcare

‘Despite overall improvements in health there remain striking differences in health outcomes not only across Member States but also within each country between different sections of the population according to socioeconomic status, place of residence and ethnic group, and gender’⁽⁸⁷⁾.

The Joint Report on Social Protection and Social Inclusion (2008)⁽⁸⁸⁾ considers that on average, people with lower levels of education, wealth or occupational status have shorter lives and suffer more often from disease and illness than more well-off groups and these gaps are not declining. ‘Income inequality, poverty, unemployment, stress, poor working conditions and housing are important determinants of health inequalities, as are lifestyle and willingness and ability to bear the costs. While healthcare systems have contributed to significant improvements in health across the EU, access to healthcare remains uneven across social groups.’ The Member States are implementing policies at national or local levels to reduce these inequalities and to overcome present barriers to accessing healthcare in terms of financial, cultural and geographical obstacles. ‘Virtually all Member States have implemented universal or almost universal rights to care and have adapted services to reach those who have difficulty accessing conventional services due to physical or mental disability or to linguistic or cultural differences. Few have begun to address health inequalities systematically and comprehensively by reducing social differences’⁽⁸⁹⁾.

Gender plays a specific role in the incidence and prevalence of certain types of pathologies (as described in Chapter 1) but also in their treatment and their impact in terms of well-being and recovery, due

to the interrelation of biological aspects, psychological and cultural behaviour (due to ethnic, social, and religious background), socioeconomic conditions and the features of the healthcare systems. Some factors can exacerbate gender inequalities in health and well-being, such as the gender pay gap and the burden of family and care responsibilities, poverty and isolation, leaving women particularly vulnerable, especially in financial terms, in accessing health services. Their longer lifespan, compared to men, increases the amount of time that they live in illness, disability and solitude. As clearly shown in the previous chapter (Table 1-1), the proportion of healthy life years for men is higher than for women throughout Europe.

This chapter considers gender differences in access to healthcare. The analysis firstly considers service provisions in health promotion, prevention and treatment, and secondly, how financial, cultural and geographical barriers may affect women and men differently in accessing service provision.

2.1. Existing service provisions: an overview of gender differences

Before considering gender differences in the provision of healthcare services, it is useful to present some indicators regarding the relevance of healthcare expenditure in European countries and its composition. Figures 2-1 and 2-2 present total healthcare expenditure as a percentage of the GDP and per capita. Differences among European countries are clearly visible: eastern European countries spend a much lower percentage of the GDP than western countries, with the lowest incidence in Estonia (5% of GDP) and the highest in France (11% of GDP). Also, per capita expenditures are much lower in eastern European countries, with Romania presenting the lowest and Luxembourg over eight times more. Most countries show a clear upward trend in expenditure between 2000 and 2006, except Estonia and Lithuania which show a decline. Differences are due to various factors, such as the country’s income level, the structure and organisation of the healthcare services and the share of the old-age population.

⁽⁸⁷⁾ Council of the European Union (2008), Joint Report on Social Protection and Social Inclusion, Directorate-General for Employment, Social Policy, Health and Consumer Affairs, Brussels.

<http://register.consilium.europa.eu/pdf/en/08/st07/st07274.en08.pdf>

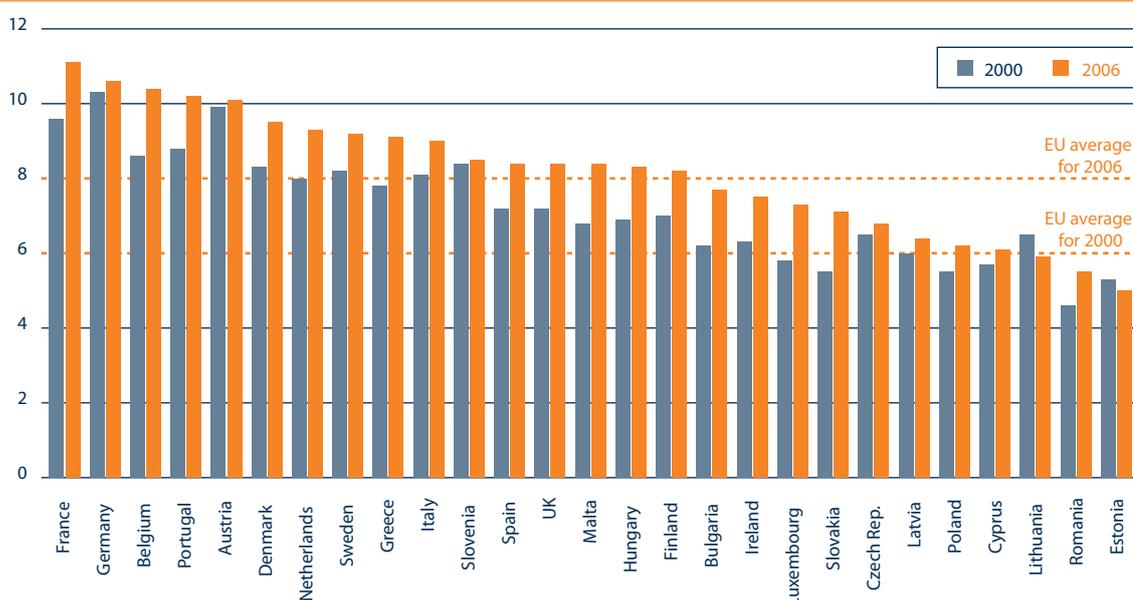
⁽⁸⁸⁾ Council of the European Union (2008), Joint Report on Social Protection and Social Inclusion, Directorate-General for Employment, Social Policy, Health and Consumer Affairs, Brussels.

<http://register.consilium.europa.eu/pdf/en/08/st07/st07274.en08.pdf>

⁽⁸⁹⁾ Council of the European Union (2008), Joint Report on Social Protection and Social Inclusion, Directorate-General for Employment, Social Policy, Health and Consumer Affairs, Brussels.

<http://register.consilium.europa.eu/pdf/en/08/st07/st07274.en08.pdf>

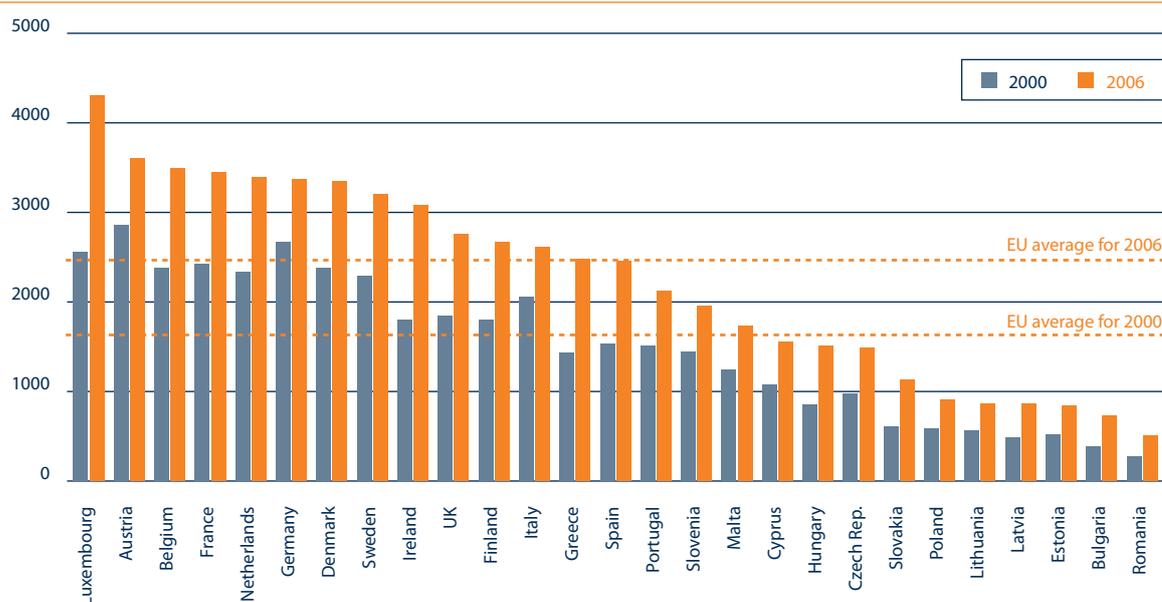
Figure 2-1 — Total healthcare expenditure as a % of GDP, in the EU-27 countries, 2000 and 2006 — ranking



Source: European Commission, New common indicators from 2006 for the Open Method of Coordination. http://ec.europa.eu/employment_social/spsi/common_indicators_en.htm, Indicator HC-P12, based on OECD health data 2007 and WHO Health for all databases.

Explanatory note: Data refer to total public and private expenditure on health as % of GDP. Public healthcare expenditure includes government spending (including central government, state/provincial government and local/municipal government) and social security funds. Private healthcare expenditure includes private health insurance (private social insurance + private insurance other than social insurance), private households out-of-pocket expenditure, non-profit institutions and private corporations other than health insurance such as private companies funding occupational healthcare.

Figure 2-2 — Total healthcare expenditure per capita, in the EU-27 countries, 2000 and 2006 — ranking



Source: European Commission, New common indicators from 2006 for the Open Method of Coordination http://ec.europa.eu/employment_social/spsi/common_indicators_en.htm, Indicator HC-P11, based on OECD health data 2007 and WHO Health for all database.

Explanatory note: Data refer to total health expenditure per capita in USD PPP.

In all European countries, most healthcare expenditures are dedicated to curative and rehabilitative care, followed by medical goods dispensed to outpatients (Table 2-1). Prevention and

public health services are still a marginal component of health expenditures, even if with relevant differences across countries (from 6.6 % of Romanian health expenditures to 0.2 % in Cyprus).

Table 2-1 — Total healthcare expenditure by function (% share of current health expenditure), in some European countries, 2005

	Services of curative care	Services of rehabilitative care	Services of curative and rehabilitative care	Ancillary services to healthcare	Medical goods dispensed to outpatient	Prevention and public health services	Health administration and health insurance
Belgium	50.6	2.6	:	4.4	19.3	1.8	6.2
Czech Republic	45.2	3.7	48.9	12.5	29.7	1.8	3.3
Denmark	:	:	56.8	3.1	13.6	2.3	1.8
Germany	50.2	3.3	53.5	4.6	20.2	3.4	5.8
Estonia	52.8	3.1	55.9	8.4	26.9	2.3	3.4
Spain	57.6	:	57.6	5.0	25.9	1.3	3.5
France	:	:	56.8	3.7	21.5	2.2	7.1
Cyprus	52.4	9.5	61.9	9.5	20.7	0.2	5.9
Lithuania	45.8	4.2	50.0	4.4	37.6	1.7	2.0
Luxembourg	53.2	2.5	55.7	5.0	11.1	1.1	9.7
Netherlands	50.6	4.4	55.0	3.9	17.1	4.7	5.8
Poland	49.9	3.0	52.8	3.8	32.5	2.4	1.6
Portugal	:	:	61.9	9.1	24.6	1.9	1.3
Romania	45.2	0.6	45.8	3.8	30.8	6.6	4.0
Slovenia	53.5	2.3	55.8	3.0	24.5	4.0	4.3

Note: no data available.

Source: European Commission, New common indicators from 2006 for the Open Method of Coordination

http://ec.europa.eu/employment_social/spssi/common_indicators_en.htm, Indicator HC-C4, based on Eurostat and OECD, based on System of Health accounts (SHA).

Explanatory note: Data refer to prevention and public health as a percentage of total current health expenditure.

Across Europe, the overarching aim of the national healthcare systems is that good health and care should be offered to the whole population on equal terms, independent of gender, country, occupation and level of education. However, apart from general statements, access to medical care remains varied in many EU countries, in terms of waiting time and waiting lists, distance, costs for patients (such as out-of-pocket payment), accessibility for specific ethnic groups, etc.

As age is a relevant variable in influencing one's health status and access to healthcare, the following analysis adopts a life-cycle approach in presenting a selection of existing service provisions for women and men. The analysis begins by presenting provisions offered during childhood and adolescence, then continues with those offered in the reproductive age, and finally presents provisions offered during old age.

2.1.1. Health promotion

The WHO defines health promotion strategies as those strategies that are not limited to a specific health problem, nor to a specific set of behaviours⁽⁹⁰⁾: they apply to a variety of population groups, risk factors and diseases, in various settings. Health promotion efforts in particular involve information campaigns, education, community development and all those measures that are aimed at the promotion of healthy choices and behaviours in raising the awareness of the population. Information and education campaigns play a key role in improving health by helping people to make healthier choices and encouraging healthier behaviours. The 2008–13 EU Public Health Programme⁽⁹¹⁾ includes

⁽⁹⁰⁾ WHO, Health Promotion.

<http://www.who.int/healthpromotion/en/> and European Commission, Health EU, the Public Health Portal. http://ec.europa.eu/health-eu/health_in_the_eu/prevention_and_promotion/index_en.htm

⁽⁹¹⁾ European Parliament and the Council of the European Union (2007), Decision No 1350/2007/EC of the European Parliament and of the Council of 23 October 2007 establishing a second programme of the Community action in the field of Health (2008–13). Official Journal of the European Union L 301/3. <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2007:301:0003:0013:EN:PDF>

actions to promote good health by addressing the major determinants of ill health associated with morbidity and early mortality. To this end, specific projects and initiatives are aimed at increasing awareness, disseminating information and sharing best practices. The focus of this section is on existing health promotion strategies (programmes or activities) specifically targeted at women or men or at groups of women and men affected by specific forms of disadvantage.

The first element to be considered is that the general tendency for health promotion programmes

throughout Europe is to target the entire population or particular age groups, focusing on specific issues. The programmes, however, usually do not develop a gender dimension, except for the areas of maternity, childbirth and reproductive health in general, where the target group of existing programmes are in the great majority of the cases women. It is also interesting to note that in particular in those countries where national health promotion activities are less developed, the role of NGOs is to be regarded as a relevant contributor to awareness-raising on issues that otherwise risk being less emphasised by public action.

Box 2-1 — The attention on the gender dimension in some health promotion programmes

France

Public policies aimed at creating a healthy environment essentially address the entire population rather than a specific category. If the youth are the target, as in the Plan for youth health launched in 2008⁽⁹²⁾, women are not subject to such attention and gender is hardly taken into account. Since these policies are not gendered, their impact on gendered health inequalities remains largely undocumented. Policies have nevertheless been developed to promote a healthy environment for women in the workplace. This is due to the French traditional 'familialist' approach⁽⁹³⁾ that tends to protect mothers' health at work in order to preserve their role within the family. Targeted actions to promote women's health have essentially been initiated by nongovernmental organisations (NGOs), such as the French movement for family planning (Mouvement français du planning familial, MFPP) created in 1956 to ensure women's rights to control their fertility and to combat against sexist violence.

The Netherlands

The Dutch organisation ZonMw is a national organisation for health research and innovation in healthcare. It finances several innovative programmes and activities regarding health promotion, including gender specific programmes which consider sex, ethnicity, age and income. Between October 2004 and May 2006, a programme was implemented in order to promote gender-specific healthcare for general practitioners⁽⁹⁴⁾.

⁽⁹²⁾ Ministre de la Santé et des Sports (2008), Présentation du plan santé des jeunes, Paris. <http://www.sante-jeunesse-sports.gouv.fr/actualite-presse/presse-sante/communiqués/presentation-du-plan-sante-jeunes.html>

⁽⁹³⁾ Lanquetin, M.-T. (1998), L'égalité professionnelle à l'épreuve des faits, in Maruani, M., Les nouvelles frontières de l'inégalité hommes-femmes sur le marché du travail, Paris.

⁽⁹⁴⁾ The programme was initiated by the University Medical Centre St. Radboud (Nijmegen) and was financed by ZonMw. This promotion programme was called 'Seks-specifieke zorg in de huisartspraktijk: drie vliegen in één klap'.

Norway

The main goal of the health policy in Norway is to increase healthy life years, reduce inequalities in health between various socioeconomic groups, ethnic groups and between women and men⁽⁹⁵⁾. The strategy for reducing health inequalities emphasises the need for gender mainstreaming within all health information.

Poland

The National health programme for 2007–15 sets six goals (called operational goals) with respect to health promotion aimed, in principle, at the entire population⁽⁹⁶⁾. None of them mentions gender openly, so they seem gender neutral.

Romania

The national health promotion programme elaborates a national strategy for health promotion, carries out studies regarding tobacco consumption, and also develops information, education and communication campaigns. These campaigns address women and men equally and target the health problems identified at national or local levels such as: HIV/AIDS discrimination, the need to develop healthy behaviours (such as healthy diet, sports and fitness, fight against obesity in children and adults, etc.), prevention methods for specific diseases (tuberculosis, heart diseases, cancer), drug prevention, health promotion for mother and child. The lack of targeted data analysis and interpretation (such as possible sex- and gender-based differences) and the scarce availability of existing data are among the weak points of the health information system.

⁽⁹⁵⁾ Helse og omsorgsdepartementet (2006), Nasjonal Helseplan, Særtrykk av St.prp. nr. 1 (2006–07). http://www.regjeringen.no/upload/kilde/hod/prm/2006/0083/ddd/pdfv/292402-nasjonal_helseplan_saertrykk.pdf

⁽⁹⁶⁾ There are also five operational goals targeted at specific subpopulations. Two of them are relevant for the gender discussion (Improvement of the care regarding mother and babies, and Making conditions for active life of the elderly) and will be mentioned in the next sections. The others refer to children and the disabled and will not be discussed.

Spain

In 2006, the Ministry launched an online Information System for Health Promotion and Education⁽⁹⁷⁾ that aimed to collect programmes and publications by territorial administrations and classify them by topic and target groups. According to the database, 6 out of the 64 registered initiatives (run on regional and local levels) exclusively addressed women's health. One of the most active public institutions on gender issues, the Women's Institute, signed an agreement in 1992 with the Ministry of Justice for the establishment of a long-term programme aimed at promoting health among women at penitentiary institutions (Programme for the promotion of healthy habits and prevention of HIV for women deprived of their liberty).

⁽⁹⁷⁾ Ministerio de sanidad y consume, Sistema de Información de Promoción y Educación para la Salud.
<http://sipes.msc.es/sipes/ciudadano/index.html>

Sweden

A broad aim of the Swedish healthcare system is that good health and care should be offered to the whole population on equal terms. It is the task of society to see to it that everyone has the same possibility to receive the care they need independently of sex, where they live, what their job is, what level of education they have or their ability to speak Swedish⁽⁹⁸⁾. It should be pointed out that in certain areas, there are long-established structures for health promotion and health prevention. Prenatal, child and youth clinics are examples of the systematic and programmed structures established to carry out these tasks. Other examples are infectious disease control, screening, registered follow-ups and health talks with asylum seekers. In 2007, all county councils had goals for gender equality for caretakers included in general policy documents⁽⁹⁹⁾.

Source: EGGSI network national reports 2009.

⁽⁹⁸⁾ Statistiska Centralbyrån, Stockholm. <http://www.socialstyrelsen.se>

⁽⁹⁹⁾ Statistiska Centralbyrån, Stockholm. <http://www.socialstyrelsen.se>

As anticipated, the following analysis of the health promotion programmes realised in European countries is articulated according to a life-cycle approach: childhood and adolescence, reproductive age and old age. For each phase, an analysis of the main features and a presentation of specific examples have been provided.

Childhood and adolescence

Across Europe, promotion programmes targeted at children and adolescents are quite rarely gendered. In general, health promotion programmes in this phase of the life cycle are targeted according to age and not to gender, and they are organised within school activities. They generally address issues such as the promotion of healthy life styles, the prevention of smoking, addiction (alcohol, drugs) and eating disorders (such as anorexia/bulimia), the promotion of physical activities, sexuality and reproductive health. Here are some examples:

- In Portugal the Health Promoting Schools project⁽¹⁰⁰⁾ is directed both to girls and boys, assuming that early information and health prevention are important tools to promote equal opportunities: the project supervises, amongst other things, medical examinations, the National Vaccination Plan (PNV), improvement in finding solutions for problems of children with special health needs at school, the promotion of oral health and encouragement for healthy student lifestyles⁽¹⁰¹⁾.

⁽¹⁰⁰⁾ Official Communication No 734/2000, 18 July, signed by the Ministers of Health and Education — establishes regulations for the extension of Health Promoting Schools project network.

⁽¹⁰¹⁾ Official Communication No 734/2000, 18 July, signed by the Ministers of Health and Education — establishes regulations for the extension of Health Promoting Schools project network.

- A similar programme is in effect in Slovenia, where there are several health promotion and educational campaigns targeted at children and promoted by the Institute for Public Health. Among them is the Slovenian network of healthy schools, and also more focused campaigns that promote vaccinations as well as awareness raising regarding the negative consequences of smoking (for teachers and pupils).

- In Liechtenstein the health education programme in schools addresses three main goals: (a) the first goal is the children's personality development, i.e. the promotion of the ability to deal with conflict, the ability to work in teams and the strengthening of self-esteem, as well as a project on violence prevention called Social Work in Schools; (b) the second goal concentrates on the physical development of children by focusing on raising health awareness with respect to healthy eating habits, exercise, addictive behaviour and sexuality; (c) the third goal is to ensure communication between government offices, parents, physicians and teachers.

- In Spain within the bilateral cooperation between the Ministry of Education and the Ministry of Health, a reinforcement process was put into effect between 2006 and 2008 in order to enhance health promotion at school. Other promotion programmes are targeted at students at the undergraduate and postgraduate levels.

- In Lithuania the programme is aimed at strengthening healthcare promotion in schools, paying particular attention to the healthcare of teenagers, the development of healthy life styles and habits for both children and parents.

- In France a series of measures have been introduced to protect the health of young people, mainly from 16 to 25, and to meet their needs regarding independence and responsibility. Faced with the worrying spread of high-risk behaviour and the development of eating disorders, the measures aim to better protect France's youth by focusing on: fighting addictive behaviour, making current legislation consistent regarding the sale of alcohol to minors; more balanced eating habits, promoting a proper environment by advertising for choice of healthy food at supermarket check-out counters and school cafeterias; fighting anorexia, with a charter to be signed soon by professionals working in the fashion sector, strengthening protection for models, and especially those under 18, through the presence of an occupational physician, and prohibiting the glorification of extreme thinness and anorexia in the media⁽¹⁰²⁾.
- Finland launched its first Action programme 2007–11 regarding the promotion of sexual and reproductive health in 2007⁽¹⁰³⁾. The programme aims to promote sexual and reproductive health among the population, focusing especially on young people. The programme is focused on health and social welfare professionals, health teachers in secondary schools and vocational schools, key partners and organisations. One of the major objectives is to improve sexual counselling, which should be integrated into basic and district level services: that means that each health centre should have employees who have completed training in sexual counselling.
- In the Netherlands the project Girls' Talk — Healthy sexual behaviour for young girls, promoted by Rutgers Nisso Groep (RNG), the Dutch expert centre on sexuality⁽¹⁰⁴⁾, is targeted at young girls/women between 12 and 25 years old with a Dutch or another ethnic background (Surinamese, Turkish, Moroccan), and a relatively low level of education. The key priorities of this programme are to provide young girls with sex-specific, culture sensitive group counselling in order to provide information on healthy sexual behaviour; increase awareness among young girls of the possible risks of unhealthy sexual behaviour; develop an evaluation method in order to measure the effect of sex-specific counselling on healthy sexual behaviour.

⁽¹⁰²⁾ Ministère de la santé et des sports (2008), Présentation du plan santé des jeunes.

<http://www.sante-jeunesse-sports.gouv.fr/actualite-presse/presse-sante/communiqués/presentation-du-plan-sante-jeunes.html>

⁽¹⁰³⁾ Ministry of Social Affairs and Health — MSAH (2007), Seksuaalija lisääntymisterveiden edistäminen. Toimintaohjelma 2007–11 [Promotion of sexual and reproductive health. Action Programme 2007–11, English abstract], Helsinki.

⁽¹⁰⁴⁾ Source: Databank effectieve jeugdinterventies — Nederlands Jeugd Instituut (Dutch Youth Institute).
<http://www.nji.nl/eCache/DEF/1/03/055.html>

Reproductive age

The following section provides an overview of health promotion programmes concerning aspects of healthy behaviour (such as alcohol consumption, smoking, diet and physical activity), mental and occupational health, or addressing specific population groups (such as the most vulnerable or rural women), HIV/AIDS, as well as maternity/breastfeeding. Many promotion programmes are targeted at adults or adolescents already in the reproductive age. Many of them are gender oriented: in some cases they are targeted at women, in others at men. Some examples across Europe have been analysed according to their main focus.

1. **Programmes aimed at reducing the consumption of alcohol:** in most EU countries, programmes of this kind are present. In some cases, such as in Denmark, Slovakia and Finland they are gender specific. In Denmark, health-promotion activities try to consider the ways the different sexes react to information and to possible symptoms of sickness. In Slovakia, the Public health awareness programme is focused on reducing the consumption of alcohol among men and in particular male smokers, with a higher consumption of beer, wine and spirits. In Finland the accidental deaths of young men are considered such a relevant problem that decreasing these deaths is one of the main aims of the national health programme (Health 2015). For this purpose, the 2004–07 Alcohol Programme and the Armed Forces launched an information campaign for men in the military and in civil service in 2006 with a leaflet entitled Test your knowledge on ways to control life! (Elämänhallinta-aineisto, testaa tietosi!)⁽¹⁰⁵⁾.
2. **Programmes aimed at reducing smoking:** most EU countries have developed programmes of this kind. In some cases they aim at different targets and scopes: in Iceland for example, the focus is mainly on men, being heavier smokers than women; in Norway and in Denmark measures to decrease smoking among pregnant women and women with small children have been mentioned by the EGGSI experts⁽¹⁰⁶⁾; in Cyprus the Ministry of Education has introduced, on a trial basis, a group psychotherapy-based smoking cessation programme in one high school and one technical school in Nicosia.

⁽¹⁰⁵⁾ Finnish Ministry of Social Affairs and Health.
http://www.stm.fi/julkaisut/esitteita-sarja/nayta/_julkaisu/1058533

⁽¹⁰⁶⁾ Helse og Omdepartementet (2006), Najonal strategi for det tobakksforebyggende arbeidet (2006–10), Oslo.
http://www.helsedirektoratet.no/vp/multimedia/archive/00009/Nasjonalt_strategi_for_9900a.pdf

3. **Programmes promoting diet and physical activity:**

examples are reported in several countries. In Hungary they are gender specific as, according to the data published in the National Public Health Programme⁽¹⁰⁷⁾, 2/3 of male adults and 1/2 of female adults in the population are overweight. The goal is to decrease the frequency of health problems connected to nutrition, and to improve the health condition of the population by healthier nutrition⁽¹⁰⁸⁾; in Slovenia the National Nutrition Policy Programme 2005–10 emphasises the importance of healthy nutrition and lists men as the more vulnerable group: women are mentioned as more inclined to malnutrition and diseases such as bulimia and anorexia; and the Ministry of Labour, Family and Social Affairs finances programmes to help women with eating disorders⁽¹⁰⁹⁾. In Sweden the National Food Administration (NFA) has demonstrated that women eat more fruit and vegetables than men, as do people with higher incomes and higher education than those with lower incomes and education, hence indicating that the NFA should focus more on men than on women, as well as on people with low incomes and education⁽¹¹⁰⁾. In Iceland the programme 'Men and cancer — lifestyle, health and nutrition' is an awareness-raising campaign aimed at drawing men's attention to the fact that the number of cancer cases can be reduced by 1/3 by doing physical exercise, improving diet, refraining from smoking and reducing alcohol consumption: men over 40 are specifically targeted. Similar campaigns are promoted in Latvia. In many other countries, programmes of this kind are not gendered. In Austria the majority of the projects can be found in the area of prevention of eating disorders, and few of them focus on female-specific prevention of addiction.

4. **Programmes promoting mental health and support for people with psychological symptoms/problems:**

mental health promotion is viewed as an interdisciplinary and socio-cultural endeavour aimed at enhancing the wellbeing of individuals, groups and communities. The process is life-long,

from pregnancy through childbirth, infancy, childhood and adolescence to adulthood and old age. Mental health promotion implies the creation of individual, social, societal and environmental conditions that enable optimal psychological and psycho-physiological development as well as a reduction in mental health problems. Mental health promotion can enhance emotional resilience, give rise to greater social inclusion and societal participation, improve the person–environment fit, as well as increase the productivity of individuals⁽¹¹¹⁾. In Norway for example, the National strategy for employment and mental health 2007–12 aims at preventing exclusion from the labour market and enhancing employment participation among people with psychological symptoms/problems⁽¹¹²⁾. As women have more problems related to mental health than men, the strategy is important from a gender perspective, even though it does not have a direct gender orientation. A similar programme is promoted in Finland: the nationwide MASTO project, launched in 2007, aimed at tackling depression as a cause of work incapacitation⁽¹¹³⁾. It also aims at developing a range of best practices concerning people on sick leave due to depression. It does not have any gender-specific targets, in spite of recognising gender segregation as part of the problem, as women's and men's symptoms and health behaviour regarding mental health differ. In Spain there are programmes promoting mental health among young people, mainly through participatory workshops for parents and adolescents aged 12–16 years old. The gender perspective has been particularly addressed with a view to the dismantling of prejudices and obsolete gender roles.

5. **Programmes promoting occupational health:**

in Sweden there are programmes on the improvement of working conditions for women employed as assistant nurses and male hospital attendants employed within the care sector⁽¹¹⁴⁾.

⁽¹⁰⁷⁾ National Public Health Programme, Budapest.
<http://color.oefi.hu/program.htm>

⁽¹⁰⁸⁾ Az Egészség Évtizedének Johan Béla Nemzeti Programja (National Public Health Programme) 2003, Budapest.
<http://color.oefi.hu/program.htm>

⁽¹⁰⁹⁾ NGO Women's Counselling Service, Projects in the field of eating disorders and body image, Zenska svetovalnica, Lubjana.
http://www.drustvo-zenska-svetovalnica.si/a_pred.php

⁽¹¹⁰⁾ Socialstyrelsen (2005), Statistiska Centralbyrån.
<http://www.socialstyrelsen.se>

⁽¹¹¹⁾ European Commission (2003), Mental Health Promotion and Prevention Strategies for Coping with Anxiety, Depression and Stress Related Disorders in Europe (2001–03).
http://ec.europa.eu/health/ph_projects/2001/promotion/fp_promotion_2001_frep_02_en.pdf

⁽¹¹²⁾ Helse og omsorgsdepartementet (2007), Nasjonal strategiplan for arbeid og psykisk helse (2007–12), Oslo.
<http://www.regjeringen.no/upload/HOD/Vedlegg/Planer/I-1127%20B.pdf>

⁽¹¹³⁾ Finnish Ministry of Social Affairs and Health.
<http://www.stm.fi/Resource.phx/eng/strag/masto/index.htm>

⁽¹¹⁴⁾ Parnsund, M. (2002), Hälsa – Arbetsliv – Kvinnoliv (projekt), Statens Folkhälsoinstitut, Stockholm.

6. Health promotion programmes and campaigns specifically targeted at more vulnerable groups:

in Spain this line of action has particularly focused on the Roma community and their specific disadvantages to accessing health services: the gender perspective has been explicitly addressed, not only as a general principle, but also regarding the problem of domestic violence, as one of the main priorities. In Cyprus a specialised educational programme has targeted female third-country nationals who come to Cyprus under the status of 'artists'. Women entering the country under this status are often employed in establishments considered 'high risk' for trafficking in women for the purpose of sexual exploitation, thus the programme targets a particularly vulnerable group that suffers various forms of exclusion, particularly in relation to health⁽¹¹⁵⁾. In Slovenia some health promotion programmes and campaigns are specifically targeted at more vulnerable groups (prisoners, refugees), and encourage the education of health workers regarding health promotion for vulnerable groups. These programmes are not gender oriented. In Austria marginalised target groups such as homeless women, sex workers, women living in women's shelters, etc. are addressed by female-specific health promotion projects, usually lasting for 1–2 years: there are very few long-term projects.

7. Programmes on health promotion addressed to rural women:

in Cyprus two programmes funded by EU programmes (Interreg and Socrates) address rural women's sexual and reproductive health⁽¹¹⁶⁾.

8. General programmes to check health status: an interesting example comes from the UK: many GP surgeries offer a 'well woman' clinic where female patients may be seen by a female doctor or a female practice nurse to check their current health status and be provided with advice on health promotion. Many also offer 'well man' clinics which are specialised healthcare clinics for men. They offer men health check-ups and a

general advice about health issues. In Austria, the New medical check-up (Vorsorgeuntersuchung neu) programme offers basic health check-ups, such as for cancer or cardiovascular diseases. Women are offered a gynaecological check-up, and for women above 40, every two years a mammography is paid. Also women-specific health centres have been established in Vienna, Graz, Salzburg, Linz and Carinthia as well as an outpatient healthcare centre in Innsbruck particularly for women.

In the field of reproductive health, some programmes address in particular HIV/AIDS. As a part of the effort to reduce HIV/AIDS, an increased focus on women is detectable in these promotion programmes, since women have an increased risk of HIV/AIDS. The focus is often on ethnic minorities. Also, the World Health Organisation has specific programmes concerning gender inequalities and HIV, considering women much more vulnerable than men: 'Gender norms related to masculinity can encourage men to have more sexual partners and older men to have sexual relations with much younger women. In some settings, this contributes to higher infection rates among young women (15–24 years) compared to young men. Norms related to femininity can prevent women — especially young women — from accessing HIV information and services. Violence against women (physical, sexual and emotional), which is experienced by 10% to 60% of women (ages 15–49 years) worldwide, increases their vulnerability to HIV'⁽¹¹⁷⁾. Many European countries have implemented programmes for sexual education and the promotion of safer sex for preventing HIV/AIDS. In Austria, a gender-specific HIV/AIDS programme of the Aids Hilfe Wien aims at the sexual empowerment of women, including also migrant women, young women, women in prison and partners of HIV-positive men. In Spain, the National Plan on AIDS includes a gender perspective in its campaigns, research and statistical data gathering, and addresses also pregnant mothers or prostitutes, with a special approach. In Sweden, pregnant women are offered HIV-testing, while in Germany educational programmes address in particular HIV homosexual men. Also in Norway, there is an increased focus on homosexual men, as well as on women, especially ethnic minorities, which show a higher incidence of infections.

⁽¹¹⁵⁾ Mediterranean Institute of Gender Studies (2007), Mapping the Realities of Trafficking in Women for Sexual Exploitation in Cyprus.

⁽¹¹⁶⁾ DELOA: Itinerant workshops for assessment, help, orientation and information on sexual education, equal opportunities and gender equality aimed at rural women, EC Socrates Grundtvig 1. Coordinating organisation: Fundación Paideia Galiza, Spain. <http://www.gender-equality.webinfo.it/cd/content/theory/theory13/fcontent.html>

⁽¹¹⁷⁾ WHO (2009), Gender inequalities and HIV, Geneva. http://www.who.int/gender/hiv_aids/en/

Box 2-2 — Good practices: gender-specific programmes/projects on reproductive health and HIV/AIDS

Cyprus

An interesting example of a gender-specific programme is 'Evaluation of the Sexual and Reproductive Health Needs of Migrant Domestic Workers in Cyprus': it was recently carried out by the Family Planning Association (CFPA) and funded by the Cyprus University of Technology. Within the framework of this programme the CFPA undertook Sunday workshops on sexual health, with particular emphasis on contraception and screening (Pap test, breast self-examination) for female domestic workers. The workshops were followed-up by clinical screening and testing services for participants, which were provided by a female gynaecologist, as a means to meet the cultural sensitivities of many of these women, who tend to be from diverse ethnic and religious backgrounds.

Hungary

Since 2003, starting on the first Sunday of May (Mother's day in Hungary), a national, non-profit series of programmes address issues about childbirth. Priority is given to information about planned pregnancy, delivery and nursing. Although the programme lasts just one week, its regional outreach is a basic feature. Moreover, the project's homepage is very informative, offering information on pregnancy (problems, expectations, etc.), preparation for delivery, mental and physical status, fatherhood, newborn babies, nursing, home delivery, etc. The target group is mainly women, but also young fathers. It gives young parents comprehensive information about pregnancy and motherhood⁽¹¹⁸⁾.

Liechtenstein

The Bureau for Sexual Matters and HIV Prevention provides gender-specific counselling on sex-education topics in schools and youth centres, such as the project 'Girl Power Days' and 'Boy Power Days' for girls and boys aged 11–13, developed in cooperation with the youth information office 'aha — Tips and Info for Young People'. The Boy Power

Days for 12 to 13-year-old boys offers information on body knowledge and changes in puberty, aggression, male-role images and sexuality, as well as contraception and protection in relationships. During the Girl Power Days girls between 11 and 13 are presented topics such as friendship, 'My Body', menstruation, etc. The goals of this project are to promote awareness, improve communication abilities, and expand behavioural competence⁽¹¹⁹⁾.

Romania

The National programme for maternal and child health aims at improving access to reproductive health services. The objectives are to maintain and increase the number of people using contraceptive methods and to reduce the number of abortions. In this respect, family doctors, family planning offices, obstetrics-gynaecology sections in hospitals and clinics provide information/educational materials and free-of-charge contraceptives for certain disadvantaged categories of the population (unemployed women, students, disadvantaged women, beneficiaries of minimum income/state benefits, women living in rural areas, poor or low-income women). Moreover, a network of community nurses and health mediators working with poorer categories of the population (rural residents, the uninsured, Roma) has been developed. The community nurses and health mediators' role is to identify people who are not registered in family doctors' lists (especially pregnant women and children) and to provide information and counselling to these families. The programme's objective is to improve access to health and social services, contribute to a change in mentality in relation to one's own health status, and to increase the responsibility of local communities concerning the needs of women and men belonging to marginalised groups.

Source: EGGS network national reports 2009.

⁽¹¹⁸⁾ See <http://www.szuleteshete.hu>

⁽¹¹⁹⁾ Commission for Equal Opportunities (2007), Third report under Article 18 of the Convention on the Elimination of All Forms of Discrimination against Women of 18 December 1979, Vaduz.

The greatest concentration of health promotion programmes targeted at women is in the area of maternity. The promotion of breastfeeding is without a doubt the most widespread programme across Europe and has been supported by evidence and common guidelines⁽¹²⁰⁾. The protection, promotion and support for breastfeeding are a public health priority throughout Europe. The Global strategy on infant and young child feeding adopted by all WHO member states at the 55th

World Health Assembly in May 2002 provides a basis for public health initiatives to protect, promote and support breastfeeding. Indeed, 'low rates and early cessation of breastfeeding have important adverse health and social implications for women, children, the community and the environment, result in greater expenditure on national healthcare provision, and increase inequalities in health'⁽¹²¹⁾. The promotion of breastfeeding is usually accompanied by more general

⁽¹²⁰⁾ European Commission (2004), Protection, promotion and support of breastfeeding in Europe: a blueprint for action, EU Project on Promotion of Breastfeeding in Europe, Directorate Public Health and Risk Assessment, Luxembourg.
http://ec.europa.eu/health/ph_projects/2002/promotion/fp_promotion_2002_frep_18_en.pdf

⁽¹²¹⁾ European Commission (2004), Protection, promotion and support of breastfeeding in Europe: a blueprint for action, EU Project on Promotion of Breastfeeding in Europe, Directorate Public Health and Risk Assessment, Luxembourg.
http://ec.europa.eu/health/ph_projects/2002/promotion/fp_promotion_2002_frep_18_en.pdf

programmes that support the health and well-being of mothers and their newly born babies, and the following provide some examples.

- In France past legislation and collective agreements were developed to protect women (night-work prohibition, except in the health sector), pregnant women (maternity leave, right of absence to visit a doctor, etc.) or mothers (right to breastfeed at the workplace, or to leave earlier for breastfeeding). Some of these regulations are still in effect (such as the maternity leave), but others have recently been removed in the name of the fight against discrimination (such as the night-work prohibition)⁽¹²²⁾.
- In Hungary several initiatives have been launched with the aim of re-evaluating women's roles as mothers. They are mainly connected to childbirth and nursing. Childbirth Week, Nursing Day or the national strategy 'The Child is Our Common Treasure', are part of the European strategy for child and adolescent health and development and aim to raise the prestige of social roles connected to children and the family. Moreover the health visitors' network focuses on infants' and young mothers' health promotion⁽¹²³⁾.
- In Romania one of the few programmes specifically targeting women is the National programme for maternal and child health. The programme is focused on improving reproductive health and childcare and one of the interventions targeting women is breastfeeding promotion. This measure aims at increasing the number of breast-fed babies and introducing alternative food for children after the sixth month of life. Trained personnel guarantee counselling for young/pregnant women regarding the advantages of breastfeeding in centres for promoting breastfeeding.
- In Slovenia targeted health promotion activities include the promotion of breastfeeding and health education for pregnant women and fathers and mothers, increasing pregnant women's physical activity. Some of the Institute for Public Health's health promotion campaigns specifically target women, especially those concerned with childbearing (they publish a leaflet for pregnant women on their rights, others on how to deal with psychological stress after the birth of a child, as well as on healthy lifestyles for future parents).
- In Norway, to increase the time and number of women who breastfeed, a measure for paid

breastfeeding breaks has been introduced and is expected to have positive effects on employed women with infants.

Old age

The first important element to be considered is that the proportion of elderly women is much higher than the proportion of elderly men (due to the higher mortality rate of middle-aged men). This means that many elderly women live alone. Health promotion programmes targeted at the elderly often provide a mix of activities concerning social and mental problems. An interesting example is a programme developed in the Netherlands, which deals with obesity and other diseases linked to a lack of movement — it is addressed to socioeconomically disadvantaged older people and older people from ethnic minority groups.

Box 2-3 — Good practice: Big! Move: health promotion for older people

In 2003, Big! Move, a project to promote health among older people, was implemented by the local health centre in the suburbs of Amsterdam (GAZO). The central aim of the project was to motivate people to fight against obesity and other diseases linked to a lack of movement. The specific target groups of this programme were socioeconomically disadvantaged older people and older people from ethnic minority groups. Within these groups, women were more likely to suffer from obesity than men⁽¹²⁴⁾.

Source: EGGS network national report 2009, the Netherlands.

⁽¹²⁴⁾ Overgoor, L., Aalders, M., Reitsma, S. (2007), Big!Move 2 — Evaluatieverslag verspreiding Big!Move in opdracht van Agis op drie locaties, Amsterdam.

2.1.2. Health prevention

Many costly and disabling conditions — such as cardiovascular diseases, cancer, diabetes, chronic respiratory diseases — are linked to common preventable risk factors, related to hereditary factors, individual health behaviour, living conditions or socioeconomic and working conditions. Screening programmes are important preventive measures, since many diseases can be cured through early detection. Gender specificities addressed by the main health prevention/screening programmes, promoted at the national and/or regional level, as well as their main features and the key challenges are presented below.

⁽¹²²⁾ Cornet, A., Laufer, J., Belghiti-Mahut, S. (2008), GRH et genre, les défis de l'égalité hommes-femmes, Vuibert, AGRH, Paris.

⁽¹²³⁾ For more information on this programme, see Box 2-11.

Childhood and adolescence

Policies and programmes of health prevention targeted at children and adolescents generally concern immunisation and screening programmes provided to the entire youth population or to specific targets among them. Only few of these programmes presented in the EGGSI national reports take specifically into account gender issues: the most widespread across Europe targeted at young girls is the vaccination programme for the human papilloma virus (HPV): what is particularly interesting to note is that across Europe, the access and the target for such a programme is different, as shown by the following five examples.

- In Belgium, since November 2007, two vaccines against this virus have been offered free of charge for girls aged 12 to 15 years, and recently up to 18 years.
- HPV vaccination was recently made available in Cyprus, and the public health services publicised recommendation for this vaccination, for girls and women under the age of 26 (although additional research may indicate that vaccination at older ages may also be appropriate). However, the state does not subsidise the HPV vaccination, and the cost may be too high for many young women and girls (the total cost for a three-phase shot is EUR 500–600).
- In Germany the vaccination against cervical carcinoma for girls was included in the catalogue of health insurance benefit schemes in the 2007 health reform. The target group was girls between 12 and 17 years old prior to their first experience with sexual intercourse. Just 1.5 years after this vaccination was officially recommended, more than a half of girls (59%) between 15 and 17 years had been vaccinated⁽¹²⁵⁾.
- In Romania in November 2008, the Ministry of Public Health started an HPV vaccination campaign in schools, targeted at 9–12-year-old girls. An average of 110 000 girls was estimated to be vaccinated. The campaign created a huge controversy among parents (in the first week, 70% of parents refused the vaccine for their daughters). The main reasons leading to the failure of the campaign were identified as: lack of information and education among parents and the general public regarding the advantages and risks of the vaccine, lack of a methodological letter sent to the physicians involved in the campaign and the use of the concept of informed

refusal. As a result, the vaccination campaign was interrupted and the Ministry of Public Health is planning to develop an information and education campaign in 2009. Depending on the results, the vaccination campaign is to be re-launched.

- In Italy the Minister of Health promoted an informative campaign on the free of charge public inoculation against HPV. In March 2008, a compulsory vaccination programme (the first in Europe) against HPV was launched. The vaccination programme is widespread throughout the national territory for all girls between the ages of 11 and 12; it is supposed to produce, in the following years, a progressive immunisation of the young female population throughout the country.

In many countries, important abortion prevention campaigns have been promoted, targeted mainly at adolescents and youths. Abortion in adolescence in fact is still a problem in Europe, with many thousands of cases per year, even though a clear reduction is detectable all over Europe (Table 2-2).

Table 2-2 — Declared legal abortions by age, 1996 and 2006 in 19 EU countries and Iceland and Norway

	Less than 15 years		Between 15 and 19 years	
	1996	2006	1996	2006
Bulgaria	319	166	11	349
Czech Republic	33	46	5	2
Denmark	58	0	2 281	2 518
Estonia	12	20	169	1 298
Finland	20	65	2	2
Germany	365	542	11 131	15 209
Greece	17	:	468	:
France	:	:	25 638	:
Hungary	256	175	11	5
Iceland	8	:	207	:
Italy	216	:	11	:
Latvia	25	10	3	1
Lithuania	9	6	2	890
Norway	:	37	:	2
Poland	:	0	:	24
Romania	862	616	36	17
Slovakia	19	12	2	1
Slovenia	3	5	780	430
Spain	100	:	7 211	:
Sweden	137	0	4	7
United Kingdom	1	:	36	:

Source: European Commission, Directorate-General for Health and Consumers on the basis of Eurostat data.

http://ec.europa.eu/health/ph_information/dissemination/diseases/docs/reproductive3_en.pdf

⁽¹²⁵⁾ Deutsche Krebsgesellschaft (2008), Aktuelle Impfraten, Hohe Akzeptanz der HPV-Impfungen bei jungen Mädchen, 20.11.2008.

<http://www.lifepr.de/presse-meldungen/deutsche-krebsgesellschaft-ev/boxid-75751.html>

An example of an overall campaign was promoted in Norway: the campaign offered free hormonal contraception for women in the 20- to 24-year-old age group⁽¹²⁶⁾ as a measure to reduce the abortion rate⁽¹²⁷⁾. As a consequence, the abortion rate for the age group 20–24 declined by 24 % from 1992 to 2000⁽¹²⁸⁾. The main focus of the campaign was on youths, young adults, ethnic minority youths, groups with special needs, i.e. the disabled, and on women/couples planning an abortion. As a consequence, measures easily accessible by young people have been established, such as information on the Internet, specific youth health centres and increased information given at schools. In addition, all hormonally based prevention is subsidised for women in the 16–19 age group. A government-supported private foundation offers nationwide, free counselling to women who have found themselves pregnant, targeting more vulnerable groups of women in particular, such as ethnic minority women and lone women with weak social networks.

Reproductive age

Health prevention in reproductive age mostly involves programmes concerning cancer screenings, programmes on maternity and sexual/reproductive health, programmes concerning domestic violence and the prevention of depression. Most of them are addressed to women but some of them are also specifically targeted at men.

Cancer screenings

The most important and widespread gendered preventive programmes implemented in Europe are cancer screenings. The European Union health ministers

have unanimously adopted a recommendation on cancer screening in 2003⁽¹²⁹⁾, based on the positive experience of the Europe Against Cancer programme and its key achievements. The European Union Council's recommendation on cancer screening acknowledges both the significance of the incidence of cancer in the European population and the evidence for the effectiveness of breast, cervical and colorectal cancer screening in reducing the incidence of disease. The Council Recommendation spells out the fundamental principles of best practice in early cancer detection and invites Member States to take common action to implement national cancer screening programmes with a population-based approach and with appropriate quality assurance at all levels, taking into account European quality assurance guidelines for cancer screening, where they exist.

Figure 2-3 presents the distribution of cervical cancer screening programmes in the European Union in 2007, by programme type and country implementation status. Programmes shown use the screening test (Pap smear) recommended by the Council of the European Union since 2003⁽¹³⁰⁾. Cytology-based cervical cancer screening is widely accepted as a public health policy in the EU. Programmes are currently running or being established in 25 of the 27 Member States. 'Population-based'⁽¹³¹⁾ programmes are currently running or being established in 15 Member States (Denmark, Estonia, Finland, France, Hungary, Ireland, Italy, the Netherlands, Poland, Portugal, Romania, Slovenia, Spain, Sweden, and the United Kingdom). Non-population-based screening programmes are running in 12 Member States (Austria, Belgium, Bulgaria, Czech Republic, France, Germany, Greece, Latvia, Lithuania, Luxembourg, Slovakia, and Spain)⁽¹³²⁾.

⁽¹²⁶⁾ Norwegian Directorate of Health.

<http://www.helsedirektoratet.no/helseogomsorg>

⁽¹²⁷⁾ Helse og omsorgsdepartementet, St.prp.nr. 1 (2006–07), For budsjettåret 2007.

<http://www.regjeringen.no/Rpub/STP/20062007/001HOD/PDFS/STP200620070001HODDDPDFS.pdf>

⁽¹²⁸⁾ http://www.helsedirektoratet.no/seksuellhelse/sex_og_samliv/reproductive_health___preventing_unwanted_pregnancies__5500

⁽¹²⁹⁾ Council of the European Union (2003), Council Recommendation of 2 December 2003 on cancer screening (2003/878/EC). Official Journal of the European Union 16.12.2003.

<http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2003:327:0034:0038:EN:PDF>

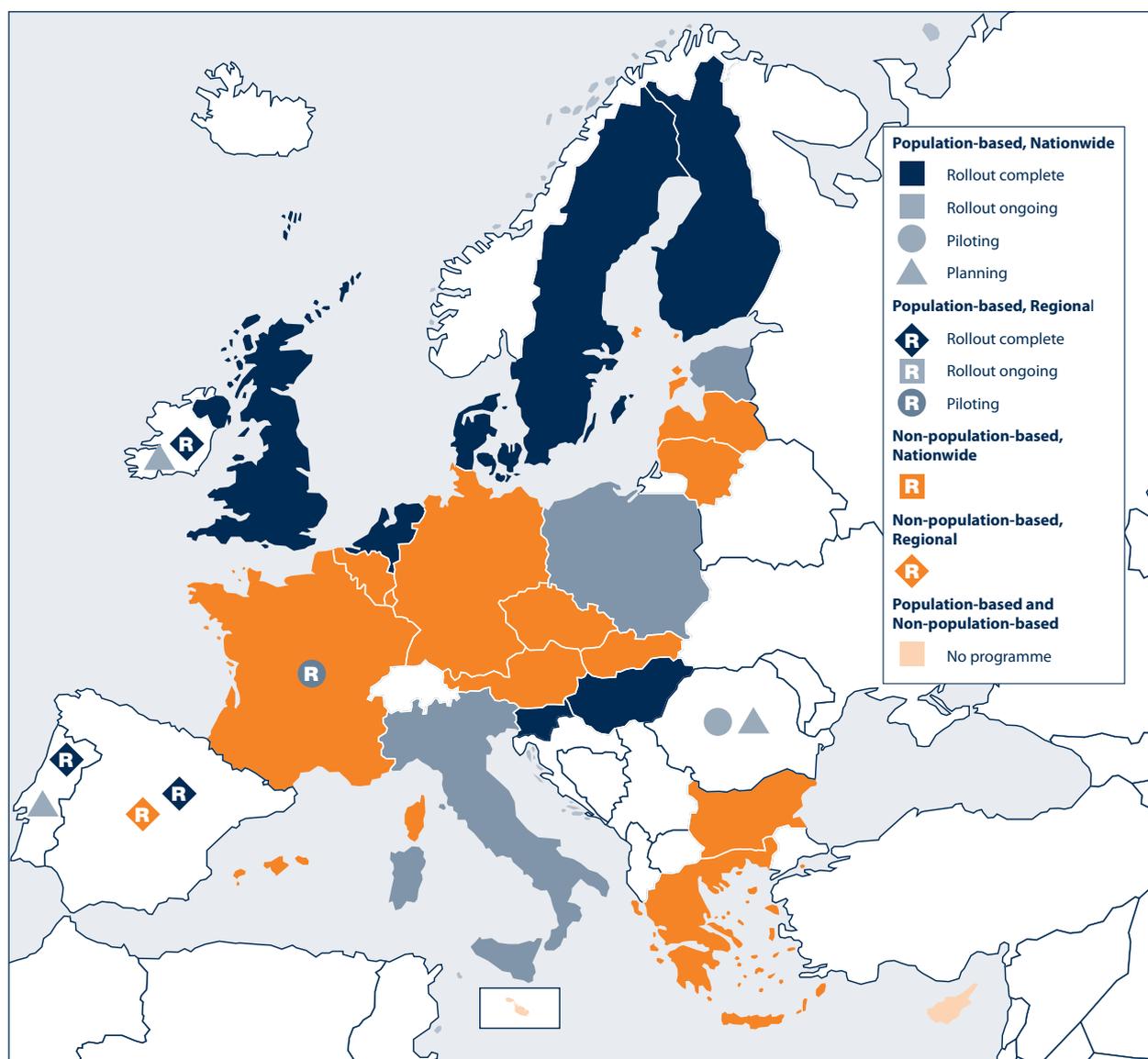
⁽¹³⁰⁾ Council of the European Union (2003), Council Recommendation of 2 December 2003 on cancer screening (2003/878/EC). Official Journal of the European Union, 16.12.2003,

<http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2003:327:0034:0038:EN:PDF>

⁽¹³¹⁾ Population-based screening means that in each round of screening the persons in the eligible target population in the area served by a programme are individually identified and personally invited to attend screening.

⁽¹³²⁾ http://ec.europa.eu/health/ph_determinants/genetics/documents/cancer_screening.pdf

Figure 2-3 — Distribution of cervical screening programmes based on cervical cytology in the EU, 2007



Source: European Commission (2008), Report from the Commission to the Council, the European Parliament, the European Economic and Social Committee and the Committee of the Region Implementation of the Council Recommendation of 2 December 2003 on cancer screening (2003/878/EC), COM(2008) 882 final 22.12.2008.

http://ec.europa.eu/health/ph_determinants/genetics/documents/com_2008_882.en.pdf

Figure 2-4 presents the distribution of the breast screening programme across Europe in 2007, by programme type and country implementation status. Programmes shown use the screening test (mammography) recommended by the Council of the European Union since 2003⁽¹³³⁾. As reported by the study in 2007 'programmes were running or being established in at least 26 of the 27 Member States. Population-

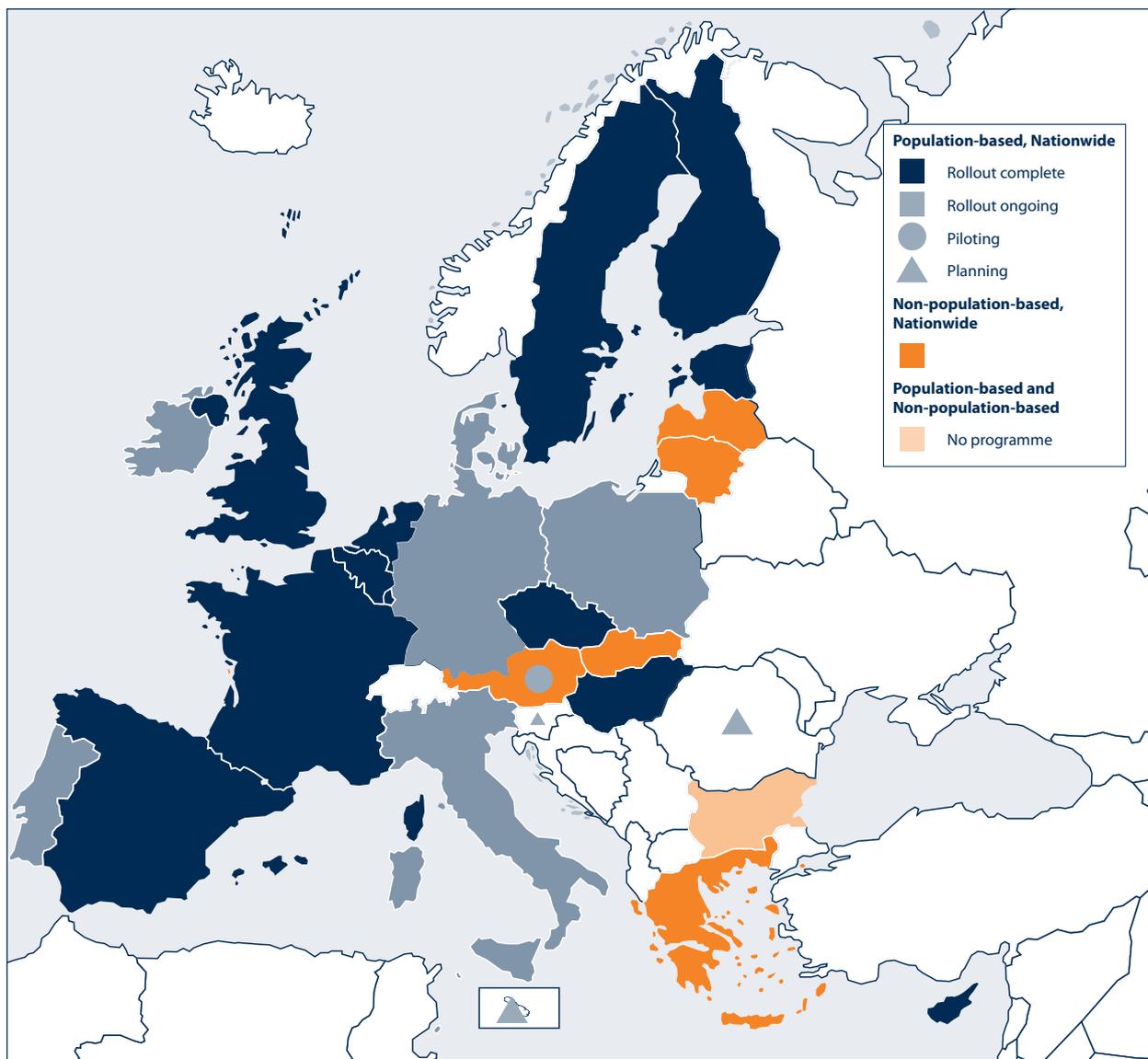
based programmes were running or being established in 22 Member States (Austria, Belgium, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Hungary, Ireland, Italy, Luxembourg, Malta, the Netherlands, Poland, Portugal, Romania, Slovenia, Spain, Sweden, and the United Kingdom). Of the five Member States operating non-population-based breast screening programmes based on mammography in 2007 (Austria, Greece, Latvia, Lithuania, and the Slovakia), one (Austria) was also piloting or planning implementation of a nationwide population-based programme'⁽¹³⁴⁾.

⁽¹³³⁾ Council of the European Union (2003), Council Recommendation of 2 December 2003 on cancer screening (2003/878/EC). Official Journal of the European Union, 16.12.2003.

<http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2003:327:0034:0038:EN:PDF>

⁽¹³⁴⁾ http://ec.europa.eu/health/ph_determinants/genetics/documents/cancer_screening.pdf

Figure 2-4 — Distribution of breast cancer screening programmes based on mammography in the EU, 2007



Source: European Commission (2008), Report from the Commission to the Council, the European Parliament, the European Economic and Social Committee and the Committee of the Regions, Implementation of the Council Recommendation of 2 December 2003 on cancer screening (2003/878/EC), COM(2008) 882 final 22.12.2008, Brussels.

http://ec.europa.eu/health/ph_determinants/genetics/documents/com_2008_882.en.pdf

Figure 2-5 presents the distribution of colorectal cancer screening programmes⁽¹³⁵⁾ based on FOBT (faecal occult blood test) in the European Union in 2007, by programme type and country implementation status. While the first two types of cancer are typically feminine, this third one has a much higher incidence among men: 'In 2006

new cases of colorectal cancer were estimated at 140 000 in women and 170 000 in men. Colorectal cancer deaths were estimated at 68 000 for women and 78 000 for men in the EU'⁽¹³⁶⁾. Colorectal cancer screening is also widely accepted as a public health policy in the EU. Programmes are currently running or being established in 19 of the 27 Member

⁽¹³⁵⁾ Programmes shown use the screening test recommended by the Council of the European Union in 2003.

⁽¹³⁶⁾ Council of the European Union (2003), Council Recommendation of 2 December 2003 on cancer screening (2003/878/EC). Official Journal of the European Union, 16.12.2003, <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2003:327:0034:0038:EN:PDF>

As the three maps above indicate, although much progress has been made, more is still required: 'The current annual volume of screening examinations in the EU is considerable; however, this volume is less than one half of the minimum annual number of examinations that would be expected if the screening tests specified in the Council Recommendation on cancer screening were available to all EU citizens of appropriate age (approximately 125 million examinations per year). Furthermore, less than one half of the current volume of examinations (41 %) is performed in population-based programmes which provide the organisational framework for implementing comprehensive quality assurance as required by the Council Recommendation'⁽¹³⁸⁾.

The following two boxes show in greater detail the first two screening programmes described above,

providing some examples of the situation across Europe from the EGGSI national reports. Box 2-4 shows that in most EU countries, the cervical cancer screening programme is free of charge and, in those best organised, women are invited, with a personal reminder, to do the test. It is also interesting to note that, where the figure is available, there is a consistent differentiation in the take-up rate: it ranges from 59 % in Belgium to 79.2 % in the UK. Some EGGSI reports evidence that income (as in Belgium) and geographical barriers (in rural areas in Hungary) play a consistent role in accessing the programme. In Italy, the screening programme is not homogeneously spread across the country. Another element to note is that the target of the programme is generally people between the ages of 25–64, but in some cases, such as in Poland, it is offered to women aged 25–59, and in Slovenia 20–75.

Box 2-4 — Cervical cancer prevention programmes in some European countries

Belgium

Even though a regular Pap smear, according to scientific literature⁽¹³⁹⁾, can detect 1 400 cases of cervical cancer, per year, only 59 % of women aged 25 to 64 go to their doctor or gynaecologist for a Pap smear systematically. There is an important social component, as women from lower income groups are 13 % less likely to perform such test (21 % less when compared with the highest income group)⁽¹⁴⁰⁾.

Cyprus

There is currently no running population or non-population based public screening programme for cervical cancer in Cyprus. However, according to the 2003 Health Survey published by the Cyprus Statistical Service, 80.9 % of women aged 25–64 stated that they had a cervical cancer test at least once in their lifetime⁽¹⁴¹⁾.

⁽¹³⁹⁾ Health Care Knowledge Centre (KCE) (2006), Dépistage du cancer du col de l'utérus et du Papillomavirus humain, Brussels. <http://www.kce.fgov.be>

⁽¹⁴⁰⁾ Mutualité chrétienne (2008), Inégalités sociales de santé: observations à l'aide de données mutualistes, MC Informations 233, septembre. http://www.mc.be/fr/109/info_et_actualite/mc_informations/index.jsp

⁽¹⁴¹⁾ Statistical services of the Republic of Cyprus. <http://www.pio.gov.cy/mof/cystat/statistics.nsf/All/D4C9C72CE63047EAC225700002B2646?OpenDocument>

Estonia

The cervical cancer screening programme has been carried out yearly since 2003 among women aged 20–59. The participation rate of cervical cancer screening is lower than that of breast cancer and the effectiveness of the programme has not been assessed yet.

Finland

The oldest nationwide mass screening programme for cancer typical for females is the Pap test, in effect since 1963 (national programme 1967). Women aged 30–60 are called in for the screening every five years. In 2005, 71.4 % of women participated in the screening. In recent years, however, only about half of young women aged 30–35 participated⁽¹⁴²⁾. Some municipalities organise screening for 65 year olds, and so in total about 15 % of this age group is screened on a voluntary basis. Of the approximately 176 500 women screened, 1 356 (0.8 %) were sent for further investigations in 2005⁽¹⁴³⁾.

⁽¹⁴²⁾ Ministry of Social Affairs and Health — MSAH (2007), Seulontaohjelmat [Screening programmes, A handbook for municipal authorities], Helsinki.

⁽¹⁴³⁾ Finnish Cancer Organisation, Finnish mass screening registry 40 years old. <http://www.cancer.fi/english/?x22567552=27328166>

⁽¹³⁸⁾ European Commission (2008), Report from the Commission to the Council, the European Parliament, the European Economic and Social Committee and the Committee of the Region Implementation of the Council Recommendation of 2 December 2003 on cancer screening (2003/878/EC), COM(2008) 882 final 22.12.2008, Brussels. http://ec.europa.eu/health/ph_determinants/genetics/documents/com_2008_882.en.pdf

Hungary

Cervical cancer screening is an important issue in Hungary. In Hungary, female mortality caused by cervical cancer was the third worst in the European Union in 2003, despite the increase in screening between 1980 and 2003. The mortality rate caused by cervix cancer is still twice as high in Hungary than in the EU⁽¹⁴⁴⁾. According to the Eurostat data⁽¹⁴⁵⁾, 84.8% of the female population between 25 and 74 had a cervical cancer screening in 2004. In order to reach endangered women in the remote countryside, where access to this service is difficult, the Hungarian Post (Magyar Posta) started a mobile screening programme in 2006. The mobile screening station drives across the country following a strict timetable and mobilises women of all endangered age groups.

Iceland

Cervical cancer screening began in 1964 and consists of a gynaecological examination and a Pap-smear. Before 1988, women were invited to a screening at two- to three-year intervals and since 1 January 1988, at two-year intervals. From 1969 to 1987, screening was limited to women aged 25–69, but as of 1 January 1988, the age limit was lowered to 20. Women are invited to the screening by a personal letter, reminding them to make an appointment. However, they may also come of their own accord, without invitation, if it has been more than 18 months since the last screening, or whenever they have new symptoms.

Italy

Since 1996, Italian national guidelines have recommended regions to implement organised, free of charge screening programmes for cervical cancer. These recommendations, largely based on European guidelines, include personal invitations to women aged 25 to 64 for a Pap test every three years (not applied uniformly across the country), a monitoring system, and quality assurance for each phase of the programme. The implementation of the regional plans has been constantly monitored. Two out of three Italian women between 25 and 64 years of age live in an area where an organised cervical screening programme is active⁽¹⁴⁶⁾.

Latvia

The health prevention programme on the prevention of cervical cancer was introduced in 2009. The programme includes primary and secondary prevention of cancer: screening and vaccination. Screening is going to be free of charge, and every woman of a certain age (between the ages of 25 and 67) will receive invitation letters to the screening examination every three years.

⁽¹⁴⁴⁾ National Strategy Report on Social Protection and Social Inclusion 2006–08, Hungary, Budapest, 2006, Annex 1-1 http://ec.europa.eu/employment_social/spsi/docs/social_inclusion/2006/nap/hungary_annex1_1_en.pdf

⁽¹⁴⁵⁾ Eurostat data on population and social conditions based on health interview surveys (HIS). http://epp.eurostat.ec.europa.eu/portal/page/portal/product_results/search_results?mo=containsall&ms=cervical+&saa=&p_action=SUBMIT&l=us&co=equal&ci=,&po=equal&pi=

⁽¹⁴⁶⁾ Ministero della Salute (2007), Libro bianco: La salute della donna, Stato di salute e di Assistenza nelle regioni italiane, Rome.

The Netherlands

Dutch female residents, between the ages of 30 and 60, receive a personal reminder via regular mail regarding cervical cancer screening every five years. This health prevention programme was initiated at a national level by the Dutch Ministry of Health, Welfare and Sport in collaboration with the National Institute for Public Health and Environment (RIVM). Every year, 800 000 women are invited to participate in this screening; approximately 66% of them actually participate⁽¹⁴⁷⁾. All women between 30 and 60 years old are invited to make an appointment with their regular general practitioner in order to undergo examination to prevent cervical cancer. This national health prevention programme gives women the opportunity to determine their chances of developing cervical cancer at an early stage. Therefore, if they show symptoms which indicate potential cervical cancer they can be treated in time. Women are examined by their general practitioner and results of the examination are sent to a medical lab where a cytologist or pathologist further studies the cervical smear. If the swab shows no anomaly during examination, women do not have to return for a screening for another five years. If the swab does show an anomaly, further examination will be initiated by the general practitioner. The visit to the general practitioner, the analysis itself, the results and even the further examination after six weeks if there is any indication for it, are free of charge. The cost is paid for by the national government.

Norway

Every three years, women in the 25–69 age group are requested to be examined in order to prevent cervix cancer⁽¹⁴⁸⁾.

Poland

The programme for the prevention and early diagnosis of cervical cancer is included in a widespread longitudinal national programme for fighting malignant neoplasms set up in 2005, spanning the period 2006–15. It offers a free conventional Pap smear test and — if needed — further medical consultations and treatment every three years (except in suspected cases) for women aged 25–59. The programme includes an educational component: patients receive information on breast/cervical cancer, on possible risk factors, prevention and treatment methods.

Romania

Despite the fact that breast cancer and cervical cancer are the primary causes of cancer-related deaths affecting women, Romania is one of the few Member States that does not have a complete screening programme for identifying and preventing these types of cancers in the early stages. However, in 2009, the Romanian Ministry of Public Health announced the launching of two screening programmes for breast cancer and cervical cancer. The screening programme is to be developed in three stages at the local,

⁽¹⁴⁷⁾ Westert, G.P., Berg, M.J. van den et al. (eds.) (2008), Dutch Healthcare Performance Report 2008, RIVM, Bilthoven.

⁽¹⁴⁸⁾ Helse og Omsorgsdepartementet (n.y.), *Najonal strategj for krefstromradet, 2006–09*, Oslo. <http://www.regjeringen.no/upload/HOD/Sykehus/krefstrategi%202006-2009.pdf>

regional and national level. In the first stage, women at high risk for this disease are tested, on recommendation of the family doctor. During the third stage, developed at national level, all women between 25 and 65 years old are tested free of charge. The programme is planned to be developed over a three-year period.

Slovenia

The prevention programme for the early detection of precancerous changes of the cervix (Zora programme) is intended for women aged 20 to 75. Women in this age group have the right to receive an examination every three years after two negative smears taken at 12-month intervals. The programme has been under way since 2003, and operates nationwide.

Sweden

Screening programmes concerning cervix cancer are widespread: all county councils offer Pap tests at a cost for the patient or free of charge. The Pap test to prevent cervix cancer has been offered since the 1970s. All women between

23 and 50 years of age are called every three years. Between 50 and 60, the screening is every five years. After the age of 50 it is very uncommon to develop cervix cancer⁽¹⁴⁹⁾.

UK

All women between the ages of 25 and 64 are eligible for a free cervical screening test every three to five years. Cervical screening began in Britain in the mid-1960s and the NHS Cervical Screening Programme was set up in 1988 to ensure that those at greatest risk were being tested, and those who had positive results were being followed up and treated effectively. The programme screens almost four million women in England each year. In 2006/7, the coverage of eligible women was 79.2%⁽¹⁵⁰⁾.

Source: EGGSI network national reports 2009.

⁽¹⁴⁹⁾ <http://www.sjukvardsradgivning.se>

⁽¹⁵⁰⁾ NHS Cervical Screening Programme. <http://www.cancerscreening.nhs.uk/cervical/index.html>

Table 2-3 — Percentage of women reporting specific preventive examinations 1996 and 2002 — EU-15

	Breast examination by X-ray (mammography)		Breast examination by hand	
	1996	2002	1996	2002
EU-15	18.8	21.0	36.8	27.7
Belgium	16.5	18.8	41.2	33.6
Denmark	30.6	11.3	52.8	15.1
Germany	20.8	17.2	56.3	49.0
Greece	11.9	13.0	21.4	17.0
Spain	18.7	20.5	29.9	18.8
France	18.2	23.4	46.8	26.9
Ireland	4.5	9.7	15.6	24.9
Italy	15.0	25.7	28.0	25.3
Luxembourg	27.1	30.4	51.6	54.4
Netherlands	18.2	25.8	27.9	11.4
Austria	28.4	37.1	52.7	45.8
Portugal	17.9	33.0	24.8	27.7
Finland	17.5	22.9	37.2	25.9
Sweden	27.5	24.2	33.1	11.2
United Kingdom	12.3	12.7	23.2	17.7

Source: Eurobarometer 43.0 and 59.0 in European Commission, health information. Percentage of women reporting specific preventive examinations — 1996 and 2002.

http://ec.europa.eu/health/ph_information/dissemination/echi/echi_15_en.pdf

Table 2-3 provides information on the take-up rate of breast cancer screening programmes in 1996 and 2002 (derived from Eurobarometer) in 15 EU countries. It shows a great variation among EU-15 countries with a wider diffusion of breast cancer examinations by mammography in Austria, Portugal and Luxembourg and by hand in Luxembourg, Germany and Austria.

Breast cancer prevention programmes as implemented across Europe generally apply the European guidelines concerning the target group (50–69 years old). As shown in the box below (Box 2-5), women on lower income tend to use these services less often and the overall take-up rate is varied among countries.

Box 2-5 — Breast cancer prevention programmes

Austria

83% of all women above the age of 40 years have undergone a mammography for the early detection of breast cancer in 2006⁽¹⁵¹⁾.

Belgium

Since 2001 (2002 in Wallonia) a campaign for breast screening (mamotest) has targeted women aged between 50 and 69. The main results of the evaluation of the programme⁽¹⁵²⁾ show that the current coverage is 59% of the eligible population, but there are important disparities between regions (higher proportion in Flanders). In terms of accessibility for lower-income groups, women benefiting from BIM⁽¹⁵³⁾ have less coverage (14% less than other women). However, they constitute 30% of the programme's participants against 23% of other women, but they also leave the programme more frequently (26% against 23%). The percentage of breast screening outside the mamotest programme is still very high, at 83%.

Cyprus

The Breast cancer screening programme began as a pilot programme in July 2003 in one health centre in the capital Nicosia. The programme is now implemented in all major areas of Cyprus. The programme is population based and targets women aged 50–69 years. The programme is offered free of charge to all women, regardless of whether they are eligible or not for free public healthcare.

Estonia

Breast cancer is one of the most common malignant tumours among Estonian women. The mammography screening pilot projects were first activated in Tallinn in 1996 and in Tartu in 1998, and the early breast cancer detection project for 2002–06 was financed by the Estonian Health Insurance Fund. The target group was women aged 45–59 and up to 10 000 women are screened yearly with a mobile mammography. In May 2009 a one-year campaign, 'don't be late' for breast screening, started, targeted at women between the ages of 50 to 65. It is financed by the Health Insurance Fund (i.e. free for women). Until now only 50% of the women who have received the invitation have come to the screening⁽¹⁵⁴⁾.

Finland

Nationwide mammography tests were started in 1987. The tests first covered women aged 50–59, but many municipalities also included women aged 60–69. In the early 2000s, a systematic review of the effectiveness of screening for 60–69 year olds was carried out. The new regulation (Act 1339/2006) introduced in 2007 included the 60–69 age group in the screening programme, and the law will be implemented gradually⁽¹⁵⁵⁾.

France

The Cancer plan launched in 2003 had five targets regarding cancer detection, among which the implementation at national level of a programme of breast cancer detection and the improvement of individual detection for cervix cancer. If the objectives to implement at national level breast cancer detection have been met (results need to be improved for cervix cancer detection), a major problem in the field of cancer prevention remains the socioeconomic inequalities in access to prevention. Among women aged 40 and more living in a modest household, 34% have never had a mammography (versus 19% for other women) and among women aged 20 to 70 living in a modest household, 12% have never had a Pap smear test (double the number compared to other women)⁽¹⁵⁶⁾. In the same way, among women aged 25 to 65 years who do not benefit from complementary medical insurance, 56% declare that they have undergone cervix cancer detection in the last three years (versus 81% for others), and among women aged 50 to 74 years who do not benefit from complementary insurance, 48% declare that they have had a mammography in the last two years (versus 80% for others)⁽¹⁵⁷⁾.

Germany

Mammography screening is only for women between 50 and 69 free of charge and part of the statutory health scheme. The entitlement for services regarding the early detection of cancer from the age of 20 onwards (for women) and from the age of 45 onwards (for men) only refers to general cancer prevention: mammography screening is only done when the patient is suspected of having cancer.

Greece

A national screening strategy does not exist. This important gap is filled by associations, such as the 'Greek Association of Women with Breast Cancer', or the Municipality of Athens (that offers free mammography to women residing in Athens) but actions like this have only a limited impact, as they are localised and do not apply to the whole national territory.

⁽¹⁵¹⁾ Federal Ministry of Health, Youth and Family (2007), Austrian Health Survey 2006/2007, Vienna. p. 43.

http://www.statistik.at/web_de/dynamic/statistiken/gesundheit/publdetail?id=4&listid=4&detail=457

⁽¹⁵²⁾ Fabri, V., Remacle, A. (2009), Programme de Dépistage du Cancer du Sein Comparaison des trois premiers tours 2001–02, 2003–04 et 2005–06, Rapport numéro 6, Agence Intermutualiste, Janvier.

⁽¹⁵³⁾ BIM stands for 'Bénéficiaire d'Intervention Majorée' (Beneficiary of increased intervention): it is an incremented reimbursement of healthcare expenses for specific categories of beneficiaries.

⁽¹⁵⁴⁾ Eesti Vähiliit. <http://www.cancer.ee/?op=body&id=162&cid=>

⁽¹⁵⁵⁾ Ministry of Social Affairs and Health — MSAH (2007), *Seulontaohjelmat* [Screening programmes. A handbook for municipal authorities], Helsinki.

⁽¹⁵⁶⁾ Saint Paul de, T. (2007), *La santé des plus pauvres*, Insee première, No 1161, October.

⁽¹⁵⁷⁾ Danet, S., Moisy, M. (2009), *La santé des femmes en France*, Communication on the work done for the book: 'La santé des femmes en France' (to be published), Drees–French Ministry of Health and Sports, 8 April 2009, Paris.

Iceland

In November 1987, two nationwide mammography screening programmes for breast cancer were set up: one for women who were 35 years old and one for the 40–69 age group: the first screening round was completed in December 1989 and Iceland was the first country to complete a breast cancer screening of the whole female population in an age group, the age group from 40–69 years. In the following years, the target age was reduced.

Italy

Since 2001, mammography has been recommended by the Ministry of Health to be provided free of charge to people in selected age groups: women between 50 and 69. Three out of four Italian women between 50 and 69 years of age live in an area with an active breast cancer screening programme⁽¹⁵⁸⁾.

Latvia

The screening examination of the breast cancer is going to be introduced in 2009: an invitation is going to be sent to all women every two years from the age of 50 years onwards. It is going to be free of charge.

The Netherlands

The breast cancer screening programme is targeted at women between 50 and 75 years old. This health prevention programme was initiated at the national level by the Dutch Ministry of Health, Welfare and Sport in collaboration with the National Institute for Public Health and Environment (RIVM). Every two years, all women above 50 years old receive a breast cancer screening reminder: each year approximately one million women are invited to undergo breast cancer screening, and approximately 80% of these women actually do participate⁽¹⁵⁹⁾. The examination usually takes place in a mobile truck and is carried out by a female healthcare professional. Participation in the breast cancer screening programme is free, paid by the Ministry of Health, Welfare and Sport, and not mandatory. In the Netherlands, the number of breast cancer cases is very high; more than 11 000 women are diagnosed with this disease annually.

Norway

The action programme regarding the prevention, diagnosis and treatment of breast cancer involves mammography screening for all women between 50–69, every two years. In addition, women with a hereditary risk for breast cancer are followed up more intensively⁽¹⁶⁰⁾.

Poland

Programmes for the early diagnosis of breast cancer are included in a widespread, longitudinal national programme for fighting malignant neoplasms set up in 2005 for

⁽¹⁵⁸⁾ Ministero della salute (2007), Libro bianco: La salute della donna, Stato di salute e di Assistenza nelle regioni italiane, Rome.

⁽¹⁵⁹⁾ Westert, G. P., Berg, M. J. van den et al. (eds.) (2008), Dutch Healthcare Performance Report 2008, Bilthoven.

⁽¹⁶⁰⁾ Social OS helsedirektoratet (2007), Najonalt handlings med retningslinjer for diagnostikk, behandling og oppfølging av pasienter med brystkreft. http://www.helsedirektoratet.no/vp/multimedia/archive/00021/Nasjonalt_handlingsp_21559a.pdf

2006–15⁽¹⁶¹⁾. The programme offers free mammography examinations and — if needed — further medical consultations and treatment for women aged 50–69 who had no such examination during the last 24 months or need to repeat a mammography within 12 months because they belong to a group at risk for specific pathologies. Women diagnosed with a breast cancer are not covered by the programme (they receive a regular treatment, under health insurance).

Slovenia

The prevention programme for the early detection of breast cancer (Dora screening programme⁽¹⁶²⁾) promoted by the Ministry of Health, Oncological Institute and the Institute for Public Health Community health centres, is intended for all women aged 50 to 69. Women from this age group are personally invited in writing for mammographic screening every two years. However, the programme was only launched in 2008 and just in one region, but coverage is planned for the entire country within three years. The previous screening programme for the early detection of breast cancer, which has been under way for several years, entitled women aged 50 to 69 to undergo a preventive mammogram every two years. However, women were not invited to these examinations. In 2007, 64% of women who underwent preventive examinations for breast cancer were aged 40 or over⁽¹⁶³⁾.

Sweden

All county councils offer mammography: the National Board of Health and Welfare (NBHW) recommendation is that all women aged between 40 and 74 are called to be screened, with the strongest recommendation for the 50–69 age bracket. Mammography is recommended every 18 months, while every two years is sufficient for older women. The examination is voluntary⁽¹⁶⁴⁾.

UK

The National Health Service (NHS) Breast Screening Programme provides free screening for breast cancer every three years to all women in the UK aged 50 and over. Set up in 1988, it was the first screening programme of its kind in the world. National coverage was reached by the mid-1990s. Today, around one and a half million women aged 50–70 are screened in the UK per year. In September 2000, research demonstrated that the screening programme had lowered mortality rates for breast cancer in the 55–69 age group⁽¹⁶⁵⁾.

Source: EGGSI network national reports 2009.

⁽¹⁶¹⁾ Dz.U. 08.54.325 and regulated by Resolution 47/2006 of the Council Minister of 4 April 2006.

⁽¹⁶²⁾ Ministerstvo zdravotništva SR, Dora cancer screening programme. See also <http://dora.onko-i.si/>

⁽¹⁶³⁾ Institute of Public Health of the Republic of Slovenia (2007), Statistical yearbook on health 2007, Slovenia.

⁽¹⁶⁴⁾ <http://www.sjukvardsradgivning.se/allakapitel.asp?CategoryID=28278&AllChap=True&PreView=artikel.asp?CategoryID=28279>

⁽¹⁶⁵⁾ National Health Service — Cancer Screening Programmes, Sheffield, United Kingdom. <http://www.cancerscreening.nhs.uk/breastscreen>

Maternity and sexual/reproductive health

Across Europe many prevention programmes address maternity. Promoting healthy pregnancy and safe childbirth is a goal of all European healthcare systems. Despite significant improvements in recent decades, mothers and their babies are still often at risk during the perinatal period, which covers pregnancy, delivery, and the postpartum period: 'Perinatal health problems affect young people — babies and adults starting families — and, as such, have long-term consequences. Impairments associated with perinatal events represent a long-term burden for children and their families as well as for health and social services. It is increasingly understood that a healthy pregnancy and infancy reduce the risk of common adult illnesses, such as hypertension and diabetes' (166). In order to better monitor such factors, in 2000 the European Commission launched the project Peristat — Indicators for monitoring and evaluating perinatal health in Europe (167) coordinated by Inserm (France). Building on the work of the Peristat projects, in 2007 the Commission funded a project for a Better statistics for better health for pregnant women and their babies (168) coordinated by Assistance Publique-Hôpitaux de Paris (France). The European Perinatal Health Report, published in 2008 as a result of this project, was the first to collect data from 2004 in all EU countries, including policy-relevant analyses of maternal and child health outcomes, care provision, inequalities and migrant health in order to develop an Action plan for sustainable perinatal health reporting. Part of the study is dedicated to mothers' health: mortality and morbidity associated with childbearing. 'Each year more than five million women give birth in the EU. Another two million women have failed pregnancies — spontaneous and induced abortions as well as ectopic pregnancies. Maternal mortality is considered a major marker of health system performance, and overall each year from 335 to 1 000 women die in Europe during and

because of pregnancy or delivery' (169). Maternal deaths occur today in relatively small numbers, but an analysis of the causes is essential for developing strategies to prevent them. EGSSI national reports have described several prevention programmes addressing maternity. In almost all EU countries, prenatal screening tests for the most common risks for foetuses and pregnant women are widely available and free of charge.

Many EGSSI national reports have described prevention projects offering support for mothers with newborn children or for mothers with special needs: all over Europe women are offered medical support during and after pregnancy, while in some countries there are specific programmes which include other kinds of support, such as psychological help, antenatal exercises and birth preparation courses for couples featuring activities in nursing care.

Other widespread prevention programmes across Europe concern sexual and reproductive health. The European Union actively promotes sexual health and encourages the development of a healthy lifestyle regarding sexual behaviours (170). This objective, with a focus on young people, is included in the EU Health Programme for 2008–13. As reported by the EU-Health website (171), the EU wants to develop ways to improve the sexual health status of all citizens and to promote the exchange of good practices and information to address major concerns such as teenage pregnancy or the prevention of sexually transmitted diseases. The EU has taken steps towards a European partnership promoting sexual and reproductive health among young people and vulnerable groups in Europe. Guiding principles for the improvement of health in general, and sexual and reproductive health in particular, have been adopted or reconfirmed at international assemblies and conferences and set out in international documents (172). A specific case of difficult access to birth control options is

(166) Euro-Peristat (2008), European Perinatal Health Report, Project coordinated by the Assistance Publique-Hôpitaux de Paris (AP-HP) and the Institut de la santé et de la recherche médicale (Inserm).

<http://www.europeristat.com/publications/european-perinatal-health-report.shtml>

(167) European Commission, Directorate-General for Health and Consumer Protection, Public Health.

http://ec.europa.eu/health/ph_projects/2000/monitoring/monitoring_project_2000_full_en.htm#7

(168) Euro-Peristat (2008), European Perinatal Health Report, Project coordinated by the Assistance Publique-Hôpitaux de Paris (AP-HP) and the Institut de la santé et de la recherche médicale (Inserm). <http://www.europeristat.com/publications/european-perinatal-health-report.shtml>

(169) Euro-Peristat (2008), European Perinatal Health Report, Project coordinated by the Assistance Publique-Hôpitaux de Paris (AP-HP) and the Institut de la santé et de la recherche médicale (Inserm).

<http://www.europeristat.com/publications/european-perinatal-health-report.shtml>

(170) See also http://ec.europa.eu/health-eu/my_lifestyle/sex/index_en.htm

(171) European Commission, Health EU, the Public Health Portal.

http://ec.europa.eu/health-eu/my_lifestyle/sex/index_en.htm

(172) See for example several documents concerning Policy and programmatic issues published on WHO website: <http://www.who.int/reproductivehealth/publications/policy/en/index.html>. Among others: Eliminating female genital mutilation: an interagency statement — OHCHR, Unaid, UNDP, UNECA, Unesco, UNFPA, UNHCR, Unicef, Unifem, WHO — 31 December 2008; The WHO Strategic Approach to strengthening sexual and reproductive health policies and programmes — 31 December 2007; Introducing WHO's reproductive health guidelines and tools into national programmes — 31 December 2007.

worth mentioning: it is presented in the Cyprus EGGSI national report. Here contraceptive options, such as the male condom, brands of combined oral contraceptives, the intrauterine device (IUD), and hormonal intrauterine systems (IUS) are available only through private clinics, pharmacies at market price, and at reduced price or for free only by the Cyprus Family Planning Association (CFPA). Frequently cited

reasons for the scarcity of birth control options in Cyprus are, on the one hand, physical barriers (the small population of the island, which means a small market that would not be sufficiently responsive to render such technologies profitable for importers) and on the other hand cultural barriers (conscience issues) as well as economic barriers (family planning is left almost entirely to the free market).

Box 2-6 — Maternal and children health prevention

In Norway for example, maternal health centres offer general medical services for pregnant women and pre-school children in a prevention perspective. The focus is on groups/individuals with special needs, to identify early signals of malaise, abnormal development and antisocial behaviour. Maternal and child health centres cooperate with kindergartens and schools, educational psychological services and child welfare authorities⁽¹⁷³⁾. Special attention is paid to addicted pregnant women: according to the national health plan, there is an increased need for knowledge and information on the part of women that become pregnant within LAR (drug-based rehabilitation), and their children⁽¹⁷⁴⁾.

Furthermore, there is an ongoing self-help campaign to support pregnant women to quit smoking. In some countries families are also supported in their development: the case of Slovakia is interesting, where a special health programme focused on women and young girls, called Healthy Family

Programme, has the main objective of creating conditions for healthy and harmonic family development⁽¹⁷⁵⁾. This programme is a reaction to the recent decreasing birth rate, the increase of the age of primiparous women⁽¹⁷⁶⁾ and the increase in the number of children raised in mono-parental families. The focus is on information about matrimony, parenthood, contraception, and the risk of drug addiction.

In Italy the current concern is to reduce regional disparities regarding the care of mothers and their newborn babies by guaranteeing uniform obstetric and paediatric care throughout the country. Regarding this, the Healthcare Plan 2008–09 identified specific priorities through a project on motherhood and infancy (*Progetto Obiettivo Materno Infantile*), which paid specific attention to a particular female target group, namely women in prison. The Healthcare Plan 2008–09 invites the regions to carry out specific, direct programmes/projects to enhance female health issues for female convicts and their children.

⁽¹⁷³⁾ Norwegian Ministry of health and care services, National strategy to reduce social inequalities in health. Report No 20 (2006–07) to the Storting.

http://www.regjeringen.no/pages/1975150/PDFS/STM200620070020000EN_PDFS.pdf

⁽¹⁷⁴⁾ Helse og omsorgsdepartementet (2006), For budsjettåret 2007, St.prp.nr. 1 (2006–07).

<http://www.regjeringen.no/Rpub/STP/20062007/001HOD/PDFS/STP200620070001HODDDDPDFS.pdf>

Source: EGGSI network national reports 2009.

⁽¹⁷⁵⁾ Ministry of Health of the Slovak Republic (2007), *Koncepcia Štátnej politiky zdravia Slovenskej republiky*, Basic principles and structure of the healthcare system in the Slovak Republic. <http://www.uvzsr.sk/index.html>

⁽¹⁷⁶⁾ Refers to women who have given birth only once.

Domestic violence prevention programmes

An issue specifically affecting women's health is domestic violence. The health sector can play a vital role in preventing violence against women, by helping to identify abuse early, providing victims with the necessary treatment, and referring women to appropriate care. Particularly important for the purposes of this report is the role of healthcare services

in screening for domestic violence and abuse in order to prevent the escalation of violence and its short- and long-term health consequences. From EGGSI national reports, there emerges a general lack of awareness among health professionals with regard to existing support services for victims and thus they are not always in a position to refer victims to the appropriate services⁽¹⁷⁷⁾, but some good practices have also been described (see Box 2-7).

⁽¹⁷⁷⁾ Apostolidou, M., Apostolidou, Z., Payiatsou, M., Mavrikiou, P. (2007), *Evaluation of Services offered to Victims of Domestic Violence by the National Health Service*, Advisory Committee for the Prevention and Compacting of Violence in the Family. <http://www.familyviolence.gov.cy>

Box 2-7 — Good practices to combat domestic violence

In Norway gender-based violence and violence within families are not considered private matters, but a political and public issue. The first National action plan to combat domestic violence was launched in 2000, the second in 2004 and the third in 2007. The third includes also the need to combat honour-based violence, forced marriages and female genital mutilation. According to the action plans, domestic violence can be prevented by factors such as: women participating in the formal economy at a rate of 80%, having their own income and economic power, owning assets. It is considered essential to make the problem emerge from the private sphere. Other important measures are: educating the police force and the public at large, a strong cooperation between the NGOs and public authorities and involving men in combating violence⁽¹⁷⁸⁾. Particular attention has been paid to preventing domestic violence in families of ethnic minority backgrounds⁽¹⁷⁹⁾. Female genital mutilation is prohibited and punishable by law in Norway, hence the prevention of female genital mutilation is an important issue, and the government emphasised 41 measures to combat female genital mutilation in its action plan. As forced marriages may cause individual trauma, health personnel are in a key position to identify and treat victims of forced marriages. Within the action plan against forced marriages, emphasis was placed on strengthening existing regional resource centres expertise, including the development of mental healthcare for victims of forced marriages. One programme directed towards ethnic minorities was the project 'Ethnicity and domestic violence 2005–07'. The programme offered therapy for battered women and battering men, delivered in a culturally sensitive way, to which both the women and men participating in the programme responded⁽¹⁸⁰⁾.

In Sweden a project called okejsex.nu launched by Operation Kvinnofrid (The National Authority Cooperation Project for Women's Peace) in November 2007, together with a number of youth organisations, magazines and municipalities was intended to address the low awareness regarding sexual violence⁽¹⁸¹⁾. The two main objectives of the project were to increase awareness about sexual violence and its extent (including definitions of sexual violence, when and where it happens according to statistics, etc.). The target group was the young population in Stockholm. Special emphasis was given to school pupils, young members active in Internet communities and youth athletic groups.

In Austria the Vienna Women's Health programme has developed training measures for hospital staff for the

detection of early signs of the consequences of violence. Over the last decade the Municipal Department — Promotion and Coordination of Women's Issues has initiated a number of research projects, publications, conferences and model projects on issues like sexual, physical and psychological violence against women and children (e.g. a model project against stalking) and subsidises several counselling centres which support women in these situations, e.g. the 24-hour women's emergency helpline and women's shelters. The concepts and measures of the Municipal Department for Women's Issues aim at removing the taboo associated with these issues and try to show that violence is a problem of society in order to bring about structural changes⁽¹⁸²⁾.

In the Czech Republic the project 'Let's discuss domestic violence together' ('Mluvme spolu o domácím násilí')⁽¹⁸³⁾ was a joint project supported by AVON cosmetics and the civic association Accorus. It was an information campaign targeted at the entire population regarding women and domestic violence. The main objective was to offer information about the various forms of domestic violence other than physical violence, such as types of behaviour that are often not considered violent (financial restrictions, interference with privacy, e.g. searching through another's personal possessions). A non-stop helpline was set up as part of this campaign. The impact of this project has been evaluated positively, as the number of calls to the helpline and contacts at the counselling centre against domestic violence increased notably since its implementation.

Sexual violence has been on the gender and health agenda since the first nationwide studies in Finland in the late 1990s. There are currently many examples of how violence issues have become increasingly part of general health treatment. Two good examples are the monitoring of possible interpersonal violence against young women and the standardised assault form for victims of violence. In the first case, maternity and child health clinics, midwives and public health nurses are the target groups for developing suitable methods for identifying, addressing and discussing domestic violence⁽¹⁸⁴⁾. Another example of how the issue of violence is being dealt with in general healthcare is a tool for improving the legal protection for assault victims: the assault form is an intervention tool which can assist healthcare professionals in going over essential matters with patients at the initial stage. The southern provincial state office of Finland has already put the assault form and the emergency care protocol into use⁽¹⁸⁵⁾.

Source: EGGSI network national reports 2009.

⁽¹⁷⁸⁾ Hole, A. (2007), Lifting Domestic Violence from the Private to the Public Sphere, Ministry of children and equality. <http://www.regjeringen.no/en/dep/bld/BLD-arbeider-for-at/Organisation/Departments/Department-of-Family-Affairs-and-Gender-Equality/Director-General-Arni-Hole/Lifting-Domestic-Violence-from-the-Priva.html?id=481305>

⁽¹⁷⁹⁾ Kjell, Erik Øie (2007), Domestic violence in families with a minority ethnic background, Ministry of children and equality. <http://www.regjeringen.no/en/dep/bld/BLD-arbeider-for-at/Other-political-staff/State-Secretary-Kjell-Erik-Oie-Social-De/Speeches-and-articles-by-the-State-Sectr/2007/Domestic-violence-in-families-with-a-min.html?id=488410>

⁽¹⁸⁰⁾ Familievold og Etnisitet (2005), Rapport fra prosjektet. <http://www.atv-stiftelsen.no/filer/Fagrappport%20familievold%20og%20etnisitet%20-%20Alternativ%20til%20Vold.pdf>

⁽¹⁸¹⁾ <http://www.okejsex.nu/om/tack>

⁽¹⁸²⁾ City of Vienna (2006), Women's Health Report 2006, Vienna. www.oebig.org/upload/files/CMSEditor/WIEN_Frauengesundheitsbericht2006.pdf

⁽¹⁸³⁾ Acorus, Avon proti domácimu násilí. http://www.acorus.cz/cz/novinky/29_acorus-je-partnerem-projektu-„avon-proti-domacimu-nasili.html

⁽¹⁸⁴⁾ Ministry of Social Affairs and Health — MSAH (2008), Recommendations for the prevention of interpersonal and domestic violence, Recognise, protect and act, How to guide and lead local and regional activities in social and healthcare services (English Abstract), Helsinki.

⁽¹⁸⁵⁾ For details see website of Etelä-Suomen lääninhallitus. <http://www.laaninhallitus.fi/Ih%5Cetela%5Csto%5Chome.nsf/Pages/1498EDC9E1753383C22570A80027DF38>

Prevention of depression

Anxiety, depression and stress-related disorders rank high among the common mental disorders in the general population in Europe. They are likely to be the major cause in the increase in the burden of disability in years to come: according to the most recent available data (2002)⁽¹⁸⁶⁾, 'neuropsychiatric disorders are the first-ranked cause of years lived with disability (YLD) in Europe, accounting for 39.7% of those attributable to all causes. Unipolar depressive disorder alone is responsible for 13.7% of YLD, making it by far the leading cause of chronic conditions in Europe'⁽¹⁸⁷⁾. Specific forms of depression, like post-natal or post-partum depression, affect mostly women while others affect mostly men. They can be dealt

with by implementing prevention programmes at the primary and secondary level: 'primary prevention is directed at reducing the incidence of depression in the community by reducing risk factors and strengthening protective factors. Primary prevention is achieved also by enhancing the coping abilities of people who are currently without a mental disorder but are believed to be at risk of developing a particular disorder. Secondary prevention involves efforts to reduce the prevalence of a disorder by reducing duration of its effect. Secondary prevention programmes are usually directed at people who show early signs and symptoms of a disorder and the goal is to shorten the duration of the disorder by early detection and prompt treatment intervention'⁽¹⁸⁸⁾. EGSSI national reports cite some national experiences in this regard.

Box 2-8 — Good practices to combat depression

In Greece there is a specific national campaign for the prevention of depression, but it is not specifically targeted at women (in fact the campaign's motto is 'depression concerns everyone'), while significant help is offered by the 'Fainareti' Non-Governmental Organisation (funded by the Ministry of Health), which organises a day centre for the psychological care of women who suffer from postnatal mental disorders. Its key priorities and aims are the following: the early identification (pregnancy and early postpartum period) of mental disorders and early intervention for women and their families in order to prevent postnatal mental disorders. The targets are pregnant women, couples, mothers and newborns.

In Austria the prevention of postnatal depression was addressed by a pilot-project carried out as a part of the Vienna Women's Health programme in 2001 and 2002 and aimed at reducing the risk of postnatal depression for pregnant women run by the Vienna programme for women's health. A network of all institutions and contact points dealing with potential cases of postnatal depression has been established and many data on the incidence of postnatal depression have been collected. Of the 3000 women who took part in the questionnaire (2001–02)

based survey 18% showed indications of depression in the early stages of pregnancy (up to the 30th week), and 13% two weeks before birth. During the period of the Austrian survey, 28% showed risky depression values in one of the four stages that were surveyed. During the project various prevention and support measures were also tested and evaluated⁽¹⁸⁹⁾.

A specific programme regarding depression and mental health targeted at men has been reported in Slovenia. It concerns the reduction of suicide rates, a problem that affects men in particular. In 2003 a prevention programme was launched locally (in the two regions of Celje and Ravne, where suicide rates are particularly high) to educate family doctors and general practitioners aimed at the early identification of people with suicidal tendencies⁽¹⁹⁰⁾.

⁽¹⁸⁹⁾ City of Vienna, Vienna Programme for Women's Health. http://www.diesie.at/projekte/abgeschlossene_projekte/nach_themen/schwangerschaft/senkung_ppd.html

⁽¹⁹⁰⁾ Institute for Public Health of the Republic of Slovenia (2005), Cost efficiency of educational programmes for general practitioners in early detection of risk factors for suicide in region Ravne and Celje.

⁽¹⁸⁶⁾ WHO (2008), New WHO report: Policies and practices for mental health in Europe, Factsheet, 10 October 2008. http://www.euro.who.int/document/mediacentre/fs_mh_10oct2008e.pdf

⁽¹⁸⁷⁾ WHO (2004), Global burden of disease estimates, Geneva. <http://www.who.int/healthinfo/bodestimates/en/index.html>

⁽¹⁸⁸⁾ Mental Health Promotion and Prevention Strategies for Coping with Anxiety, Depression and Stress-Related Disorders in Europe (2001–03). http://ec.europa.eu/health/ph_projects/2001/promotion/fp_promotion_2001_frep_02_en.pdf

Programmes targeted at men

The EGGSI national reports have evidenced that gendered prevention programmes implemented in Europe are mainly targeted at women, while specific male pathologies, where prevention could be useful, are cited less frequently. This is the case, for example, of two typical masculine forms of cancer: prostate and testicular cancers. The first one occurs in older men while the second usually occurs in young or middle-aged men. While prostate cancer is widespread, being the fifth most common cancer in the world and the second most common in men⁽¹⁹¹⁾, testicular cancer is far rarer.

According to the WHO-Regional Office for Europe⁽¹⁹²⁾ 'there are no obvious preventive strategies, therefore screening has been considered to reduce the number of deaths. Opportunistic screening is widely carried out but there are no known national programmes to screen for prostate cancer.' In several EGGSI national reports, the experts specify that there are no national screening programmes for these types of cancers: this is explicitly mentioned for example in UK, Poland and Estonia. On the contrary, in the EGGSI national report of Austria it is stated that 55% of all men above 40 underwent a prevention check-up for the early detection of carcinoma of the prostate, increasing to 70% for men above 65⁽¹⁹³⁾. In Finland in the 1990s, the Cancer Society of Finland developed new methods of mass screening tests also for typically male cancers to indicate the amount of prostate specific antigen (PSA)⁽¹⁹⁴⁾. In the Netherlands a population-based prostate cancer screening programme is under scientific and policy discussion.

Another example is osteoporosis: a pathology that is perceived as predominantly affecting women, even

though men can suffer from it as well, but prevention programmes rarely include men within the target groups of prevention campaigns.

Old age

In many EGGSI national reports, programmes addressing osteoporosis are the most frequently cited among prevention programmes targeting old age. This disease, in which the bones become porous and break easily, is one of the most common, debilitating, and costly chronic diseases in Europe. Wrongly often thought of as an 'old woman's disease', osteoporosis affects not only one in three postmenopausal women, but also one in five men over the age of 50, younger women and even children. 'DXA⁽¹⁹⁵⁾ scans are vital in order to properly diagnose and monitor osteoporosis. Yet access to bone mineral density measurement is sub-optimal in many European countries. Reasons include limited availability of densitometers, restrictions in personnel permitted to perform scans, low awareness of the usefulness of BMD testing, limited or non-existent reimbursement. Many of the DXA scanners are not available to the public healthcare system, or regional disparities mean that some parts of a country are under-served'⁽¹⁹⁶⁾.

Guidelines are effective tools for promoting evidence-based clinical practice. Since some aspects of osteoporosis management vary according to country (i.e. availability of resources), country-specific guidelines are required. In 2004, the majority of European countries had guidelines (apart from some cases such as Ireland and Cyprus), but an important next step is to ensure that they are endorsed by their governments⁽¹⁹⁷⁾.

⁽¹⁹¹⁾ 'There were 679 000 new cases of prostate cancer worldwide in 2002, making this the fifth most common cancer in the world and the second most common in men (11.7% of new cancer cases overall); testicular cancer is relatively rare, with 49 000 new cases annually of 0.8% of cancers in men' Parkin, M., Bray, F., Ferlay, J., Pisani, P. (2002), Global Cancer Statistics, International Agency for Research on Cancer, Lyon.

⁽¹⁹²⁾ WHO, Should mass screening for prostate cancer be introduced at the national level?

http://www.euro.who.int/HEN/Syntheses/prostate/20040518_3

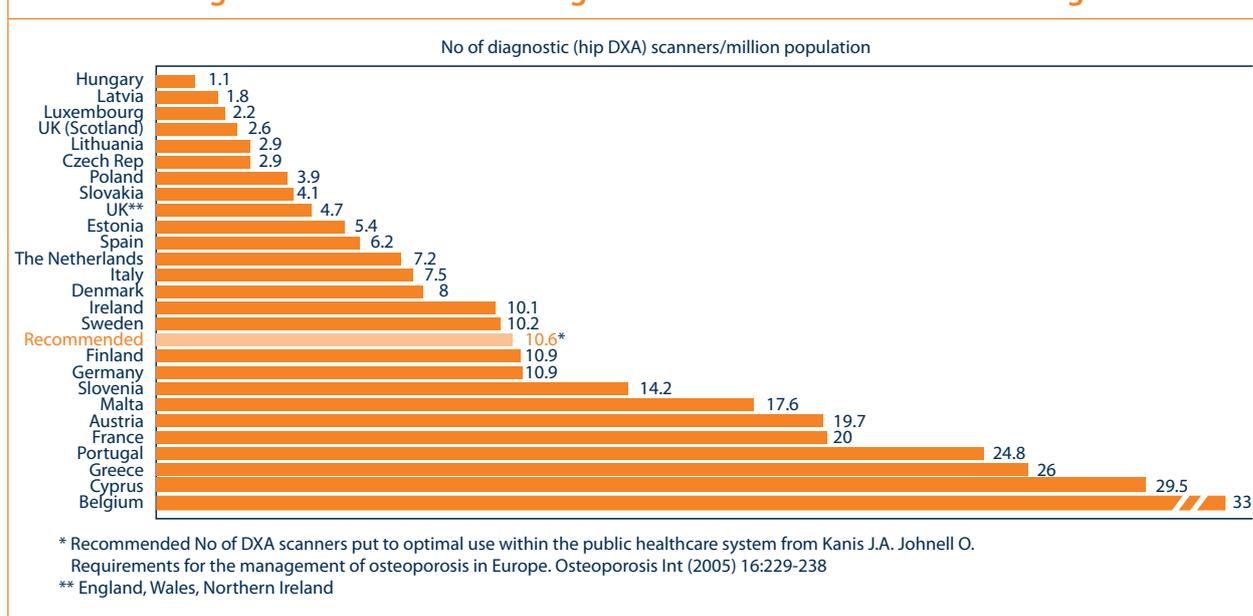
⁽¹⁹³⁾ The survey was carried out from March 2006 to February 2007. Data presented in: Federal Ministry of Health, Youth and Family (2007), Austrian Health Survey 2006/2007, Vienna. www.gesundheitsministerium.at/cms/site/artikel.pdf?channel=CH0713&doc=CMS1187768952223

⁽¹⁹⁴⁾ Finnish cancer organisation (2008), Finnish mass screening registry 40 years old. <http://www.cancer.fi/english/?x22567552=27328166>

⁽¹⁹⁵⁾ DXA is the Dual energy X-ray absorptiometry: it is a means of measuring bone mineral density (BMD).

⁽¹⁹⁶⁾ International Osteoporosis Foundation (2005), Osteoporosis in Europe: Indicators of progress and Outcomes from the European Parliament Osteoporosis Interest Group and European Union Osteoporosis Consultation Panel Meeting, November 10, Nyon.

⁽¹⁹⁷⁾ International Osteoporosis Foundation (2005), Osteoporosis in Europe: Indicators of progress and Outcomes from the European Parliament Osteoporosis Interest Group and European Union Osteoporosis Consultation Panel Meeting, 10 November, Nyon.

Figure 2-6 — Number of diagnostic scanners in the EU — ranking

Source: International Osteoporosis Foundation (2005), Osteoporosis in Europe: Indicators of progress and Outcomes from the European Parliament Osteoporosis Interest Group and European Union Osteoporosis Consultation Panel Meeting, 10 November, Nyon.
<http://www.iofbonehealth.org/publications/eu-policy-report-of-2005.html>

Table 2-4 — Reimbursement policy in the public healthcare system for diagnostic (DXA) scan of the hip and spine and average charge for a diagnostic scan of the hip and spine combined

	Reimbursement	No reimbursement	Euro	
Austria	YES */**		Finland	Free of charge
Belgium		NO	Poland	10 to 15
Cyprus	YES***		Lithuania	10 to 15
Czech Republic	YES		Czech Republic	18
Denmark	YES*		Latvia	25
Estonia	YES*		Germany	30
Finland	YES*		Slovakia	30
France		NO	Hungary	32
Germany	YES*		Slovenia	33
Greece	YES*		Estonia	35
Hungary	YES*		Belgium	40
Ireland		NO	Austria	50
Italy	YES*		France	50
Latvia		NO	Luxembourg	50
Lithuania		NO	UK	70–100 (when paid privately because of lack of access in the public healthcare system)
Luxembourg	YES*		Italy	75
Netherlands	YES		Cyprus	78 (for those not eligible for coverage)
Malta	YES		Ireland	80
Poland	YES****		Spain	90
Portugal	YES		Netherlands	100
Slovakia	YES		Portugal	100
Slovenia		NO	Greece	104
Spain	YES		Denmark	188 (covered by healthcare. Patients cannot pay for examinations performed in a public hospital)
Sweden	YES		Malta	190
UK – England, Wales, Northern Ireland	YES		Sweden	335
UK – Scotland	YES			

* With restrictions;

** Varies by region;

*** Extent of reimbursement depends on the individual's income;

**** Only as part of consultation

Source: International Osteoporosis Foundation (2005), Osteoporosis in Europe: Indicators of progress and Outcomes from the European Parliament Osteoporosis Interest Group and European Union Osteoporosis Consultation Panel Meeting, 10 November, Nyon.
<http://www.iofbonehealth.org/download/osteofound/filemanager/publications/pdf/eu-report-2005.pdf>

2.1.3. General treatment

This section focuses on general treatment provisions where gender differentiation is clearly detectable, such as treatment for reproductive care and for gender-specific diseases and health risks, as, for example, treatments for eating disorders, sexually transmitted diseases, breast and cervical cancer, home accidents and domestic violence. Treatment provisions for other health issues which present gender differences in terms of the extent and form of the health risks are also considered, such as health and mental disorders, heart and cardiovascular diseases, work-related illnesses and age-related illnesses.

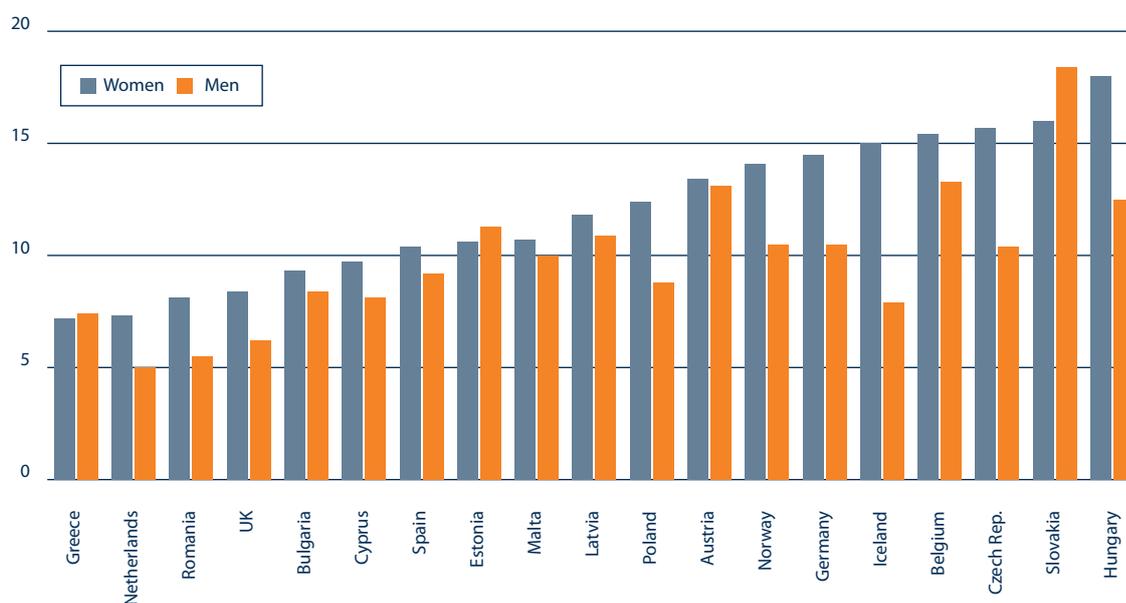
The issue of general treatment is considered in a threefold manner: description of the difference between women and men in the use of care; selected treatment provisions and their gender specificities in a lifecycle perspective; and programmes to support the access to healthcare for disadvantaged women.

Gender differences in the use of healthcare services

Generally women are more aware of their health status and are more frequent users of healthcare services than men, due to their reproductive role, their role as caregivers for dependants (children, the elderly, the disabled), their higher number among the older population and also due to gender stereotypes, since men usually do not consider it normal to complain about their health and visit physicians.

Men and women show different patterns in the types of health services they use. Overall, women are more likely than men to make use of preventive services. Available Eurostat data relative to the year 2004 shows that in most European countries, women represent a higher percentage of inpatient hospitalisation and consult doctors more often than men (Figures 2-7 and 2-8 and Annex, Table 2).

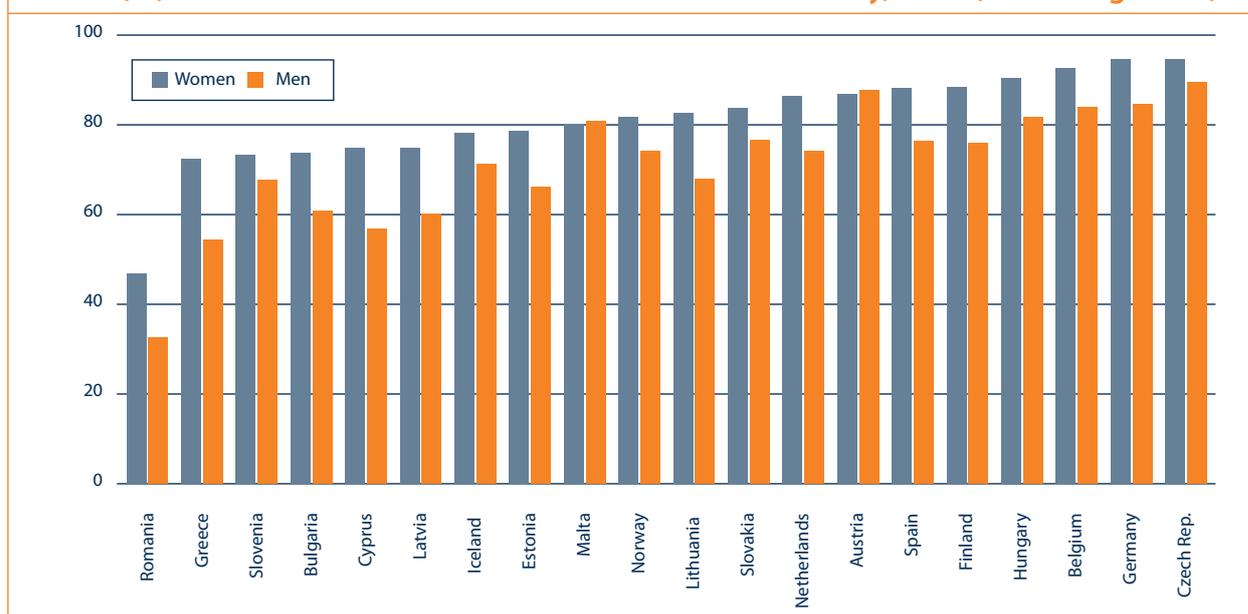
Figure 2-7 — Inpatient hospitalisation of women and men during the past 12 months (%) in some EU Member States and Iceland and Norway, 2004 (increasing order)



Source: Eurostat data based on national Health Interview Surveys (HIS round 2004: period 1999–2003).

Explanatory note: This indicator is not included in the Indicator list of the EU-level Open Method of Coordination for Social Protection and Social Inclusion. Data refers to the number of persons (15 years and older) who were hospitalised for more than one day. Data refers to persons living in private households and for some countries also in institutions like homes for the elderly.

Figure 2-8 — Consultation of a medical doctor during the past 12 months by women and men (%) in some EU Member States and Iceland and Norway, 2004 (increasing order)



Source: Eurostat data on Population and social conditions, Healthcare, based on Indicators from the national Health Interview Surveys (HIS round for 2004: period 1999–2003).

Explanatory note: This indicator is not included in the Indicator list of the EU-level Open Method of Coordination for Social Protection and Social Inclusion. The 2004 data refers to the years 1999–2003. For most countries, the population covered consists of all persons aged 15 and over living in private households, and for some countries also in institutions like homes for the elderly.

The share of women who declare they have consulted a medical doctor during the past 12 months varies greatly from country to country, ranging from 94.6% (compared to 89.4% for men) in the Czech Republic to 46.8% in Romania (compared to 32.6% for men). Inpatient hospitalisation rates are much lower, from 18% in Hungary (compared to 12.5% for men) to 7.2% in Greece (compared to 7.4% for men). The rates of inpatient hospitalisation among women compared to men are especially high in the reproductive age: women's rates are much higher than men's until the age of 44, while in old age, men present a higher inpatient hospitalisation rate than women in most countries (Table 3 in Annex).

Besides age, income and education are also other important determinants for access to healthcare for women and men. For similar levels of health needs,

individuals with lower incomes are more likely to use primary healthcare more intensively, whereas specialised assistance tends to be underutilised⁽¹⁹⁸⁾. As long as women tend to have lower income levels than men, these different patterns in access to healthcare may also have a gender specificity.

Education also appears to especially affect access to specialist care rather than other healthcare services, as better-educated women and men are significantly more likely to visit healthcare specialists than women and men with a lower level of education. According to a recent study considering data collected in nine European countries (Belgium, Denmark, Estonia, France, Germany, Ireland, Latvia, Hungary and Norway), differences in accessing specialist services between individuals of low and high educational levels are higher for women than for men⁽¹⁹⁹⁾.

⁽¹⁹⁸⁾ See for instance: Urbanos, R. M. (2004), El impacto de la financiación de la asistencia sanitaria en las desigualdades, Gaceta Sanitaria 2004, No 18 (Supl. 1), pp. 90-5 (2004) and London School of Economics (2007), Health Status and Living conditions in an enlarged Europe, Monitoring Report prepared by the European Observatory on the Social Situation — Health Status and Living Conditions Network, London.
http://ec.europa.eu/employment_social/spsi/docs/social_situation/sso2005_healthc_report.pdf,

⁽¹⁹⁹⁾ Mielck, A., Kiess, R., Stirbu, I., Kunst, A. (2007), Educational level and utilisation of specialist care: Results from nine European countries, chapter 26 in 'Taking Health Inequalities in Europe: An Integrated Approach, Eurothine Project.'
<http://mgzlx4.erasmusmc.nl/eurothine/>

Selected treatment provisions in a life cycle perspective

Gender-specific health-related risk behaviour is starting to be documented⁽²⁰⁰⁾ and knowledge about the necessity to provide gender-specific health treatment is increasingly diffused. However, gender differences in most treatments are often not taken into account, apart from reproductive care (basic service provisions for pregnant women and childbirth). Some other common health policies specifically addressed to women's health include treatment of breast and cervix cancer.

The 2009 EGGSI national reports show that women and men are usually treated in similar ways despite the fact that problems, resources and needs are often different. In many cases the knowledge utilised is based on studies conducted on men, which results in treatment that is in some cases poorly adjusted to the needs of women. A recent European Parliament comparative study also indicates that 'most research and clinical trials are done on men and extrapolated to women, and research on the kinds of treatment that are best for women remains limited'⁽²⁰¹⁾. In other cases, different patterns of medical responses towards female and male patients emerge in treatment, showing, for example, that the prescription of psychoactive drugs is much more frequent among women⁽²⁰²⁾.

The physical, psychological and social barriers that prevent many women from making healthy decisions are often less visible and seldom addressed by health treatment programmes and regulations. For example, there is usually little recognition of gender specificities in the treatment of some pathologies such as: heart diseases, sexually transmitted diseases, mental disorders, or work-related illnesses and of the long-term consequences on women's health of violence and abuse. Regulations regarding health and safety in the workplace usually do not cover housework and serious domestic accidents are not regularly

recorded and are thus left out of the statistics. Also, the treatment of some diseases related to gendered behaviours, such as alcohol addiction and alcohol-related diseases, which are predominantly — although not exclusively — a male problem, do not consider gender differences sufficiently.

Health service provisions targeted specifically at men are also little recognised, even if in some countries there is an increasing attention to these issues. For example in Austria and in Norway health and resource centres for men have been established with the aim to increase knowledge on health issues relevant for men and to provide advice on the psycho-social dimensions of men's health⁽²⁰³⁾.

Since age is an important determinant in the health status of women and men, as in the previous sections on healthcare promotion and prevention the analysis of access to general treatment services is based on a life-cycle perspective.

Treatment provisions in childhood and adolescence

Gender differences in access to medical treatment occur starting from childhood. According to a WHO Study in childhood⁽²⁰⁴⁾ boys are presented to doctors more often than girls, while from puberty onwards, girls seek medical care more frequently and suffer more frequently than boys from psychosomatic complaints and emotional disturbances (headaches, nervousness, sleep disorders).

In some countries specific programmes have been implemented for the treatment of eating disorders and sexually transmitted diseases which particularly affect girls, while specific healthcare centres for adolescents have been set up in only a few European countries. An example is the NGO 'Friends of the adolescents — centre for the prevention and healthcare of adolescents (KEPYE)' set up in Greece in 2006 within the University of Athens⁽²⁰⁵⁾. The centre provides advice, diagnosis,

⁽²⁰⁰⁾ See for instance European Parliament (2007), Discrimination against women and young girls in the health sector, Directorate-General Internal Policies, by the European Institute of Women's Health, Brussels.

<http://www.europarl.europa.eu/sides/getDoc.do?sessionid=42D62CA22BDD5134ABE684A2B6C616BC.node1?pubRef=-//EP//TEXT+TA+P6-TA-2007-0021+0+DOC+XML+V0//EN>

⁽²⁰¹⁾ European Parliament (2007), Discrimination against women and young girls in the health sector, Directorate-General Internal Policies, by the European Institute of Women's Health, Brussels.

<http://www.europarl.europa.eu/sides/getDoc.do?sessionid=42D62CA22BDD5134ABE684A2B6C616BC.node1?pubRef=-//EP//TEXT+TA+P6-TA-2007-0021+0+DOC+XML+V0//EN>

⁽²⁰²⁾ Velasco Arias, S. (2008), Recomendaciones para la práctica del enfoque de género en programas de salud, Observatorio de Salud de la Mujer, Ministerio de Salud y Consumo, Madrid.

⁽²⁰³⁾ In Austria the Männergesundheitszentrum (M.E.N.),

<http://www.men-center.at/>

and in Norway the Ressurscenter for Men.

http://www.reform.no/index.cfm?kat_id=11

⁽²⁰⁴⁾ Kolip, P. And Schmidt, B., Gender and Health in Adolescence, Health policy for children and adolescents (HEPCA), series No 1. Copenhagen, WHO (1999).

⁽²⁰⁵⁾ European Institute of Women's Health — EIWG Greece Country Reports to the European Parliament, 2006.

www.eurohealth.ie/countryreport/word/greece.doc

preventive and curative treatment to adolescent girls for eating disorders, sexually transmitted diseases [such as condyloma virus infections⁽²⁰⁶⁾], pregnancy and abortion, menstruation difficulties, cervical inflammations. The centre's staff is trained in adolescent medicine and healthcare, and the opening hours, contacts and interviews are organised so as to meet adolescents' needs⁽²⁰⁷⁾.

Healthcare for sexually transmitted diseases

As discussed in the first chapter, women (especially young women) are more vulnerable to sexually transmitted diseases compared to men and the consequences are more serious for them. Since many sexually transmitted diseases are asymptomatic in women, they often go untreated and this represents a risk factor for HIV.

In some European countries there are programmes monitoring and treating sexually transmitted and other communicable diseases. An example is the National programme for communicable diseases implemented in Romania, which aims at monitoring and controlling communicable diseases such as HIV/AIDS, tuberculosis, hepatitis, etc. The programme is aimed at the identification and treatment of infected individuals, early diagnosis/treatment and follow-up of infected cases. Across the country, different district public health authorities, hospitals and providers of primary assistance and research institutes are involved⁽²⁰⁸⁾.

Healthcare for eating disorders

Eating disorders, such as bulimia and anorexia, are more likely to affect teenagers and young women rather than men (even if cases are becoming more frequent among young men). Knowledge about eating disorders is still limited and the percentage of people with eating disorders is unknown. Obesity is

also an increasing phenomenon. The proportion of women who are obese is usually lower than men, but among 13 year olds, obesity is higher in girls than boys because girls are less involved in sports and physical activities⁽²⁰⁹⁾. Being overweight during adolescence compromises long-term health, and is associated with coronary heart diseases, arteriosclerosis⁽²¹⁰⁾ and colorectal cancer.

While in many western EU countries there are specialised clinics or medical centres for treating these disorders, in eastern EU countries, the healthcare provision for eating disorders is still underdeveloped, even if the necessity to establish specialised care is increasingly recognised.

For example, in Bulgaria the National action plan on food and nutrition and the National programme and action plan on mental health have some targets directed to reducing anorexia and bulimia. The Ministry of Health is planning to establish special sectors in psychiatric hospitals and to develop specialised standards and programmes for treating eating disorders⁽²¹¹⁾.

In Slovenia the Clinical department for mental health, which is part of the Psychiatric Clinic in Ljubljana, is specialised in the treatment of adolescent psychiatry, eating disorders, crisis interventions, psychotherapy, and alcohol abuse⁽²¹²⁾.

An interesting programme aimed at increasing knowledge about eating disorders is the Swedish Riksät (National Quality Registry for Specialised Treatment for Eating Disorders) programme which was created in 1999 in order to collect data, increase knowledge and reduce both personal suffering and costs. In 2007, 64 clinics reported data to Riksät. From 2003 to 2007, 5 396 new treatments started with adolescents and young women as main beneficiaries⁽²¹³⁾.

⁽²⁰⁶⁾ Condyloma refers to an infection of the genitals caused by a virus called human papilloma virus (HPV), which can affect both men and women. It is also known as: wart, genital wart, venereal wart, which can be transmitted during sexual intercourse. Infection with HPV is very common, although the majority of people have no symptoms (asymptomatic). Source: <http://www.condyloma.org/main.html>

⁽²⁰⁷⁾ European Institute of Women's Health (2006), Discrimination against Women and Girls in the Health Sector, Brussels. <http://www.eurohealth.ie/countryreport/pdf/euparcountryrep.pdf>

⁽²⁰⁸⁾ The Romanian Ministry of Health-Programmes 2008.

⁽²⁰⁹⁾ European Institute of Women's Health (2006), Discrimination against Women and Girls in the Health Sector, Brussels.

<http://www.eurohealth.ie/countryreport/pdf/euparcountryrep.pdf>

⁽²¹⁰⁾ Arteriosclerosis is a condition where arteries become thick, blocked and inelastic as a result of a film of fat (atheromas) forming on their walls. It hinders effective blood circulation depriving the body organs of oxygenated blood. Source: <http://arteriosclerosis.org/>

⁽²¹¹⁾ European Institute of Women's Health, 2006, Discrimination against Women and Girls in the Health Sector, Brussels.

<http://www.eurohealth.ie/countryreport/pdf/euparcountryrep.pdf>

⁽²¹²⁾ Psihiatrica Klinika Ljubljana.

<http://www.psih-klinika.si/index.php?id=113/>

⁽²¹³⁾ Riksät (2008), Nationellt kvalitetsregister för ätstörningsbehandling, Rapport 2006–07.

http://www.kpvcentrum.se/register/riksat/arsrapport_2006-2007.pdf

Treatment provisions in reproductive age

Gender-specific health treatment in reproductive age mostly involves care services for pregnant women and childbirth, the treatment of specifically female diseases such as, for example, breast and cervical cancer and the treatment of domestic violence. In the other cases, health treatment is usually gender neutral, even if women and men present differences in symptoms and outcomes. This is the case for example in the treatment of heart and cardiovascular diseases, mental health and addiction, work-related diseases.

Heart and cardiovascular diseases

This is an area where usually general treatment is considered gender neutral, but where sex- and gender-based differences in detection rates, medication treatment and survival rates have been observed⁽²¹⁴⁾. Women and men experience heart problems differently and show different symptoms, which complicates diagnosis. Men appear to have a better long-term survival rate than women.

A European Parliament Study⁽²¹⁵⁾ refers to recent research which suggests that fewer women than men with suspected acute heart attack symptoms are referred for non-invasive tests and fewer are recommended for further testing and treatment. Since women often present different symptoms than men, there is a higher incidence of unrecognised myocardial infarction⁽²¹⁶⁾ in women than in men. Thus women treated with 'male-based' treatments may not respond in the expected way and may require different treatments. There is, however, too little knowledge about the female heart, given that the majority of studies have been made on male hearts. Since women have a high fatality rate associated with a first heart attack, it is necessary that women with suspected heart attack be carefully and promptly evaluated.

⁽²¹⁴⁾ European Institute of Women's Health (2006), Discrimination against Women and Girls in the Health Sector, Brussels. <http://www.eurohealth.ie/countryreport/pdf/euparcountryrep.pdf>

⁽²¹⁵⁾ European Parliament (2007), Discrimination against women and young girls in the health sector, Directorate-General Internal Policies, by the European Institute of Women's Health, Brussels, p. 21. <http://www.europarl.europa.eu/sides/getDoc.do?sessionId=42D62CA22BDD5134ABE684A2B6C616BC.node1?pubRef=-//EP//TEXT+TA+P6-TA-2007-0021+0+DOC+XML+V0//EN>

⁽²¹⁶⁾ A myocardial infarction (known more commonly as a heart attack) occurs when the supply of blood and oxygen to an area of heart muscle is blocked, usually by a clot in a coronary artery. Often, this blockage leads to arrhythmias (irregular heartbeat or rhythm) that can cause a severe decrease in the pumping function of the heart and may bring about sudden death. If the blockage is not treated within a few hours, the affected heart muscle will die and be replaced by scar tissue. Source: [http://www.patient.co.uk/health/Myocardial-Infarction-\(Heart-Attack\).htm](http://www.patient.co.uk/health/Myocardial-Infarction-(Heart-Attack).htm)

Box 2-9 — Good practice examples in the treatment of cardiovascular diseases (CVD)

Treatment of CVD — the Swedish Go Red campaign

The Go Red campaign was initially started in 2004 by the American Heart Association⁽²¹⁷⁾. In Sweden the Heart-Lung Foundation promotes the campaign in cooperation with 1.6 million sports clubs and the Swedish Society of Cardiologists. The main objective is to raise awareness and funds so as to secure future research on the female heart, necessary for equal treatment of heart disorders. During the 2009 campaign, the programme collected SEK 5 million⁽²¹⁸⁾ to finance two research positions to increase knowledge on the female heart⁽²¹⁹⁾.

The Icelandic Association of Heart Patients, Hjartaheill

The association, founded in 1983, runs a well-equipped rehabilitation centre in Reykjavik in cooperation with other organisations for the treatment of heart patients. The heart and lung training centre assists about 400 patients, providing daily rehabilitation and permanent physical training programmes. The main aim of the association is to improve general health services and social conditions for heart patients, to improve facilities and medical equipment in hospitals for research and the treatment of heart diseases and to create proper conditions for rehabilitation. They also provide heart patients with information on their social rights, e.g. taxation, financial support, insurance, pension, medical treatment abroad. The association is actually implementing a special division for women in order to raise awareness and reach out to more women⁽²²⁰⁾.

Source: EGGS network national report 2009 – Sweden and Iceland.

⁽²¹⁷⁾ Go Red Foundation.

<http://www.goredforwomen.com.au> and

<http://www.1.6miljonerklubben.com/aktiviteter/gored/>

⁽²¹⁸⁾ Equivalent to approximately EUR 0.5 million (August 2009).

⁽²¹⁹⁾ <http://www.hjart-lungfonden.se/Kampanj---kvinnohjartan-2009/om-kampanjen/>

⁽²²⁰⁾ Icelandic Association of Heart Patients, Hjartaheill. http://www.hjartaheill.is/index.php?option=com_content&task=view&id=107&Itemid=87

The EGGSI national reports present evidence of gender differences in treatment from heart attacks and coronary diseases in some European countries.

- In Finland, according to recent studies, men receive more active treatment than women⁽²²¹⁾.
- In Sweden, 55 women per day die from heart disease and 42 women suffer a cardiac infarction, yet women are not offered the same treatment as men⁽²²²⁾. According to the Swedish Heart–Lung Foundation, of four different examined methods of treatment, women were undertreated in 89% of the cases⁽²²³⁾. The campaign Go Red — introduced in March 2006 (see Box 2-9) — is an important initiative for improving treatment for women suffering from heart diseases, by raising awareness on female specificities in heart disease and raising funds for research on the female heart.
- In the United Kingdom, men are more likely than women to be referred to heart specialists for surgery for cardiovascular diseases (CVD) and to be treated intensively once diagnosed, due to a cultural perception that this is a male disease⁽²²⁴⁾.

Mental healthcare and the treatment of addiction

As discussed in Chapter 1, recent research shows that women are twice as susceptible as men to developing depression and depression-related problems. In addition, some common mental disorders present gender specific risk factors: domestic abuse usually results in high rates of depression and anxiety; female single parents and retired women living alone are at high risk for social isolation and anxiety; the role overload of working women with care responsibilities have further impact on

mental health⁽²²⁵⁾. According to the WHO⁽²²⁶⁾, in fact caregivers are frequently depressed and anxious, and are likely to use psychotropic medications to treat their psychological distress due to the heavy load of their care work.

The seeking of help and treatment patterns for mental and psychological disorders are also gender differentiated. Women are more likely to seek help from their primary care doctor, while men are more likely to seek specialised care and are the principal users of inpatient care. Women are also more likely to be diagnosed with depression and be prescribed mood-altering psychotropic drugs than men with identical symptoms⁽²²⁷⁾. Girls are heavier medication users as compared to boys, and these differences persist in adulthood⁽²²⁸⁾.

Gender differences in addiction patterns and in mental illnesses are usually not recognised in medical treatment, even if they may affect response to treatment. For example, there is evidence to suggest that drugs to induce cessation are not equally effective for both sexes. In recent years some countries have promoted specific programmes for the treatment of addiction and mental health problems targeted at women⁽²²⁹⁾.

In Iceland a hospital and detoxification clinic run by an NGO created a special detoxification treatment programme for women in 1995 (see Box 2-10). In Spain a programme of the Health and Social Services of the Women's Institute, on the basis of an agreement with the Ministry of Health and Consumption, included a project for bio-psychosocial assistance to women. This programme is mainly oriented towards some aspects of women's mental health that deserve specific psychosocial attention by primary healthcare professionals.

⁽²²¹⁾ Kattainen, A. et al. (2006), Coronary heart disease: from a disease of middle-aged men in the 1970s to a disease of elderly women in the 2000s, *European Heart Journal*, 27(3), 296–301. and Kiiskinen, Urpo, et al. (2008), Terveiden edistämisen mahdollisuudet. Vaikuttavuus ja kustannusvaikuttavuus [Evaluation of Health promotion opportunities — effectiveness and cost-effectiveness], Publications of the Ministry of Social Affairs and Health 2008:1, Helsinki.

⁽²²²⁾ According to statistics from the NBHW, the municipalities of Sweden, the Open Comparison Registers of the County Councils and national registers of heart intensive care. Source: Hjärt Lungfonden (2009), Kvinnor underbehandlas vid hjärtinfarkt, <http://www.hjart-lungfonden.se/HLF/Pressrum/Pressmeddelanden/Kvinnor-underbehandlas-vid-hjartinfarkt/>

⁽²²³⁾ This might be related to scarce research and knowledge on the female cardiovascular disease.

⁽²²⁴⁾ Wilkins, D., Payne, S., Granville, G., Branney, P. (2008), The Gender and Access to Health Services Study, Department of Health, London.

⁽²²⁵⁾ European Parliament (2007), Discrimination against women and young girls in the health sector, Directorate-General Internal Policies, by the European Institute of Women's Health, Brussels. <http://www.europarl.europa.eu/sides/getDoc.do?sessionId=42D62CA22BDD5134ABE684A2B6C616BC.node1?pubRef=-//EP//TEXT+TA+P6-TA-2007-0021+0+DOC+XML+V0//EN>

⁽²²⁶⁾ WHO (2003), Key policy Issues in Long-term care, Geneva. http://www.who.int/chp/knowledge/publications/policy_issues_1tc.pdf

⁽²²⁷⁾ http://www.who.int/mental_health/prevention/genderwomen/en/

⁽²²⁸⁾ Kolip, P., Schmidt, B. (1999), Gender and Health in Adolescence, World Health Organisation, HEPCA series, No 1.

⁽²²⁹⁾ National Centre for Chronic Disease Prevention and Health Promotion Tobacco Prevention and Information (2001), Women and Smoking — A report of the Surgeon General, cited in: European Parliament (2007), Discrimination against women and young girls in the health sector, Directorate-General Internal Policies, by the European Institute of Women's Health, Brussels. <http://www.europarl.europa.eu/sides/getDoc.do?sessionId=42D62CA22BDD5134ABE684A2B6C616BC.node1?pubRef=-//EP//TEXT+TA+P6-TA-2007-0021+0+DOC+XML+V0//EN>

In Germany a network for depression and suicide addresses post-partum depression.

On the other hand, according to the EGSI expert in Cyprus the only closed facility offering long-term

treatment and rehabilitation services for addicts is only open to men⁽²³⁰⁾. In Malta too, a good-practice programme aimed at reintegrating people suffering from mental problems back into the community after years of institutionalisation is only targeted at men⁽²³¹⁾.

Box 2-10 — Good practice examples in the treatment of addiction and mental healthcare

The SAA National Centre for Addiction Medicine in Iceland

A special treatment programme for addicted women was started in the city of Vik in 1995. Women can go for a four-week treatment specially designed for them at Vik Rehabilitation Centre. They also receive support from the outpatient wards in Reykjavik and Akureyri (on the north coast of Iceland) for a year after completing the treatment programme at Vik. The outpatient programme includes individual interviews and a women's support group. Since the start of this special programme for women, far fewer women drop out of treatment before the end of the programme than before. The programme has encouraged a special type of bonding among women with alcohol and drug addiction problems resulting in the establishment of support groups for women around the country (Kjarnakonur-Strong women), which help to tackle the distinct types of problems and isolation experienced by female patient groups⁽²³²⁾. In addition, a cohabitation centre for women started operating at the beginning of 1996, housing 15 women at a time with room for children who accompany their mothers. The patients themselves are responsible for covering part of the costs⁽²³³⁾.

The programme on bio-psychosocial assistance for women in primary healthcare in Spain

The main action of the programme is the provision of training courses for health professionals (mostly primary healthcare doctors) in order to implement a new treatment model for certain unmet psychosomatic needs identified in women. The programme is exclusively oriented to enhancing women's mental health and quality of life, although the results of the programme have been monitored in both male and female patients. It was implemented within the Programme on

Health and Social Services supported by the Women's Institute in cooperation with the Public Health Service of Murcia, and assisted by an external consultant. According to the evaluation report of the programme, professionals have increased their knowledge and capacity to address these problems, and they have acquired greater control over their own stress. Some 77% of patients have shown a noticeable clinical improvement of symptoms and a reduction of medicine consumption. Some improvements in the efficiency of the health system have also been detected: greater patient satisfaction, less overuse of primary healthcare, reduction of medicine consumption, and less overuse of complementary tests. The project was identified as a good practice by the information system 'Practical Experiences and Initiatives in Social Cohesion' of the project EUROsocial, by EuropeAid⁽²³⁴⁾.

The 'German Network for Depression and Suicide' is a widespread German network — present in more than 50 regions and cities — aimed at improving the knowledge regarding 'depression' through information campaigns, to sensitise the German population on the issue, improve the care system and improve the living conditions of people affected by depression. The activities of the network include information campaigns targeting children and youth, the migrant population, or other, different campaigns, such as 'Depression after giving birth' or 'Depression of the elderly' or 'Depression at the workplace'. A pilot project implemented in Nurnberg in 2001, included hospitals, general practitioners, specialists, churches and other organisations, aimed to support people at risk of suicide and to reduce the number of suicides through an intensive information campaign. The campaign was financed by the Ministry for Education and Research for two years, and is now supported by charitable donations⁽²³⁵⁾.

Source: EGSI network national reports 2009 — Iceland, Spain and Germany.

⁽²³²⁾ Kjarnakonur, support groups for women and their relatives after receiving treatment.

<http://www.saa.is/islenski-vefurinn/felagsstarf/kjarnakonur/>

⁽²³³⁾ SAA, National Centre of Addiction Medicine.

<http://www.saa.is/enski-vefurinn/rehabilitation-program/>

⁽²³⁴⁾ EPIC database, Eurosocial.

<http://epic.programaeurosocial.eu/buscador/buscar.php>

⁽²³⁵⁾ Deutsches Bündnis gegen Depression.

<http://www.buendnis-depression.de/>

⁽²³⁰⁾ The 'Ayia Skepi Therapeutic Community' is an inpatient long term (12–18 months) therapeutic community that serves adult dependent users of illicit substances. Its main aim is to assist addicts in recognising and adopting new strategies and therefore become able to live without the use of substances. The programme is based on the bio-psychosocial model and cognitive behavioural theory.

<http://www.emcdda.europa.eu>

⁽²³¹⁾ Malta National Report on Strategies for social protection and social inclusion, 2008–10, http://ec.europa.eu/employment_social/spsi/docs/social_inclusion/2008/nap/malta_en.pdf http://ec.europa.eu/employment_social/spsi/docs/social_inclusion/2008/nap/malta_en.pdf

Work-related diseases

Regulations on health and safety at the workplace mainly cover the risks that men are more commonly exposed to, while little consideration is given to health risks women are more likely to experience in female intensive occupations and sectors. Criteria for hard work is still based on a traditional vision of heavy work in construction and industrial sectors as masculine, and not on work relating to service provision, care (children, older people) and housework. In addition, the fact that more women than men are employed in low-paid, precarious jobs, often entailing poor working conditions and high health and safety risks (such as domestic (care) work) is not recognised and paid domestic work is usually excluded from coverage⁽²³⁶⁾.

The notion of professional illness is interpreted in a restrictive way and numerous repetitive strain injuries (RSI)⁽²³⁷⁾ are usually dismissed by insurance schemes⁽²³⁸⁾. Still little attention is paid by regulations on health and safety at work to work-related stress due to lack of job security, psychological and sexual harassment. Compensation arrangements are more likely to cover work-related injuries in male-dominated jobs, because these types of injuries have a more evident work-

related explanation. As reported in the 2003 study by the European Agency for Safety and Health at Work 'if a multi-factorial work exposure is present, as in many jobs dominated by women, the resulting disease is much less likely to be covered by industrial compensation arrangements, or even, if covered, it is much less likely to actually receive compensation'⁽²³⁹⁾.

In addition there appear to be relevant barriers to women's participation in rehabilitation programmes. Some studies conducted in the Netherlands⁽²⁴⁰⁾ have found that fewer women than men are rehabilitated into the workforce after a long spell of ill health; other studies⁽²⁴¹⁾ show that women have a higher risk of being diagnosed as disabled for work purposes after the first year of absence due to sickness, whereas men are more commonly provided with therapeutic support aimed at their return to work. This also appears to be due to the attitudes of occupational health physicians and of employers, who feel that rehabilitation is more important for men than for women⁽²⁴²⁾.

Disabilities or diseases related to home care and the care of dependants are usually not considered in insurance schemes, and no preventive and long-term care programmes are envisaged in most countries.

⁽²³⁶⁾ Fagan, C., Burchell, B. (2002), Gender, jobs and working conditions in the European Union, European Foundation for the Improvement of Living and Working Conditions, Dublin. <http://www.eurofound.europa.eu/pubdocs/2002/49/en/1/ef0249en.pdf>

⁽²³⁷⁾ Repetitive strain injury, also known as Cumulative Trauma Disorder (CTD) and Musculoskeletal Disorder (MSD), is a potentially debilitating condition resulting from repetitive, forceful or awkward body movements. Workers in many jobs (such as those working at assembly lines, cashiers, sign languages interpreters) or employers using a computer (such as using keyboards and mouse) are especially at risk.

⁽²³⁸⁾ Vogel, L., L'insoutenable légèreté du travail professionnel des femmes, in Les politiques sociales ont-elles un sexe Ed. Vogel-Polsky E, 2001, p. 107.

⁽²³⁹⁾ European Agency for Safety and Health at Work (2003), Gender issues in safety and health at work, a review, Luxembourg, p. 107. <http://osha.europa.eu/en/publications/reports/209>

⁽²⁴⁰⁾ Veerman et al. (2000), cit. in: European Agency for Safety and Health at Work (2003), Gender issues in safety and health at work, a review, Luxembourg, p. 106. <http://osha.europa.eu/en/publications/reports/209>,

⁽²⁴¹⁾ Houtman et al. 2002, cit. in European Agency for Safety and Health at Work (2003), Gender issues in safety and health at work, a review, Luxembourg. <http://osha.europa.eu/en/publications/reports/209>

⁽²⁴²⁾ Vinke et al. (1999); Cuelenaere (1997) and Doyal (2002), cit. in: European Agency for Safety and Health at Work (2003), Gender issues in safety and health at work, a review, Luxembourg. <http://osha.europa.eu/en/publications/reports/209>

Box 2-11 — Current EU directives on health and occupational safety

The European Commission has set minimum requirements in the field of labour rights and work organisation through specific directives for ensuring safety and health at work and for promoting high-quality workplaces and healthy working environments. The legislation is related to: general provisions, the workplace and the protection of specific groups of workers (such as pregnant women, young people (below 18 years) or temporary workers) ⁽²⁴³⁾.

The 1989 EU framework directive (Council Directive 89/391/EEC) ⁽²⁴⁴⁾ introduced measures ⁽²⁴⁵⁾ to encourage the improvement of safety and health of workers at work (Art. 1), by including preventive measures for eliminating occupational risks due to accidents at work and

occupational diseases. It applies to all public and private sectors of activities (industrial, agricultural, commercial, administrative, service, educational, cultural, leisure, etc.), except certain specific activities in public and civil protection services. The directive covers general provisions for psychosocial issues, such as violence from the public and work organisation, stress, work-related limb disorders, which are not covered by other directives.

Directives regarding safety at work (Council Directive 89/654/EEC) ⁽²⁴⁶⁾ or personal protective equipment (89/655/EEC) ⁽²⁴⁷⁾ concern the minimum level of worker safety by general obligation of a well-equipped workstation and adequate personal protective equipment.

The protection of specific groups, such as women who are pregnant or recently gave birth, is guaranteed though Council Directive 92/85/EEC ⁽²⁴⁸⁾, which introduces measures to improve the safety and health of pregnant workers and those who have recently given birth. It includes requirements for identifying risky work conditions, risk assessment and provisions for pregnant or new mothers regarding restrictions, such as provisions for avoiding contact with chemicals and other hazardous products, exclusion from night work, as well as female employment rights issues, maternity leave, ante-natal examinations, and protection against discriminatory dismissal.

Source: http://europa.eu/legislation_summaries/employment_and_social_policy

⁽²⁴³⁾ European Agency for Safety and Health at Work (2003), Gender issues in safety and health at work, a review, Luxembourg, p. 124. <http://osha.europa.eu/en/publications/reports/209>

⁽²⁴⁴⁾ Council Directive 89/656/EEC of 30 November 1989 on the minimum health and safety requirements for the use by workers of personal protective equipment at the workplace (third individual directive within the meaning of Article 16 (1) of Directive 89/391/EEC). <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:31989L0656:EN:HTML>

⁽²⁴⁵⁾ For instance, employers are obliged to identify and evaluate occupational risks, to provide adequate protective and preventive services, report on accidents, and to inform, consult and train their workers and representatives on safety aspects. This includes, for example, the correct use of machinery and the means of production, use of adequate personal protective equipment and safety devices, as well as seeing to the fulfilment of security requirements by the workers. In accordance with national laws and practices, the health of the workers has to be regularly monitored.

⁽²⁴⁶⁾ <http://www.ueanet.com/facts2/summ/sum-89-654-en.pdf>

⁽²⁴⁷⁾ <http://www.ueanet.com/facts2/summ/sum-89-655-en.pdf>

⁽²⁴⁸⁾ http://europa.eu/legislation_summaries/employment_and_social_policy/health_hygiene_safety_at_work/c10914_en.htm

Reproductive care

As already mentioned, most European countries offer widespread services for reproductive healthcare. In most European countries, accessing the services of gynaecologists and obstetricians is easier than accessing other specialised services, and pregnant women usually receive medical treatment for free even if they are not insured.

In many countries (such as Norway, Hungary, Italy, France, Slovenia) besides healthcare at birth, maternity

care services are offered to pregnant women and children through local health promotion programmes. In addition to specialised centres and clinics, family doctors in most countries provide counselling on family planning and contraception methods. A parallel network for family planning is usually implemented by non-governmental organisations. The follow-up offered by health professionals, including home visits and health check-ups, usually provides a good continuation of contact between the family and health services. Some examples of good practices are presented in Box 2-12.

Box 2-12 — Good practices in maternity care services in some European countries

In Slovenia home-care nursing is available for pregnant women and women with infants right after the birth of a child. Home-care nursing is well developed and operates within local community healthcare centres. It is financed mainly by the Ministry of Health and the Health Insurance Institute⁽²⁴⁹⁾.

In Hungary, the Health Visitors' services has been operating since 1915 and is based on a network of district health visitors (usually women), who inform all families with small children and (young) mothers as to the benefits they are entitled to and support their accessibility. They pay special attention to pregnant women and to young mothers, initiating social assistance when needed, and placement in shelters for expectant mothers. They also initiate child protection measures by providing prophylactic care⁽²⁵⁰⁾ and all mandatory inoculations and they guarantee continuous health and social monitoring. Activities include visits to families, ongoing care for pregnant women and families with children, as well as measures for preventing, recognising, and eliminating health problems and mental and social risks. Since the Health Act of 1997, health visitors have been included within the primary care framework⁽²⁵¹⁾.

In Sweden, the SFINX⁽²⁵²⁾ programme is aimed at reducing perineal tearing⁽²⁵³⁾. The percentage of deliveries with third and fourth degrees of perineal tearing has increased⁽²⁵⁴⁾ from approximately 1% in 1990 to 4% in 2004, with over 3 000 women affected each year. Possible reasons are the increased number of assisted deliveries and the increased size of the babies. Most women recover and do not suffer from permanent damage, but they still suffer emotionally

from worry about incontinence, sexual performance and future pregnancies⁽²⁵⁵⁾. SFINX was implemented in 2000 at the County Hospital Ryhov in Jönköping with the aim of lowering III and IV degree perineal tearing to below 2% for all deliveries, as well as to decrease the amount of all perineal tearing to less than 5% and to reduce the number of assisted deliveries. In order to do this, the staff received continuous education and training one to two times a year and all perineal tears are analysed and documented. In 2008, only 1.3% of all deliveries had III or IV degree perineal tearing⁽²⁵⁶⁾.

In Norway, municipalities are required to offer maternity care through local programmes providing follow-up visits by health professionals, including home visits and health check-ups. This facilitates a continuing contact between the family and health services⁽²⁵⁷⁾.

In Bulgaria the Maternal health programme guarantees free access to systematic healthcare from the beginning of the pregnancy until 42 days after delivery. Women and adolescent girls are the main targets, but access is still problematic in remote rural areas⁽²⁵⁸⁾.

In the Czech Republic, since 2005 the Freedom of choice programme (Možnost volby)⁽²⁵⁹⁾ has aimed at mapping the main critical points of the current maternity care system and designing viable reforms. The project is divided into three stages: the first stage was mapping the existing system of natal care, with particular focus on care during physiological pregnancy, childbirth and puerperium. These results are summarised in the 'Report on the current status of obstetric care in the Czech Republic.'⁽²⁶⁰⁾ The second stage is focused on the comparison model of natal care in the Czech Republic and in selected EU countries. In the third phase the current system of maternity care in the Czech Republic will be analysed and changes will be proposed.

In France the National Perinatal Plan 2005–07⁽²⁶¹⁾ is aimed at reducing maternal mortality from 9 to 5 per 100 000 and perinatal mortality from 6.5 to 5.5 per 100 000, by improving

⁽²⁴⁹⁾ Slovenian Ministry of Health,

<http://www.mz.gov.si/en/>
and Slovenian Health Insurance Institute.

<http://www.zzs.si/zzs/internet/zzseng.nsf>

⁽²⁵⁰⁾ The basic meaning of prophylactic is to prevent or protect from. Prophylactic treatment, then, is an approach to preventing a disease or condition before it affects a patient. This might include, for example, vaccination and regular controls.

⁽²⁵¹⁾ Hungarian Government (2004), National Action Plan on Social Inclusion, Hungary, 2004–06, drafted by the Committee to combat social exclusion.

<http://www.stopcsbe.hu/download.php?ctag=download&docID=14303>

⁽²⁵²⁾ Boij, R., et al. (2008), Aktivt perinealskydd förebygger sfinkterskador, Stockholm.

http://www.sfog.se/presentationer_sfogv08/Perinealskydd%20boj_Roland%20Boij.pdf

⁽²⁵³⁾ Perinatal tearing means that — when giving birth — the perineum may tear or the caregiver may decide it should be cut to make a wider opening for the baby's head, a procedure called an episiotomy. Tears are more common in women having their first vaginal birth and range from small nicks and abrasions to deep lacerations affecting several pelvic floor muscles. See: Online Medical Library.

<http://www.merck.com>

⁽²⁵⁴⁾ Boij, R., et al. (2008), Aktivt perinealskydd förebygger sfinkterskador.

http://www.sfog.se/presentationer_sfogv08/Perinealskydd%20boj_Roland%20Boij.pdf

⁽²⁵⁵⁾ SKL and Socialstyrelsen (2008), Quality and Efficiency in Swedish Health Care, Regional Comparisons 2007, Stockholm.

⁽²⁵⁶⁾ Dagens Medicin, Målmedveten satsning mot bristningar gav resultat.

<http://www.dagensmedicin.se/nyheter/2008/08/26/malmedveten-satsning-mot-b/index.xml>

⁽²⁵⁷⁾ Norwegian Directorate of Health (2008), Health creates welfare — the role of the health system in the Norwegian Society.

http://www.helsedirektoratet.no/vp/multimedia/archive/00062/Health_creates_welfa_62299a.pdf

⁽²⁵⁸⁾ Eurohealth (2006), Country report on Health care, Bulgaria. <http://www.eurohealth.ie/countryreport/word/bulgaria.doc>

⁽²⁵⁹⁾ Aperio, Healthy parenting association.

<http://www.aperio.cz/porodnictvi/projekty.shtml#moznostvolby>

⁽²⁶⁰⁾ Mrzílková Susová, I. (2005), Zpráva o stávajícím stavu porodnické péče v České republice 2004 [Report on the current status of obstetric care in the Czech Republic], Praha.

⁽²⁶¹⁾ Collet, M. (2008), Satisfaction des usagères des maternités à l'égard du suivi de grossesse et du déroulement de l'accouchement, Etudes et résultats, Drees, No 660, September.

the quality and security of maternity care. Another aim is to improve pregnancy monitoring through interviews before and after childbirth.

In Poland, the Decent Birth Giving campaign⁽²⁶²⁾ is aimed at improving the quality of care and medical services at maternity clinics and obstetric wards. The campaign was launched in 1994 by a newspaper and has received considerable feedback and support. Friendly maternity clinics are nominated and a Foundation with educational and promotional goals was created in 1996.

In Romania the National Programme for Mother and Child Health⁽²⁶³⁾, implemented in 2004 but based on a precedent programme from 1993 onwards, aims at decreasing maternal mortality by improving the quality and efficiency of maternity care and supporting intensive therapy

⁽²⁶²⁾ <http://www.rodzicpoludzku.pl>

⁽²⁶³⁾ The Romanian Ministry of Health — Programmes in 2008. http://www.ms.ro/fisiere/programe_nationale/17_51_520_anexa_2-30.03.doc

services for new-born babies. The programme offers health prevention interventions for prophylaxis, screening for the early diagnosis of birth defects, prenatal and postnatal services, check-ups and testing for HIV and syphilis, as well as the provision of powdered milk free of charge. Teenage mothers are specific targets of the programme.

In the UK postnatal depression prevention intervention was carried out in primary care. Health visitors (nurses) were trained in the clinical assessment of postnatal depression in order to offer psychological intervention sessions to low-risk women. Evaluation studies report a 32% reduction in the numbers of new episodes of depression in mothers⁽²⁶⁴⁾.

Source: EGGSI network national reports 2009. For the UK case: European Commission (2008), Prevention of Depression and Suicide, Consensus paper prepared by Wahlbeck, K. and Makinen, M., Luxembourg.

⁽²⁶⁴⁾ Wahlbeck, K., Makinen, M. (2008), Prevention of depression and suicide, Consensus paper, European Commission, Luxembourg.

However, some recent trends described in the EGGSI national reports may have negative effects on women's access to reproductive care and the quality of treatment they receive. The following present some examples.

- In some countries (such as Italy and Poland), as a result of the restructuring of the health sector (in Italy) and the increased quality standard in service delivery (in Poland), in recent years there has been a decrease in the number of clinics and health services available to women. This especially affects decentralised and rural areas, where delivery rooms and maternity wards in small hospitals and clinics have been closed.
- In Greece, caesarean sections in childbirth are much more frequent than in other European countries, representing 52% of all childbirths, due to the financial reimbursement system applied in this country⁽²⁶⁵⁾.
- In Romania a high number of deliveries occur at home, often without medical assistance and appropriate prenatal care⁽²⁶⁶⁾. It is estimated that as many as half of maternal deaths occur due to obstetrical risks and that nearly half of the pregnant women who die during delivery have not received prenatal care. Women from poor communities (including the Roma and immigrant women) or women living in rural/isolated areas have

⁽²⁶⁵⁾ Mossialos, E., Allin, S., Karras, K., Davaki, K. (2005), An investigation of Caesarean sections in three Greek hospitals: The impact of financial incentives and convenience, *European Journal of Public Health*, 15 June: pp. 288–295.

⁽²⁶⁶⁾ European Observatory on Health Systems and Policies (2008), *Healthcare systems in transition*, Vol. 10, No 3, Romania Health System Review, p. 112.

limited access to information on the importance of monitoring pregnancy and how to care for themselves during this period.

Abortion remains a particularly controversial issue for public health services in many countries. According to a recent survey on abortion legislation in Europe carried out by the by the IPPF European Network⁽²⁶⁷⁾, the provision of services varies greatly in the different European countries.

- For example, in many countries, such as Poland, Cyprus, Belgium, Italy, France, Luxembourg and Portugal, legislation allows for abortion in specific cases, usually when pregnancy constitutes a threat to the life or the health of a pregnant woman. In these countries, if the pregnancy is not considered a 'threat to the woman's health', access to (legal) abortion may be denied. In addition, abortion is only rarely performed free of charge in public hospitals, and women may also face conscientious objection by health personnel and long waiting lists. In the private health sector, on the other hand, abortion services are usually routinely provided, often upon the woman's request. In Cyprus, abortion is only available through private physicians at a relatively high price, which makes it particularly difficult for women from lower income groups, as well as migrant women, to have recourse to the procedure.
- In some European countries (like Ireland), abortion is strictly regulated and not covered by the state insurance, so that women travel abroad. In Austria

⁽²⁶⁷⁾ IPPF (2007), *Abortion legislation in Europe*, International Planned Parenthood Federation European Network. <http://www.ippfen.org/en/Resources/Publications/Abortion+Legislation+in+Europe.htm>

abortion is legal, but not covered by public health insurance and difficult to access in the western and rural areas of the country.

- In other countries (such as Bulgaria, the Czech Republic, Denmark, Hungary, Iceland, the Netherlands, Norway, Spain, Sweden, the UK – except for Northern Ireland), abortion services are freely accessible and free of charge under certain conditions concerning the stage of pregnancy and are also available to girls under 18 years of age with the informed consent of one of the parents. Non-residents are, however, usually excluded from access to free abortion services, except for spontaneous abortions.
- In Finland, Estonia, Latvia, Lithuania and Slovakia, women have to pay part of the costs (either the hospital fees or a quota of total costs).
- In Romania, where contraceptive use remains low (only 23% of women and men use modern contraceptive methods and only 10% of persons aged 15 to 49 use condoms)⁽²⁶⁸⁾, the high rate of abortion indicates that many women still use this method as a substitute for contraception.

Oncological care

As previously discussed, in most European countries there is a well-developed system of screening and treatment for breast and cervical cancer, while for other cancer typologies, which are considered men's diseases, women tend to face higher barriers in accessing oncological care. For example, a recent Spanish study⁽²⁶⁹⁾ showed that in the case of colorectal cancer⁽²⁷⁰⁾, women are less likely than men to be readmitted to the hospital, even after a check-up for tumour characteristics, mortality, and co-morbidity⁽²⁷¹⁾.

In some cases even accessing treatment for breast cancer is becoming more difficult. For example in Cyprus, despite free availability through the public health services to all cancer patients, there has been an increase in the use of private services for breast-

cancer-related surgery due to the lack of personalised care in the public sector. For example, patients are not able to choose their physician and may be treated by a different doctor depending on availability.

The EGGSI national reports provide the following examples of oncological care, paying specific attention to women's needs:

In Bulgaria specialised territorial units (Regional Dispensaries for Oncological Diseases) provide integrated care to cancer patients. Breast cancer patients receive treatment and care at all the stages of the disease and all costs are covered by the national health system.

In Greece the 'Everybody Pink' programme has provided psychological support to women with breast cancer through a dedicated telephone line since 2006. The programme is promoted by the Greek Association of Women with Breast Cancer and is co-financed by Roche Pharmaceuticals. In the 2007–08 period, over 1 200 calls were registered.

Treatment for domestic violence

In some European countries there is increasing recognition of domestic violence as a source of physical and mental illness among women and children and special healthcare treatment services have been implemented. Specialised training has been provided in some cases to general practitioners (GPs) and emergency room personnel in order to increase their awareness regarding the physical or mental complaints of women, victims of partner abuse or domestic violence.

As shown in the good practices examples described in the box below, in many countries special initiatives have been put into effect to strengthen the quality of public health services in treating sexually and physically abused children and women. Greater awareness of domestic violence within all kinds of public services, including health and medical services is emphasised.

⁽²⁶⁸⁾ European Observatory on Health Systems and Policies (2008), Healthcare systems in transition, Vol. 10, No 3, Romania Health System Review, p. 112.

⁽²⁶⁹⁾ González, J.R., et al. (2005), Sex differences in hospital readmission among colorectal cancer patients, *Journal of Epidemiology and Community Health* 2005, No 59, pp. 506–511.

⁽²⁷⁰⁾ Colorectal cancer can begin in either the colon or the rectum. Cancer that begins in the colon is called colon cancer, and cancer that begins in the rectum is called rectal cancer.

⁽²⁷¹⁾ Other studies also indicate that women are less likely to be screened, as colorectal cancer is considered a men's disease. See for example: Stewart, Susan C. (1999), *Screening for Colorectal Cancer in Women: Not Just a Man's Disease*.

Box 2-13 — Good practices in the treatment of women victims of domestic violence and abuse

The Memosa programme⁽²⁷²⁾ in the Netherlands was promoted in 2006 by the regional public health authority of Rotterdam-Rijmond, together with the Medical Faculty of the Radboud University Nijmegen (Women's Studies). Ten mothers with children in the area of Rotterdam were trained as mentors to support other young mothers with children suffering from partner abuse and living in isolated situations. For up to 16 weeks, mentors made weekly home visits to pregnant women and mothers of children up to 12 years old who suffered abuse or were at risk of abuse, to promote professional support for depression, prevention of partner abuse and general health and mother-child relations. The main target group was informed and supported to adequately respond to the threat of domestic violence and positively influence the behaviour of the abuser. This decreased the chances that the threat could turn into real domestic violence. In some cases, the abuser asked for the advice and support of the mentor and was subsequently referred to the mental health sector. In addition, the programme provided specific training to 25 general practitioners in order to recognise and cope with cases of domestic violence and partner abuse and to cooperate with local support organisations. The programme evaluation showed high participation rates of women of ethnic background. Despite the overall low number of participants, the outcomes were significant: partner abuse was reduced by 50%; complaints about depression were reduced by 37%; and the mentors indicated an improvement of their social support network. Furthermore, the mentors reported in over 55% of the cases that their support in (domestic) education turned out very positively and helped to improve the family situation. In some cases, the partner/father asked the mentor for supportive advice.

In Germany the Signal intervention project to end violence against women⁽²⁷³⁾ was started in 1999 in the emergency room of the Benjamin Franklin University Hospital of Berlin. It provides abused women with support and treatment. Nurses and physicians have been trained to identify violence and inquire on abuse, to document injuries and health problems for use in legal proceedings, to develop a health plan and to inform and refer victims to counselling programmes and women's shelters. The project has shown the importance of emergency departments as first contact points for women who have been victims of abuse and violence. Since 2008, this project is also active in the German region Baden-Württemberg and has implemented a programme for

the itinerant treatment of women who have experienced violence⁽²⁷⁴⁾.

In Norway, the recent action plan against domestic violence 2008–11⁽²⁷⁵⁾ emphasises the importance of acknowledging at-risk groups of women who are less likely to seek help in case of domestic violence, such as disabled women, women with poor language skills, women that have been in Norway for a short period and women with poor integration in the labour market. Women with a history of drug abuse or women with mental health problems are also considered at risk. The central goal of this new action plan is to offer all women that have experienced domestic violence a secure and independent life-situation. A crisis centre for women is going to be implemented. Training will also be provided for the personnel at the women's crisis centre to address special needs for disabled women, women with a history of drug abuse and women with poor language skills⁽²⁷⁶⁾.

In Spain the Women's Institute has promoted a new Protocol for the detection of domestic violence cases, which was set up in various regional administrations, together with training courses for health professionals, in order to acquire a better understanding of the physical and psychological evidence of this phenomenon.

In Iceland, the Emergency reception for victims of rape was established in 1993 at Landspítali Hospital in Reykjavik in the Crisis Centre. It is staffed by professionals who have expert knowledge and special training in treating people who have experienced a sudden major crisis, like the suicide of a loved one, natural catastrophes, serious accidents, house fires, etc. The Emergency unit for victims of rape recruits specialised professionals to treat this particular group of patients, offering appropriate services not only to the victims but also to the abusers. The programme consists of a medical examination upon arrival by a medical doctor, and a more comprehensive interview by a nurse and a medical doctor specialised in legal medicine. This is followed up by psychological treatment, support and rebuilding of self-awareness and assertive training provided in 10 individual sessions. Finally, the patient is appointed a legal adviser/lawyer who will follow her throughout and take care of all the necessary procedures involved in the process of the judiciary system in the event that legal action is undertaken. This service is free of charge for the victims. The great majority of the users are female, but a growing number of

⁽²⁷²⁾ ZonMw — <http://www.zonmw.nl/>

⁽²⁷³⁾ European Parliament (2007), Discrimination against women and young girls in the health sector, Directorate-General Internal Policies, by the European Institute of Women's Health, Brussels. <http://www.europarl.europa.eu/sides/getDoc.do?sessionId=42D62CA22BDD5134ABE684A2B6C616BC.node1?pubRef=//EP//TEXT+TA+P6-TA-2007-0021+0+DOC+XML+V0//EN> see also: Bundesministerium für Gesundheit — <http://www.bmg.bund.de/>

⁽²⁷⁴⁾ The project has been implemented in Baden-Wuerttemberg in 2008, supported by the Ministry of Labour and Social Affairs, See: Pflegebrief (2008), Signal — Intervention gegen häusliche Gewalt, Modellprojekt in Baden-Württemberg, 18.07.2008. <http://pflegen-online.de/nachrichten/aktuelles/signal-intervention-gegen-haeusliche-gewalt.htm?nlp=20080723>

⁽²⁷⁵⁾ Ministry of Justice and the Police (2004), Action Plan Domestic violence (2004–07), Norway. http://www.regjeringen.no/upload/kilde/jd/reg/2004/0028/ddd/pdfv/227003-action_plan_domestic_violence_2004_2007.pdf

⁽²⁷⁶⁾ Ministry of Justice and the Police (2007), Vendepunkt, Handlingsplan mot vold i nære relasjoner 2008-2011, Norway. <http://www.regjeringen.no/upload/JD/Vedlegg/Handlingsplaner/Vendepunkt.pdf>

males are now among the users. Research indicates that the number of male victims of sexual crimes or violence might be higher, since male victims might find it more difficult to seek help⁽²⁷⁷⁾. Therefore, in order to reach and to address problems of access due to gender differences, the staff gives lectures, speaks at conferences and runs seminars for health and social care professionals. Clinical guidelines addressing gender differences are now being developed. Since many of the victims are children under 18, the team has had to mobilise a wide range of professional social networks⁽²⁷⁸⁾.

⁽²⁷⁷⁾ Tryggvadóttir, A.B. (2008), Eðli og alvarleiki kynferðislegs ofbeldis hjá þolendum sem leita til Neyðarmóttöku LSH: Er munur á áfengis- og/eða vímuefnatengdu og öðru kynferðislegu ofbeldi?, University of Iceland, Social Sciences Department.

⁽²⁷⁸⁾ Agnarsdóttir, G., Skúladóttir, S. (1994), A New Rape Trauma Service at the Emergency Department of the Reykjavik City Hospital, Arctic Medical Research, Vol.53, Suppl.2., pp. 531–533.

In some European countries, the project Formation des professionnels de santé à la violence conjugale⁽²⁷⁹⁾, funded by the Daphne Initiative in 1999, aims at improving the treatment of women suffering from domestic violence by providing working and training tools for healthcare workers. Partners of the project were health professionals and members of aid organisations from France, Spain, Portugal, Italy and Belgium, which took advantage of interactive Internet to provide information on practical advice, detention and medical care for female victims and their children and practical information, such as guidance towards other, non-medical assistance.

Source: EGGSI network national reports 2009

⁽²⁷⁹⁾ European Commission, Daphne Report, Illustrative case No 19 on domestic violence.

http://ec.europa.eu/justice_home/daphnetoolkit/files/others/illustrative_projects/19_domestic_en.pdf

Treatment provisions for the elderly

Women live longer than men and, thus are more likely to be affected by age-related illnesses and disabilities. From the scattered research and data available, it appears that older women are more affected than men by chronic ailments and psychological disorders (especially those which increase with age, such as sleeping disorders and anxiety problems)⁽²⁸⁰⁾, but they usually receive less treatment than older men, even if they rely more often on institutional care than men do (see Chapter 3 on Long-term care).

As anticipated in previous chapters, menopause and osteoporosis are treated as women-specific diseases in old age. However, not all European countries have specific treatment programmes, and in some cases discrimination against men has been reported. This is the case in Belgium where reimbursement for osteoporosis medication was until recently exclusively reserved to women. The situation changed after various legal actions leading to a man affected by the disease winning his case⁽²⁸¹⁾.

Specialised programmes for the treatment of osteoporosis and other old-age-related illnesses are reported in the following countries.

- In Bulgaria⁽²⁸²⁾ the ‘Treatment of osteoporosis with a pathological fracture programme’ involves only menopausal women with osteoporotic fractures. The National Health Insurance covers the cost of diagnostic and treatment procedures, the specialist’s follow-up exams and part of the cost of the medication. However, for women not in the programme, the treatment costs are not covered by the state and remain largely unaffordable. To overcome these problems, a National programme for the limitation of osteoporosis (2006–10) was launched, to make osteoporosis one of the priorities of Bulgarian health policy. The main target groups are menopausal, pregnant and breastfeeding women. A national network of 56 specialised centres has been set up for prevention, screening, diagnosis and treatment. However the financial resources for this programme have not been set.
- In Denmark a specific healthcare programme is aimed at the elderly over 75 years old. The programme provides home visits by specialists who assess the elderly persons’ needs, inform them of their rights and help them to get the necessary care, as well as train them in the prevention of home accidents⁽²⁸³⁾.
- In Hungary a national osteoporosis programme includes several initiatives for the prevention and treatment of osteoporosis⁽²⁸⁴⁾.

⁽²⁸²⁾ European Institute of Women’s Health (2006), Discrimination against Women and Girls in the Health Sector, Brussels.

<http://www.eurohealth.ie/countryreport/pdf/euparlcountryrep.pdf>

⁽²⁸³⁾ Højgaard, B., et al. (2006), Evidensbaseret forebyggelse i kommunerne, Dokumentation af effekt og omkostningseffektivitet, København, DSI.

⁽²⁸⁴⁾ <http://www.harmonet.hu/cikk.php?rovat=104&alrovat=129&ckid=8125> and Poor, G. (n.y.), A csontritkulás népegészségügyi jelentősége, a Nemzeti Osteoporosis Program eddigi eredményei, Society for Osteoporosis

<http://www.konzilium.hu/csontrit/content/nop.htm>

⁽²⁸⁰⁾ European Institute of Women’s Health (2006), Discrimination against Women and Girls in the Health Sector, Brussels.

<http://www.eurohealth.ie/countryreport/pdf/euparlcountryrep.pdf>

⁽²⁸¹⁾ IEFH, informant from legal service. This is also the case for reimbursement of medication to men having breast cancer.

Treatment provisions for disadvantaged women

Access to healthcare treatment is often difficult for women who present specific disadvantages, such as immigrant women and women of ethnic origin, disabled women, lone mothers, prostitutes, homeless women. These groups of women often need targeted programmes able to help them overcome the isolation and multiple disadvantages they often suffer from.

Women of ethnic origin

In general, the ethnic minority population, and especially the Roma population, have worse health conditions than the national population, due to the effects of hard working conditions, social and economic exclusion, lack of information and isolation⁽²⁸⁵⁾.

Women from an ethnic minority background usually report 'bad health' to a greater extent and consider their health situation worse than men of the same ethnic group and women of the majority population. In addition, pregnancies and childbirth tend to present more difficulties⁽²⁸⁶⁾.

Differences in language, culture and religious beliefs, practices and interpretations may lead to less effective care for ethnic minority women. For example, Muslim women, or their partners, may be reluctant or even refuse to be treated by male medical doctors in hospitals, and all the more by a male gynaecologist. On the other hand, healthcare workers usually have insufficient experience and training to address the cultural and religious issues posed by ethnic minority women. The lack of adequate preparation by health professionals to adapt to these aspects reduces the accessibility of these services for ethnic minority women. In most countries there is also a lack of information material in minority languages, and there is a need to develop interpreting and mediating services to assist ethnic minority women in hospitals.

⁽²⁸⁵⁾ Corsi, M., Crepaldi, C., Samek Lodovici, M., Boccagni, P., Vasilescu, C. (2008), Ethnic minority and Roma women in Europe: A case for gender equality?, report prepared by the Network of experts in gender equality, social inclusion and health- and long-term care (EGGSI network) for the European Commission, Directorate-General for Employment, Social Affairs and Equal Opportunities. <http://ec.europa.eu/social/BlobServlet?docId=2481&langId=en>; Fagan, C., Burchell, B. (2002), Gender, jobs and working conditions in the European Union, European Foundation for the Improvement of Living and Working Conditions, Dublin. <http://www.eurofound.europa.eu/pubdocs/2002/49/en/1/ef0249en.pdf>

Fagan, C., Hebson, G., 'Making work pay' debates from a gender perspective. A comparative review of some recent policy reforms in thirty European countries, Report prepared by the Group of Experts on Gender, Social Inclusion and Employment for the Unit Equality for women and men, Directorate-General for Employment, Social Affairs and Equal opportunities of the European Commission, Office for Official Publications of the European Communities, Luxembourg, 2005.

⁽²⁸⁶⁾ Based on information of the EGGSI network national reports, 2008 for Estonia, Austria, the UK and the Netherlands.

Although equal access to the healthcare systems is guaranteed in various countries, as is the right to access public health services in emergency situations, in some countries access is related to the individual's legal and employment status and private health services are very expensive. The result is that a significant number of migrants and stateless groups have no proper health insurance and support. Actually, many immigrants have no public health insurance due to the lack of a job or informal employment, so they have to pay high fees for private health services. For instance, in Bulgaria, ethnic minority women are often excluded even from services provided for pregnant women and their children. In the Czech Republic, pregnant women without legal resident status are excluded from the public health insurance and therefore obliged to pay for the more expensive private health insurance, which might be denied them due to their high risk. In Greece pregnant migrant women may experience serious financial difficulties with regard to their hospitalisation fees⁽²⁸⁷⁾.

In Cyprus as in other southern European countries, immigrant women are often employed as domestic workers in households and often cannot take time off and are hesitant to ask for time off for healthcare, especially when needing reproductive care.

In France immigrants are often rejected by health professionals⁽²⁸⁸⁾. However, migrant women, less often than migrant men, renounce medical consultations, examinations or prescriptions (32% of men declare they have totally renounced healthcare compared to 19% of women). Immigrant women consult healthcare for different reasons than men: pregnancy and childbirth represent 3 out of 10 consultations for women and 7 out of 10 hospitalisations, with a high frequency of risky pregnancies and complex childbirths (28% of women hospitalised) because of precarious life conditions and because foreign immigrant women (particularly African women) consult doctors less than other pregnant women. According to doctors, AME beneficiaries tend to consult doctors in emergencies (15% of AME patients) after having waited until it is quite late (5%), this is even worse in the case of hospitalisations⁽²⁸⁹⁾.

⁽²⁸⁷⁾ Based on information of the EGGSI network national reports, 2008 for Bulgaria, the Czech Republic and Greece.

⁽²⁸⁸⁾ According to the French EGGSI network national report, 2009, two obstacles are reported as limiting immigrants' access to healthcare: their own financial difficulties and the refusal from the part of health professionals because of existing delays for reimbursement or because they are forced to apply basic social security tariffs to these patients. More than one third of the AME (Medical state aid — AME) beneficiaries have experienced such a refusal, essentially on the part of a doctor or a chemist.

⁽²⁸⁹⁾ Boisguérin, B. (2004), Etat de santé et recours aux soins des bénéficiaires de la CMU, Etudes et résultats, Drees, No 612, December.

In Slovakia, immunisation has become a problem in poorer Roma communities living in rural areas. In 2005, 6.2% of paediatric districts did not reach the 90% level of vaccination⁽²⁹⁰⁾. The highest percentage of under-immunised districts was in the eastern part of Slovakia (Prešov, Košice) which suffer from the highest unemployment levels, especially in rural areas. In under-immunised districts, paediatricians have been doing vaccination directly in Roma settlements in cooperation with municipalities. In some cases the insufficient vaccination result depends on the low number of paediatricians per 10000 inhabitants in regions with high demand for paediatric services, the under-financed local hospital and health centres and the expensive public transport services from distant rural areas to district towns.

In some countries specific programmes are aimed at immigrants. For instance, in Finland, maternity

services reach immigrant women satisfactorily. In Italy and Germany, while prenatal diagnosis is usually less widespread among immigrant women, social protection for pregnancy, maternity and children's health is usually ensured for immigrant women⁽²⁹¹⁾.

The distribution of information material in different languages and the multicultural training of health workers are among the actions carried out to reduce cultural and language barriers and facilitate the access of ethnic minority women to the healthcare system.

Some projects, on the other hand, focus on specific health problems, for example helping the disabled of national minorities (Latvia), African women with HIV and women who have suffered from violence or have mental health problems (Belgium), as well as women exposed to health risks having suffered genital mutilation (such as Somali women in Sweden).

Box 2-14 — Good practices in the treatment of disadvantaged communities

The 'Tesserino di Temporaneo Soccorso' is a programme implemented by the Italian region Emilia-Romagna since 2002 to support access to healthcare treatment for illegal immigrants, the homeless and people living in situations of great social disadvantage. Specific attention is given to the health needs of female immigrant prostitutes. Since 2002, 10000 persons have used this service.

In Sweden, people of foreign background but with a residence permit have the same rights to medical care as people born in Sweden. All children in Sweden have the right to health and medical care including those seeking asylum or who are in hiding⁽²⁹²⁾. Asylum-seeking adults have the right to a health conversation/medical check-up and the right to 'immediate health and medical care which cannot wait', if the doctor deems it is necessary if the injury or illness is life threatening or may lead to serious permanent injury if untreated. If a person is in great pain, she/he may also receive care. If a woman is pregnant, she will receive free maternity care. If a woman so chooses, she has a right to an abortion as well as contraceptive advice services which are free of charge. There are two reception offices available for asylum-seeking adults in the Stockholm region.

In some areas of France, Médecins du monde (MDM) provides free healthcare to socially disadvantaged and excluded people and to illegal immigrants in particular. There are 31 free medical centres managed by the association, one in Paris and others in different towns. Women represent an increasing proportion (45%) of the patients consulting the MDM centres, they are mostly quite

young (under 25) or older (55 and over) patients; nine out of 10 are foreigners, especially from Sub-Saharan Africa, Maghreb and Romania⁽²⁹³⁾.

In Slovakia, a programme aims to increase the number of health insurance cards issued and the sensitiveness of outpatient doctors regarding the health problems of the Roma, in order to attract disadvantaged communities, such as refugees and the homeless, to make use of available healthcare. Community workers carry out outreach training in health education, disease prevention, maintaining healthy lifestyles and distribute health education materials in selected Romani settlements. The programme supports the cooperation of the 30 Community workers with schools, field social workers and doctors (general practitioners for adults, general practitioners for children and adolescents, gynaecologists, dentists) together with municipal authorities, health insurance companies and non-governmental organisations. Due to the involvement of different groups, the disadvantaged groups are expected to be better reached⁽²⁹⁴⁾.

Source: EGGSI network national reports 2009 — Italy, Sweden, France and Slovakia.

⁽²⁹²⁾ Vårdguiden, Stockholms läns landsting.

⁽²⁹⁰⁾ Kusá, Z. et al. (2007), Tackling child poverty and promoting the social inclusion of children, a Study of National Policies, Institute for Sociology of the Slovak Academy of Sciences, Bratislava. http://ec.europa.eu/employment_social/spsi/docs/social_inclusion/experts_reports/slovakia_1_2007_en.pdf

⁽²⁹³⁾ Boisguérin, B., Haury, B. (2008), Les bénéficiaires de l'AME en contact avec le système de soins, Etudes et résultats, Drees, No 645, July.

⁽²⁹⁴⁾ Based on the report of the European Commission (2007), Social Determinants of Health in the Slovak Republic: A Case Study, Report prepared by the Expert Group on Social Determinants and Health Inequalities.

http://ec.europa.eu/health/ph_determinants/socio_economics/documents/slovakia_rd01_en.pdf

⁽²⁹¹⁾ EGGSI network national reports 2008, for Finland, Italy and Germany.

Disabled women

Women with disabilities are particularly vulnerable to inequalities in the health system, despite their being usually eligible for free public healthcare. Women with disabilities, including hearing and sight impairment as well as physical disabilities, are more at risk of poverty and social exclusion due to the lack of education and employment opportunities, physical and social barriers, dependence on carers, among other reasons. There is very little research and information on the needs of and healthcare services received by disabled women in European countries.

The situation in Cyprus is indicative of a more generalised situation. Representatives of associations and organisations representing disabled people report a lack of specialised health personnel in public health centres and hospitals, and difficulties in access to information on family planning and sexual and reproductive health, resulting in the reduced provision of primary and preventative care (such as breast cancer screening, Pap tests, etc.). For example, representatives of the Pancyprian Organisation for the Deaf report that there are no interpreters for the deaf in public hospitals and health centres. Furthermore, representatives from the Cyprus Paraplegics Organisation state that there are no specialised personnel for prenatal care and that women with physical disabilities usually undergo caesarean sections in order to avoid possible complications. In terms of psychological support, there is no permanent personnel for psychological support and counselling for women (and men) with disabilities in public hospitals, and patients do not have the freedom to choose their health provider and the location of such health provider. Thus, despite being eligible for free care in the public health system, women with disabilities often opt for private healthcare citing privacy, personalised care, and choice of health provider as a priority⁽²⁹⁵⁾.

In Ireland, the National Women's Council argue that the rehabilitation needs of Irish women with mental illness have been neglected and that health and social service provision needs to expand to include housing for mothers with mental illness. In addition, the need for improving access for reproductive health services for women with disabilities and for disability awareness training among health professionals has been highlighted⁽²⁹⁶⁾.

Some interesting programmes to support disabled mothers or mothers with disabled children are

presented in a recent report by the Irish National Disability Authority⁽²⁹⁷⁾.

- In Great Britain, in some hospitals there are special needs advisors in maternity wards which help in identifying disabled women's needs and assess any possible restrictions facing pregnant women with disabilities. In addition, Maternity Alliance has produced guidelines for disabled mothers and for health practitioners to improve the care of disabled women during pregnancy and after childbirth⁽²⁹⁸⁾.
- In Ireland the Health Service Executive (HSE) provides a counselling nurses service offering support to disabled mothers with home visits and referral to other agencies and organisations of home support service.
- In Belgium: ToF Service provides domestic assistance to mothers with disabled children.
- In Sweden there is an assistance service for the disabled where it is the disabled person who chooses the assistant, the content and time schedule of assistance (which may go from help in caring for children, to help in getting training or for leisure activities).

Other disadvantaged groups

Single mothers often present higher health risks than average. They present a higher incidence of mental problems than married mothers. In terms of access barriers, single mothers predominantly have the problem of finding time to consult a health service. More flexible opening hours and the possibility for childcare provision during the utilisation of health services are crucial factors in improving access.

Prostitutes are another group particularly at risk. There are no up-to-date statistics on the number of prostitutes and their living situations. In some European countries there are however specific healthcare programmes targeted at prostitutes. In Austria, registered prostitutes undergo a regular health check-up at the local health authority. Since the early 1990s, a continuous decline in registered prostitutes and an increase in the number of illegal prostitutes has been reported. However, the situation of immigrant sexworkers and trafficked women is particularly precarious: they have little or no access to the regular labour market and the public health system, and there is hardly any information available for these women in

⁽²⁹⁵⁾ This information was provided during a conference entitled 'Women with Disabilities and Long-term illnesses: Opportunities for access to Life', organised by the National Machinery for Women's Rights, Cyprus Ministry of Justice and Public Order, on 17 March 2009.

⁽²⁹⁶⁾ National Women's Council of Ireland (2005), Women's Mental Health: Promoting a Gendered Approach to Policy & Service Provision, Dublin: The Women's Health Council.

⁽²⁹⁷⁾ National Disability Authority (2006), Exploring the research and policy gaps — A review of literature on women and disability, Disability research series No 7. Women's Education, Research and Resource Centre (WERRC). Dublin.
<http://www.nda.ie/cntmgmtnew.nsf/0/BF3A14B644017A648025729D0051DD2B?OpenDocument>

⁽²⁹⁸⁾ Maternity Action. <http://www.maternityaction.org.uk/id1.html>

their native languages⁽²⁹⁹⁾. In Cyprus, the Family Planning Association (CFPA) has launched a specialised educational programme entitled 'Age Education for Foreign Artists' which provides information on different issues, such as HIV/AIDS, sexually transmitted diseases, contraception. The programme addresses female third country nationals who came to Cyprus under the status of 'artists', but which are often employed to work in establishments considered 'high risk' for trafficking in women for the purpose of sexual exploitation⁽³⁰⁰⁾. Since 1998 the programme is sponsored by the Ministry of Health. Even though the 'artiste visa' is no longer applicable foreign women are still assisted by the CFPA. About 60–70 lectures per year are conducted, usually in Russian or English, by CFPA-trained staff and volunteer doctors, including training on HIV/AIDS, sexually transmitted infections, and safer sex. Participants are provided with free condoms.

Homelessness was, until recently, seen as a problem that affected mainly men. It is hard to say to what extent women are actually affected, as there are no representative studies on this problem. Women are often 'invisibly' homeless, i.e. they react by seeking temporary solutions: living with family, friends, 'convenience partners' or casual acquaintances. This is in part influenced by specific female behaviour patterns, but could also be due to a lack of female-specific alternatives in this area. A good practice in supporting access to healthcare for homeless women is the 'women and homelessness programme' implemented in Austria.

Box 2-15 — Good practice: The Austrian programme for homeless women

Since 2003 the Supervised living group of the Fonds Soziales Wien has been responsible for housing and supporting homeless people. 'Women and homelessness' was one of the central topics of the Fonds Soziales Wien in 2004. An outreach programme was developed by the neunerAMBULANZ, a healthcare service of the private association Neunerhaus, together with the Women's Health Centre FEM to provide care for homeless women and men in Vienna who require special medical or psycho-social attention due to chronic or mental health problems and to provide assistance for homeless women which goes beyond mere basic gynaecological care. The project started at the beginning of 2005 with a mobile medical team. A follow-up project was launched in 2006⁽³⁰¹⁾.

Source: EGGSI network national report 2009 — Austria.

⁽³⁰¹⁾ Federal Ministry of Health, Youth and Family (2008), Women's Health Report Austria 2005/2006: Best practice examples, Vienna.

⁽²⁹⁹⁾ City of Vienna (2006), Women's Health Report 2006, Vienna. www.oebig.org/upload/files/CMSEditor/WIEN_Frauengesundheitsbericht2006.pdf

⁽³⁰⁰⁾ Mediterranean Institute of Gender Studies (2007), Mapping the Realities of Trafficking in Women for Sexual Exploitation in Cyprus. http://www.medinstgenderstudies.org/wp-content/uploads/migs-trafficking-report_final_711.pdf

2.1.4. Gender mainstreaming in healthcare: recent trends

In many European countries, (like Austria, Bulgaria, Germany, Iceland, Ireland, Italy, Norway, Slovenia, Spain, the Netherlands, and the UK) there is increasing awareness of the need to acknowledge gender differences in healthcare. This is the case among governmental institutions, universities, and especially NGOs which have traditionally been very active in providing specialised services to women, ethnic minorities and other disadvantaged groups. Gender-sensitive strategies have been implemented within healthcare and medical research, and resource centres and research institutes with special knowledge of women and health have been created. In addition, specific training programmes aimed at general practitioners and healthcare providers have been implemented. It must nevertheless be noted that the gender-mainstreaming approach to healthcare is generally still underdeveloped and, aside from reproductive care, little taken into account when offering service provisions.

In Austria women's health was placed on the institutionalised political agenda for the first time at the beginning of the 1990s. Various health programmes for women have been established in the main Austrian cities. The Vienna and Innsbruck Women Health Centres are the most advanced examples of clinical centres providing integrated services, including inpatient treatment and outreach activities targeted at women who face barriers in accessing healthcare, such as women of ethnic origin or lower educated women. Furthermore, gender mainstreaming is beginning to be applied in the Austrian health sector, aimed at analysing the gender sensitivity of healthcare, health promotion and health prevention. Since 1995, several women's health reports have been published at the federal and provincial level, such as the Women's Health Report Austria 2005/2006⁽³⁰²⁾.

In Bulgaria, the National action plan for gender equality promotion (2008–09) for the first time envisages an annual analysis of the health status of men and women in a comparative perspective to be elaborated. The principles of gender equality in access to healthcare are also addressed in the national programmes for the prevention, treatment and rehabilitation of drug addicts, smoking cessation, mental health and the treatment and control of HIV/AIDS and STD⁽³⁰³⁾. In

⁽³⁰²⁾ City of Vienna (2006), Women's Health Report 2006, Vienna. pp. 40–68.

www.oebig.org/upload/files/CMSEditor/WIEN_Frauengesundheitsbericht2006.pdf,

⁽³⁰³⁾ European Institute of Women's Health (2006), Discrimination against Women and Girls in the Health Sector, Brussels. <http://www.eurohealthie/countryreport/pdf/euparcountryrep.pdf>

most of these programmes, the main focus is on the reproductive and sexual health of women. In addition, women's health is one of the main programme directions of the Centre for women's studies and policy foundation in Bulgaria.

In Germany a department specifically devoted to women's health has been set up within the Federal Ministry of Health. In addition, the ministry has conducted two gender mainstreaming projects. Other governmental institutions, universities and NGOs have been very active in supporting projects and programmes in the area of women's health⁽³⁰⁴⁾.

In Iceland in the 1980s, the influence of the feminist movement and Women's Alliance in Parliament in Iceland resulted in policy initiatives which progressed into general treatment programmes in which gender differences were recognised and the more gender-specific needs were addressed. Examples of this approach are the creation in 1995 of a special treatment programme for women with alcoholic and drug addiction problems and the creation of an open multidisciplinary emergency centre for victims of sexual assaults.

In Ireland the national 'Plan for women's health 1997–99' and the creation of the Women's Health Council in 1997 initiated the formal recognition of the gender dimension in health policy. The National Health Strategy (2001) identified issues of specific concern to women and, in parallel, issues of concern to men. Each of the then existing Health Boards⁽³⁰⁵⁾ was required to produce a health plan for the women in its area. The main achievement appears to have been the beginning of preventive screening programmes. The current National Health Strategy identified five target areas which relate specifically to women (reducing smoking by young women, national roll-out of cervical and breast cancer screening, a crisis pregnancy strategy, policies against domestic violence, a plan for high-quality maternity care).

In Italy increasing attention is being paid to gender differences in healthcare. Gender differentiated data are becoming available, the national Ministry of Health has implemented an Internet portal on women's health⁽³⁰⁶⁾. In 2008, a 'Report on the health situation of women

in Italy' was produced⁽³⁰⁷⁾. In addition, a National Observatory on Women's Health (ONDa)⁽³⁰⁸⁾ was created in 2006 with the aim of increasing research on the main pathologies affecting women, to propose preventive strategies and develop actions to promote gender mainstreaming in healthcare policies. The Observatory has implemented a nationwide evaluation programme which awards a 'pink ribbon' to those hospitals showing a commitment to women's healthcare and high quality standards in service provisions.

In Norway, the Strategy for women's health 2003–13 emphasises the need to develop all health and care services from a gender perspective. A gender perspective is also acknowledged within clinical research and development. The government follows up the national strategy to promote health on a yearly basis, by focusing on the various measures that are discussed within the plan. National statistics and an annual seminar monitor the progress with respect to the objectives of the plan. The gender perspective is also acknowledged for ethnic minority policies.

In Slovenia, there are some gender specific arrangements in the healthcare system. Special attention is given to the access to health treatment for women in the field of reproductive health, as they are entitled to (personal) gynaecologists. Also special focus is given to pregnant women and women with infants — through visits of nurses at home. In the field of health promotion prevention programmes for early discovery of breast cancer and precancerous changes to the cervix are implemented. Some promotion campaigns target specific topics which are relevant for women, such as coping with stress after birth and the rights of pregnant women.

In Spain a Quality plan for the national health system is exclusively devoted to cutting down inequalities in health, with particular emphasis on gender issues (Strategy 4). In order to comply with this goal, the plan defines two separate lines of action: first, to promote knowledge on gender inequalities in health and to strengthen the gender approach regarding health and the training of health professionals, and second, to promote awareness on issues regarding inequality through the dissemination of good practices on equity promotion, aimed at all disadvantaged groups. Most of these actions are performed by the Observatory of Women's Health, created in 2004 as an inter-ministerial institute, mostly providing publications, intervention guides and holding congresses for experts and professionals. Although gender issues have been

⁽³⁰⁴⁾ European Parliament (2007), Discrimination against Women and Young Girls in the Health Sector, Directorate-General Internal Policies, Brussels.

<http://www.europarl.europa.eu/sides/getDoc.do?sessionid=42D62CA22BDD5134ABE684A2B6C616BC.node1?pubRef=-//EP//TEXT+TA+P6-TA-2007-0021+0+DOC+XML+V0//EN>

⁽³⁰⁵⁾ As reported above, Health Boards have now been replaced by the Health Services Executive (HSE).

⁽³⁰⁶⁾ Ministero del Lavoro, della Salute e delle Politiche sociali.
<http://www.ministerosalute.it/saluteDonna/saluteDonna.jsp>

⁽³⁰⁷⁾ Ministro delle Salute (2008), Lo stato di salute delle donne in Italia, Rome.

http://www.assodisfvg.it/files/rapporto_salute_donna_2008.pdf

⁽³⁰⁸⁾ Osservatorio Nazionale sulla Salute per la Donna, Italy.
<http://www.ondaosservatorio.it/index.asp>

included regarding specific women's needs (pregnancy, menopause, etc.) or the prevention of domestic violence, there are no specific provisions regarding unequal treatment concerning common pathologies.

In some eastern European countries, such as the Czech Republic and Poland, projects focused on gender equality in access to healthcare treatment have been carried out,

especially by NGOs. They are usually focused on women reproductive rights and reproductive care. In Poland, women NGOs are numerous and promote relevant programmes aimed at women in reproductive age, women victims of domestic violence and the elderly⁽³⁰⁹⁾.

Interesting examples of good practices are presented in Box 2-16.

Box 2-16 — Good practice examples in some European countries

Austria — Women Health Clinic Innsbruck

Considered to be a very good practice since it is one of the few initiatives pursuing an integrated approach for promoting and treating women's health, this programme not only provides numerous services including inpatient treatment, but also aims at addressing a clientele that often faces barriers in accessing medical institutions — such as migrant women. The provision of childcare during the opening hours of the outpatient clinic is particularly positive.

The centre provides information for women of all ages and from various social and ethnic backgrounds on medical issues and medical treatment. The focus of the services is on the provision of integrated, creative, interdisciplinary health services for women, information on women's health, an outpatient clinic and inpatient clinic exclusively for women. The Women's Health Clinic is also active in research on women's health issues which shall be integrated into the daily work at the clinic.

The outpatient clinic provides second opinions; considers the risk of cardiovascular diseases, breast cancer and malignancy; deals with the clarification of grievances when psychological strain predominates; offers after-care for female patients discharged from the gynaecological department, performs risk evaluation, prevention, check-ups, supplies information on current events and lectures on women's health issues. In addition, there are special clinics for Turkish women, Serbo-Croatian women, evening hours for professional women and specific counselling for nutrition, social issues and physical therapy.

The inpatient clinic is aimed at women who cannot be treated as outpatients, e.g. elderly and ill people, women living far away, or women who prefer female doctors for religious or cultural reasons. Outreach services include: 'diagnosis streets', health days and outreach work in mosques to reach Turkish women in particular, for which services are carried out in Turkish with Turkish medical staff, covering the Tyrol area and with support from Muslim institutions⁽³¹⁰⁾.

UK — 'Well woman' clinic

Many General Practitioners' surgeries offer a 'well woman' clinic where patients may be seen by a female doctor or a female practice nurse to check current health status and provide advice on health promotion.

⁽³¹⁰⁾ Vienna Programme for Women's Health. <http://www.diesie.at>

Many also offer 'well man' clinics which are specialised healthcare for men. They offer men health check-ups, which usually involve having a blood and urine test and offer general advice about health issues. Well man clinics are less diffused than well women clinics⁽³¹¹⁾.

The Netherlands — Gender Guidelines for General Practitioners

The programme Gender Guidelines for General Practitioners was initiated in 1997 by the University Medical Centre St. Radboud (Nijmegen) and financed by ZonMw⁽³¹²⁾. This promotion programme was called 'Sex specific care in the work of general practitioners: three flies in one go' ('Seksespecifieke zorg in de huisartspraktijk: drie vliegen in één klap')⁽³¹³⁾. The key priorities of this programme were threefold: (a) Gender specific recommendations regarding the NHG⁽³¹⁴⁾ standards for angina pectoris, depression and urine incontinence; (b) Training in professional behaviour regarding sex specific recommendations for general practitioners (c) Consolidation of sex-specific quality measures in the quality policy of the participating healthcare practices. A training module was also developed for medical doctors in training and their trainers on the gender-specific aspects of angina pectoris, depression and urine incontinence. At the end of the project a qualitative study was carried out among general practitioners. The interviews had the implicit goal to draw attention to gender-specific consulting and to emphasise that this topic should be further included in the everyday practice of general practitioners. The programme was disseminated on a national level and the Dutch Council for General Practitioners supported the diffusion of gender-specific guidelines for the diseases mentioned. According to the existing evaluation, the key priorities have been attained.

Source: EGGSI network national reports 2009 — Austria, the Netherlands, United Kingdom.

⁽³¹¹⁾ Banks, I. (2001), No man's land: men, illness, and the NHS, British Medical Journal, No 323, 3 November.

⁽³¹²⁾ ZonMw — <http://www.zonmw.nl/en/>

⁽³¹³⁾ See also: [http://www.zonmw.nl/nl/system/zoekresultaten/delfi/projecten-database/project-detail/?tx_videlfiprojecten_pi1\[project_id\]=2000124154](http://www.zonmw.nl/nl/system/zoekresultaten/delfi/projecten-database/project-detail/?tx_videlfiprojecten_pi1[project_id]=2000124154)

⁽³¹⁴⁾ Nederlands Huisartsen Genootschap/Dutch Council for General Practitioners.

⁽³⁰⁹⁾ See for instance www.oska.org.pl which gives the most comprehensive information on support activities of women NGOs ['pomoc' or 'grupy wsparcia'].

2.2. Barriers to accessing service provisions

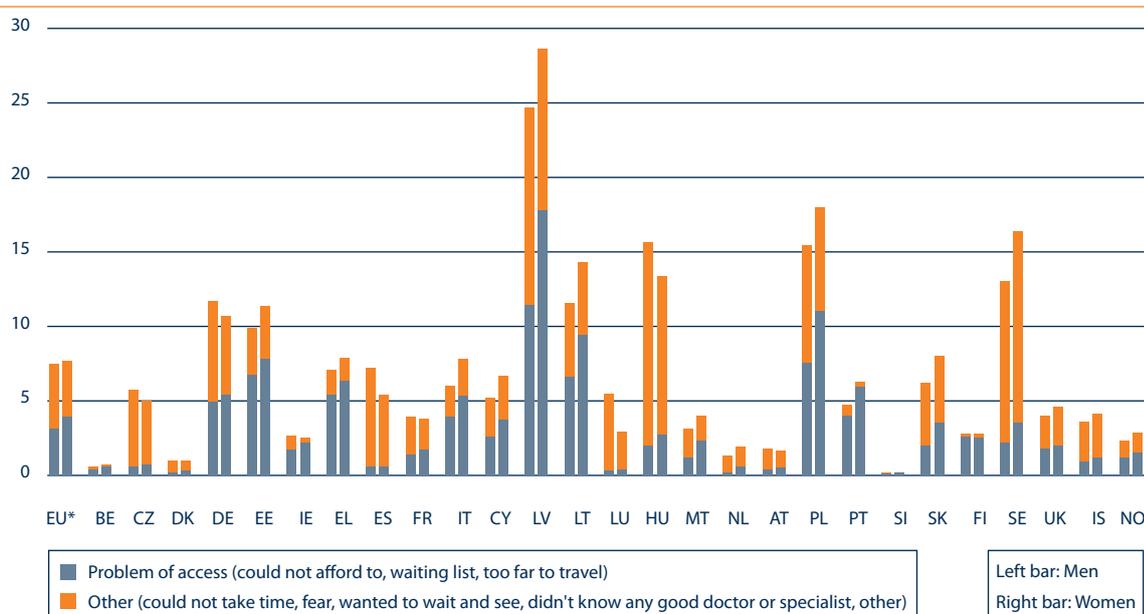
Healthcare access means the ability to obtain appropriate healthcare services in a short time and at a low cost. Even if universal or nearly universal rights to care are basic principles in most Member States and most of the EU population is covered by public health insurance, these basic principles do not always translate into equal access to and use of healthcare services. Socioeconomic factors can affect accessibility to healthcare for specific groups. Low income levels, lack of mobility (the disabled) or language competence (migrants), as well as lack of information (people with low levels of education), time constraints (single mothers) or lack of services for specific groups explain differences in access to health systems.

EU-SILC 2006 data⁽³¹⁵⁾ on unmet medical needs show that women in general are more likely than men to perceive unmet medical needs, even if gender differences are small: in the EU-25, on average 7.7% of women respondents declare unmet medical needs relative to 7.5% of men. Out of these countries, only in seven (Hungary, Germany, Spain, the Czech Republic, Luxembourg, Ireland and Austria) do men show a

higher percentage of unmet medical needs, the figures ranging from 15.6 in Hungary (women 13.4), 11.7% in Germany (w: 10.7), 7.2% in Spain (w: 5.4%) to 5.7% in the Czech Republic (w: 5%), 5.5% in Luxembourg (w: 2.9) 2.7% in Ireland (2.5%) and 1.8% Austria (w: 1.7%). The Baltic countries, Poland, Sweden and Hungary present higher percentages of both women and men declaring unmet medical needs than the average of the considered European countries, while the lowest percentages are in Slovenia, Belgium, Denmark, Austria and the Netherlands. The countries where women's unmet medical needs are the highest are Latvia (28.6%), Poland (18%), Sweden (16.4%), Lithuania (14.3%), Hungary (13.4%) and Estonia (11.4%), while the lowest are in Slovenia (0.2%), Belgium (0.7%), Denmark (1%), Austria (1.9%) and the Netherlands (1.9%).

Gender differences are more relevant when considering the reasons for unmet medical needs: women are usually more likely than men to be constrained by barriers to access, such as the cost of medical care, time and geographical barriers ('could not afford', 'waiting list', 'too far to travel'), while men are more likely than women to declare other reasons such as: 'could not take time', 'fear', 'wait-and-see strategies', 'didn't know any good specialist or doctor' (Figure 2-9).

Figure 2-9 — People with unmet needs for medical examination (%), EU-25 and Iceland and Norway, 2006



Source: Eurostat data based on the EU-SILC survey 2006.

Explanatory note: EU refers to EU-25. Data for Bulgaria and Romania are not available for 2006. The reference population is private households as well as current members over 15 years of age within the national territory at the time of the data collection.

⁽³¹⁵⁾ Eurostat (2009), Perception of health and access to healthcare in the EU-25 in 2007, by Baert, K. and de Norre, B., Statistics in Focus, No 24/2009, Luxembourg.

http://epp.eurostat.ec.europa.eu/cache/ITY_OFFPUB/KS-SF-09-024/EN/KS-SF-09-024-EN.PDF

Barriers to access appear to be particularly relevant for women in the Baltic countries (especially in Latvia), in Poland and in Greece. Portugal, Germany and Italy also show perceptions of unmet needs among women due to problems of access above the average.

Income levels significantly affect the perception of unmet medical needs. As shown in Table 2-5, income

levels especially affect the perception of financial and geographical barriers to healthcare access. The Baltic countries, Poland, Portugal, Italy, Germany, Hungary and Sweden present the highest perception of unmet needs among women and men in the lowest quintile and the largest differences between the respondents' perception in the lowest and in the highest income quintile.

Table 2-5 — Unmet needs for medical examination of women and men by lowest and highest income quintile (%) and reason, EU-25 and Iceland and Norway, 2006

	All reasons				Problems of access (could not afford to, waiting list, too far to travel)				Other (could not take time, fear, wanted to wait and see, didn't know any good doctor or specialist, other)			
	< 20 %		> 80 %		< 20 %		> 80 %		< 20 %		> 80 %	
	women	men	women	men	women	men	women	men	women	men	women	men
EU-25	10.5	10.4	5.8	6.0	6.5	5.7	1.9	1.5	4.0	4.7	3.9	4.5
Austria	2.9	2.2	2.1	1.6	1.0	0.8	0.4	0.1	1.9	1.4	1.7	1.5
Belgium	2.1	2.2	0.1	0.2	2.0	1.5	0.1	0.2	0.1	0.7	:	:
Cyprus	9.2	8.5	3.2	3.1	7.0	6.1	0.6	0.5	2.2	2.4	2.6	2.6
Czech Republic	6.5	6.8	4.7	6.4	1.4	1.4	0.4	0.1	5.1	5.4	4.3	6.3
Denmark	1.8	2.0	1.1	1.1	0.4	:	0.2	0.2	1.4	2.0	0.9	0.9
Estonia	17.2	20.2	6.0	3.7	12.9	17.0	4.2	2.1	4.3	3.2	1.8	1.6
Finland	4.8	4.9	1.6	1.1	4.8	4.6	1.1	0.8	0.0	0.3	0.5	0.3
France	6.9	7.9	2.3	2.9	3.9	4.7	0.7	0.5	3.0	3.2	1.6	2.4
Germany	15.3	17.2	6.9	8.2	9.6	9.2	2.0	2.3	5.7	8.0	4.9	5.9
Greece	10.0	8.1	3.4	3.7	8.5	7.2	1.9	2.1	1.5	0.9	1.5	1.6
Hungary	15.1	18.6	10.6	13.8	4.6	3.1	0.8	0.9	10.5	15.5	9.8	12.9
Ireland	3.5	4.4	0.5	1.7	2.6	2.9	0.2	1.1	0.9	1.5	0.3	0.6
Italy	12.7	10.8	5.0	4.2	9.8	8.3	2.6	1.6	2.9	2.5	2.4	2.6
Latvia	39.1	34.1	18.9	17.7	31.5	24.8	7.0	4.6	7.6	9.3	11.9	13.1
Lithuania	18.3	20.0	10.8	7.5	14.7	12.2	5.0	2.8	3.6	7.8	5.8	4.7
Luxembourg	5.2	7.7	2.1	4.7	0.7	1.1	0.5	0.3	4.5	6.6	1.6	4.4
Malta	6.0	5.5	2.8	2.4	4.0	2.7	1.1	0.6	2.0	2.8	1.7	1.8
Netherlands	3.1	2.3	1.1	0.4	1.5	0.2	0.5	0.2	1.6	2.1	0.6	0.2
Poland	21.9	16.9	16.7	16.6	15.7	10.8	7.2	5.5	6.2	6.1	9.5	11.1
Portugal	11.3	8.6	1.8	1.5	11.2	7.6	1.1	1.0	0.1	1.0	0.7	0.5
Slovakia	12.0	9.0	6.2	5.0	7.7	4.6	0.8	0.7	4.3	4.4	5.4	4.3
Slovenia	0.4	0.3	0.3	0.1	0.3	0.2	0.3	:	0.1	0.1	:	0.1
Spain	6.2	7.4	5.5	8.1	0.9	1.0	0.1	0.3	5.3	6.4	5.4	7.8
Sweden	15.7	16.0	12.9	8.7	4.8	3.2	1.2	1.1	10.9	12.8	11.7	7.6
UK	5.7	5.1	4.3	3.5	2.5	2.8	2.0	1.1	3.2	2.3	2.3	2.4
Iceland	2.8	6.0	3.0	1.1	1.0	1.9	:	0.4	1.8	4.1	3.0	0.7
Norway	4.8	2.3	1.5	1.5	2.2	0.9	0.4	0.9	2.6	1.4	1.1	0.6

Source: Eurostat data based on EU-SILC survey.

http://epp.eurostat.ec.europa.eu/portal/page/portal/product_details/dataset?p_product_code=HLTH_SILC_08

Explanatory note: The equivalised income quintiles are constructed by country; it is an ordered measure of the equivalised income of a respondent. If a respondent belongs to the first quintile (0–20%), this means that they are amongst the 20% of respondents of their country with the lowest equivalised income during the income reference period. The equivalised income is calculated from the household income taking into account household size and composition.

The following sections describe the main financial, cultural and geographical barriers which impede access to healthcare, focusing on barriers which especially affect women or men and, among women, the most disadvantaged groups: disabled women, women of ethnic origin, older women, teenagers, poor women and single mothers, based on information provided by the EGGSI network.

2.2.1. Financial barriers: insurance coverage and individual costs

The financial cost for the individual is one of the main barriers to accessing healthcare services. While all European countries are committed to ensuring access to adequate healthcare and long-term care, significant inequalities remain, especially due to the lack of insurance coverage, the cost of certain (specialised) types of care (such as dental, ophthalmic and ear care) which are often not covered by public insurance schemes, the increasing role of private insurance schemes and of out-of-pocket costs for care, as well as the persistence of informal payments in many eastern (such as Slovakia, Romania, Bulgaria, Hungary, Poland, Lithuania, Latvia) and southern European (such as Italy and Greece) countries.

All European countries have achieved almost universal coverage for healthcare costs for at least a core set of services⁽³¹⁶⁾. EU health systems cover preventive and public health services, primary care, ambulatory and inpatient specialist care, prescriptions pharmaceutical, mental healthcare, dental care, rehabilitation, home care and nursing home care. There is however some variation across the European countries in the range of services covered by public insurance schemes and the extent of cost sharing required. In addition, in some countries there is a gap between what is officially covered and what is actually available and in some countries informal additional payments increase the financial barriers to healthcare. Given that residency is the most common basis for entitlement to healthcare in the EU, some population groups are not usually covered by public insurance: ethnic minorities and especially the Roma people, homeless people, asylum seekers and illegal immigrants without identity documents are outside

of the public healthcare systems and are often only guaranteed emergency care services.

The need to contain increasing healthcare costs due to ageing and new technologies have encouraged many countries to reform their public-private mix and introduce cost-sharing schemes with the aim of reducing costs, moderate healthcare demand and improve efficiency⁽³¹⁷⁾.

Most European countries have introduced out-of-pocket fees to be paid for healthcare services and medicines; reduced exemptions and introduced procedures aimed at containing the demand for health services; supported the development of private insurance schemes and rationalised the supply of services by closing clinical centres in peripheral, low-populated areas. Reproductive care, screening programmes and mandatory preventive programmes are usually excluded, but these trends still may negatively affect access to healthcare, especially for individuals with poor economic and educational backgrounds and of ethnic origin.

Tax-based public health insurance schemes remain however the main funding sources for healthcare systems in European countries, even if the incidence of out-of-pocket payments and, to a lesser extent, of private insurance in financing total health expenditure has been increasing in most European countries. Their incidence over total healthcare expenditure varies greatly from country to country. In 2005, the incidence of private expenditure on total healthcare expenditure (Figure 2-10) ranged from the low levels of Luxembourg (8.2%), the Czech Republic (11.1%), the United Kingdom (12.9%), Sweden (15.4%) and Denmark (15.8%) to the highest incidence in Greece (57.2%), Cyprus (55.7%) and in some eastern European countries such as Latvia (43.4%), Bulgaria (42.4%) and Romania (33.9%).

Since 1996, public expenditure as a proportion of total expenditure on health has fallen in 17 Member States, with the largest decline in Belgium, Bulgaria, Estonia, Hungary and Slovakia; 10 Member States have instead increased public spending, with the largest rises in Cyprus, Malta and the UK⁽³¹⁸⁾.

⁽³¹⁶⁾ Thomson, S., et al. (2009), Financing healthcare in the European Union, Challenges and Policy responses, European Observatory on Health Systems and Policies, Observatory Studies Series, No 17. <http://www.euro.who.int/document/e92469.pdf>

⁽³¹⁷⁾ London School of Economics (2007), Health Status and Living conditions in an enlarged Europe, Monitoring Report prepared by the European Observatory on the Social Situation — Health Status and Living Conditions Network, London, p. 113. http://ec.europa.eu/employment_social/spsi/docs/social_situation/sso2005_healthlc_report.pdf

⁽³¹⁸⁾ Thomson, S., et al. (2009), Financing healthcare in the European Union, Challenges and Policy responses, European Observatory on Health Systems and Policies, Observatory Studies, No 17, p. 30. <http://www.euro.who.int/document/e92469.pdf>

Figure 2-10 — Public and private expenditure on health as a proportion of total expenditure on health in the EU-27, 2005 (*)

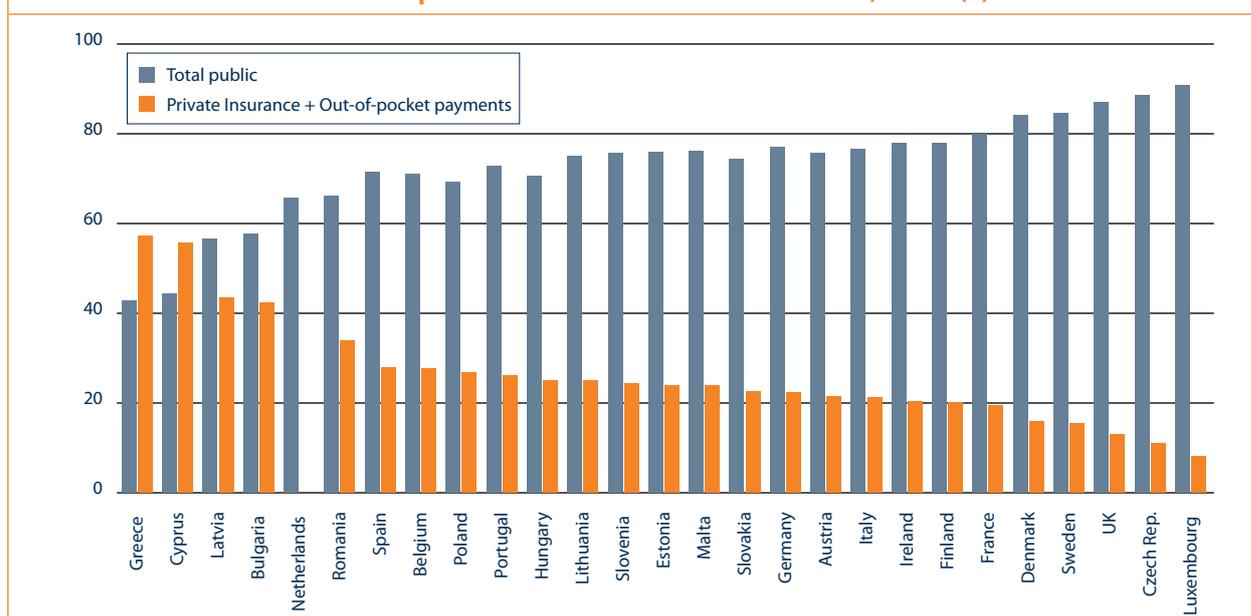


Figure elaborated by IRS.

Data source: European Commission, New common indicators from 2006 for the Open Method of Coordination. http://ec.europa.eu/employment_social/spsi/common_indicators_en.htm, Indicator HC-C3, based on OECD Data.

(*) 2004 data for RO, HU, LT, SI, EE, MT, LU.

Explanatory note: No data on Private Insurance + out-of-pocket payments available for NL, data for BE + NL: share of current expenditure, data of EL + UK: separate estimates of private health insurance not available, LU: Only covers cost-sharing element of out-of-pocket spending. Total public expenditure includes government spending plus social security funds according to System of Health accounts (SHA). Out-of-pocket payments expenditure is presented as a percentage of total health expenditure.

While all European countries have exemptions or reductions in relation to cost sharing⁽³¹⁹⁾ for specific groups of the population (usually minors, pregnant women and mothers of young children, the unemployed, low-income individuals, the disabled and the chronically ill), some countries have actually increased the number of cost-sharing schemes (Czech Republic, France, the Netherlands, Latvia) or reduced exemptions (Ireland). The financial cost of healthcare is especially high in Cyprus and Greece. On the other hand, some countries (Hungary, Slovakia) have withdrawn the cost-sharing schemes that were implemented, or improved system coverage (as, for example, Portugal for dental care)⁽³²⁰⁾.

Private insurance schemes may lead to a regressive distribution of the financial burden for health services (low-income people pay proportionally more than high-income people, due to the difficulty in reducing health expenditures and their usually worse health status) and increase inequalities in access to treatment, especially when private schemes substitute (as in Germany and in the Netherlands prior to the 2006 reform) or complement (as in France, Denmark and in Slovenia) statutory public health insurance⁽³²¹⁾. In addition, these schemes tend to attract and insure people with a lower than average expected risk of ill health and deter those with higher than average risks.

⁽³¹⁹⁾ Exemptions usually refer to the exemption from out-of-pocket payments for prescription pharmaceuticals and/or for medical examinations for specific groups of population (such as minors, pregnant women, the unemployed, the chronically ill, low-income people) or for treatment of chronic illnesses (as, for example, diabetes). Reductions in cost-sharing usually refer to the lower rates applied for those with income below a certain threshold and for those who exceed the annual ceiling in out-of-pocket payments.

⁽³²⁰⁾ European Commission (2009), Proposal for the Joint Report on Social Protection and Social Inclusion 2009, Commission staff working document, accompanying document to the Decision of the European Parliament and of the Council establishing a European Microfinance Facility for Employment and Social Inclusion, COM(2009) 58 final, SEC(2009) 141, Brussels. <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2009:0058:FIN:EN:PDF>

⁽³²¹⁾ Private schemes substitute public health insurance when they cover groups of people either excluded from the statutory system or who are allowed to opt out from it, as in Germany and in the Netherlands before the 2006 healthcare reform. Private insurance is complementary to the statutory system, when it either covers services excluded from the publicly financed benefits package (like specialist care in most EU countries) or it covers statutory cost-sharing requirements (as in France, Belgium, Denmark, Slovenia, Ireland, Italy, Latvia, Portugal and Luxembourg). Supplementary schemes, on the other hand, cover faster access to care or access to care in the private sector (as in the UK, Ireland and in most of the Member States). Source: Thomson S., et al. (2009), Financing healthcare in the European Union, Challenges and Policy responses, European Observatory on Health Systems and Policies, Observatory Studies series, No17.

For these reasons, some groups of people may not be able to obtain an affordable level of coverage or any coverage. Finally, private insurance schemes usually enable insured people to bypass waiting lists in the public sector or to obtain higher quality care.

Cost-sharing requirements and lack of public coverage for certain types of care also create financial barriers to access healthcare services which may lead to significant inequalities in access and health status, by reducing the use of healthcare (especially for specialist and quality care and prescription drug use) for people with a low income.

The increasing role of private health insurance and out-of-pocket payments may also give rise to gender inequalities in accessing healthcare, men being more likely to be covered by private insurance than women and women being higher consumers of healthcare services and medicines. Women usually have a lower income and do not benefit from the same kind of company-based private insurance coverage as men. Women present lower employment rates in the regular economy (many women are either inactive or work at home or in the informal sector) and, when employed, they are more likely to be employed in the public sector or by small firms (which are less likely to provide supplementary private insurance schemes) with part-time and/or with temporary contracts in low-paying jobs. In addition, private insurance schemes are less attractive to women since contributions are usually defined considering age and gender-specific risks. Women who bear the 'risk' of pregnancy and birth and have a longer life expectancy risk paying higher contributions than men of the same age group, even if Directive 2004/113 establishes the principle of gender-neutral tariffs⁽³²²⁾.

Women from ethnic minorities and poor households may be especially penalised by the privatisation of health services and the increase in out-of-pocket spending on healthcare.

Gender effects of financial barriers in national healthcare systems

European countries use a wide variety of institutional arrangements to provide health insurance coverage and to finance and deliver healthcare services. National differences are relevant in explaining gender gaps in

relation to insurance coverage and financial barriers in accessing healthcare services. While it is difficult to identify systematic differences, it is possible, however, to identify at least three different groups of countries when considering the public–private mix of health insurance schemes and the coverage and financing of public insurance systems (as shown in Table 2-6)⁽³²³⁾.

The first group is characterised by the presence of a tax-based, comprehensive national public system providing universal coverage. In the second, more numerous, group of countries the public healthcare system is mainly financed through compulsory social insurance contributions, while the third group presents a high incidence of out-of-pocket payments and private insurance schemes.

In countries with comprehensive national public systems, the system is usually based on individual citizenship rights and funded mainly through general taxation. It is usually centrally organised with some local level of responsibility (local and/or regional bodies) and provides universal coverage, with a very limited presence of private supplementary insurance. Targeted programmes are often implemented to facilitate access to healthcare for disadvantaged groups.

The Nordic countries (Denmark, Finland, Iceland, Norway and Sweden), the UK and Ireland are included in this group of countries and present the lowest financial barriers to low income and disadvantaged groups. In general, healthcare is either free of charge or offered at very reasonable, state-supported prices up to a pre-defined cost ceiling. Ireland is however different from the other countries of this group, because private insurance schemes cover more than half of the population, playing a mixed supplementary and complementary role and offering faster access to care, access to private sector care and reimbursement of cost sharing.

Some southern European countries (Italy, Spain, Portugal and Malta) also present a National Public Health Service which provides universal coverage, without distinction by gender, age, income and occupational status. In Italy, Spain and Portugal, however, the management of healthcare is decentralised to local authorities and this has increased territorial differences in the quality and accessibility of healthcare services. In Malta the free comprehensive public healthcare system is coupled with means-tested entitlements to pharmaceuticals, dental and optical care for those with low incomes and the chronically ill. Around 25% of the population is covered by voluntary private health insurance for basic care.

⁽³²²⁾ European Community (2004), Council Directive 2004/113/EC of 13 December 2004 implementing the principle of equal treatment between men and women in the access to and supply of goods and services.

<http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2004:373:0037:0043:EN:PDF>

Since the directive allows for exceptions under certain conditions, all Member States have introduced rules which allow them to make use of the exception clause and apply gender differentiated tariffs.

⁽³²³⁾ The adopted classification follows the one considered in Thomson, S., et al. (2009), Financing healthcare in the European Union, Challenges and Policy responses, European Observatory on Health Systems and Policies, Observatory Studies Series No 17. <http://www.euro.who.int/document/e92469.pdf>

Table 2-6 — Health insurance coverage, share of population in the EU-27, 2005

	Public health insurance			Primary private health insurance	Private health insurance (all types)
	1997	2000	2005	2005	2005
Belgium	99	99	99	:	44
Bulgaria	:	:	n.a.	:	:
Czech Republic	100	100	100	:	:
Denmark	100	100	100	:	6.8
Germany	90.8	90.9	89.6	10.2	24.3
Estonia	:	:	94.5	:	:
Ireland	100	100	100	:	51.6
Greece	100	100	100	:	15.6
Spain	99.8	:	99.5	:	11.9
France	99.4	99.9	99.9	:	87.2
Italy	100	:	100	:	:
Cyprus	:	:	n.a.	:	:
Latvia	:	:	n.a.	:	:
Lithuania	:	:	n.a.	:	:
Luxembourg	97.6	98.2	100	:	:
Hungary	100	100	100	:	:
Malta	100	100	100	:	:
Netherlands	74.6	75.6	62.1	35.8	92.8
Austria	99.0	99.0	98.0	:	:
Poland	:	:	97.3	:	:
Portugal	100	100	100	:	17.4
Romania	:	:	n.a.	:	:
Slovenia	:	:	98.7	:	:
Slovakia	100	98.8	97.6	:	:
Finland	100	100	100	:	:
Sweden	100	100	100	:	:
United Kingdom	100	100	100	:	11

Source: European Commission, New common indicators from 2006 for the Open Method of Coordination, http://ec.europa.eu/employment_social/spsi/common_indicators_en.htm, Indicator HC-P3, based on OECD health data.

Explanatory note: The percentage of the population covered by public health insurance (defined as tax-based public health insurance and income-related payroll taxes including social security contribution schemes) and the percentage of the population covered by private health insurance including private mandatory health insurance, private employment group health insurance, private community-rated health insurance, and private risk-rated health insurance.

In some of these countries the number of cost-sharing and private insurance schemes has increased in recent years, with negative effects on gender and income inequalities in accessing healthcare services. For example, according to the EGGSI national reports, in Denmark, Iceland and Sweden the introduction of user charges and private insurance schemes may have increased financial barriers, especially for women. In Italy in recent years there has been an

increase in user co-payments in the public system, a growing utilisation of private providers with direct out-of-pocket payments and an increased number of people with private insurance. In contrast to other EU countries, the private insurance sector mainly provides services that substitute rather than complement those supplied by the NHS. Private health insurance is either provided by employers as a fringe benefit or directly purchased by individuals.

Box 2-17 — Trends in comprehensive national health systems

In Denmark, user charges prevail especially in relation to medicine consumption and dental treatment. No systematic knowledge is available to document that user charges have a gender dimension, but given the income difference between men and women, user charges might imply a weaker position for single mothers and ethnic minority women, especially those outside the labour market. The chronically ill might also face an implicit reduction in medicine consumption, even though special rules reduce the total costs. A more pronounced problem is the increase in private healthcare insurance paid for by individuals and/or companies, especially to cover the costs of surgical treatments. The data is not distributed according to sex, however based upon the yearly report on fringe benefits (such as supplementary health insurance, company car, etc.)⁽³²⁴⁾, men have access to these types of benefits to a higher degree. This implies a gender difference in the degree of access to these types of insurance. Furthermore, private healthcare insurance is prevalent in the private sector, and, this implies a gender difference due to gender-segregated labour markets.

Since the enactment of the Social Security Act in 1971, the Icelandic healthcare system has provided all citizens with universal, comprehensive healthcare services. Thus the whole population is covered and no groups are excluded. Since 1993, the eligibility criteria are based on six months residence in the country. The system is financed through general taxation in which earmarking for health or other public services does not take place. In 2007, public health expenditure made up 82.5% of total health expenditure. Private health expenditure only exists in the form of out-of-pocket payments from users. Although out-of-pocket payments for healthcare in Iceland are quite similar to other Nordic countries and charges are not very high, there is evidence of financial barriers impeding access to healthcare in Iceland. National sources⁽³²⁵⁾ report evidence that household out-of-pocket health expenditures increased by 29% in real terms between 1998 and 2006. The largest expenditure items in 2006 were drugs, dental care, equipment, drugstore items, and physician care (in this order). The highest household expenditure burden was observed among women, younger and older individuals, single and divorced, smaller households, the unemployed and non-employed, individuals with the lowest education and income, the chronically ill, and the disabled. This study concluded that household out-of-pocket healthcare expenditures differ substantially between population groups in Iceland, and have reached a risky level in affecting individual and group access to health services⁽³²⁶⁾.

In Ireland, all residents with income below a certain level are entitled to a means-tested medical card. Holders are entitled

to free primary care from a local GP and free prescription medicines as well as other medical services. There is a separate means-tested GP card for those with incomes above the medical card threshold which entitles holders to free GP visits only. Those without either medical card must pay their own costs and therefore purchase health insurance which is tax deductible. Traditionally medical cards covered over a third of the population⁽³²⁷⁾. Recent government policy has involved a major reorganisation and centralisation of the public health system and a greater use of private provision. According to the most recent data, 25% of the population has a medical card, and 49% have private insurance, while 3% have both medical card and health insurance⁽³²⁸⁾.

In Sweden, since the mid-nineties, inequalities in accessing healthcare re-emerged with low-educated people using outpatient care to a lesser extent than those with a higher educational level. In 2006, 15% of the population in need of medical attention was not getting it, which is high compared to other EU countries⁽³²⁹⁾. This is still more common among female blue-collar workers: 16.1% of female blue-collar workers were in this situation, relative to 10.7% female white collars, 12.0% male blue collars and 8.4% male white collars. In the 2006 Swedish national public health survey, people were asked whether they had refrained from buying medicine for which they had received a prescription⁽³³⁰⁾ during the preceding three months. The result showed that more women (7%) than men (6%) had refrained from buying medicine. This was also more common among the unemployed women with long-term illnesses.

In Finland, public healthcare services are open to everyone. Local healthcare centres and public hospitals charge customer fees for which there is a state-regulated maximum amount (ceiling) per year. Individual ceilings for yearly healthcare costs have been introduced to reduce the financial burden on users of healthcare. The ceiling for municipal healthcare fees is EUR 590 per year and it accumulates from all municipal healthcare services except health services during home visits or dental healthcare. Once a patient has exceeded the yearly ceiling, outpatient healthcare becomes free of charge and the fee for short-term inpatient care in hospitals drops to about a half of the original. There are separate ceilings for yearly payments for prescribed medication (EUR 643 per year) and transportation costs (EUR 157 per year) regarding healthcare. Medication and transportation fees below the ceiling are partially compensated by the National Health Insurance. If the ceilings are exceeded, medication will cost EUR 1.5 per medicine and transportation becomes free of charge⁽³³¹⁾.

⁽³²⁷⁾ Tussing, A.D., Wren, M.-A. (2006), How Ireland Cares: The case for healthcare reform, Dublin.

⁽³²⁸⁾ Smith, Samantha (2009), Equity in Health Care: A view from the Irish Health Care System, Adelaide Hospital Society, Dublin.

⁽³²⁹⁾ Eurostat, data based on EU-SILC survey: People with unmet needs for medical examination in Sweden, by sex and median equivalised income quintile (%).

⁽³³⁰⁾ Folkhälsöinstitutet (2008), Health on Equal Terms, Results from the 2006 Swedish National Public Health Survey, Östersund.

⁽³³¹⁾ Finnish Ministry of Social Affairs and Health.
http://www.stm.fi/sosiaali_ja_terveyspalvelut/asiakasmaksut

⁽³²⁴⁾ http://www.skm.dk/public/dokumenter/publikationer/personalegoder/personalegoder2007_rev.pdf

⁽³²⁵⁾ Rúnar Vilhjálmsson, (2009), Direct household expenditure on healthcare in Iceland, *Læknablaðið* (The Icelandic Medical Journal), Forthcoming.

⁽³²⁶⁾ Rúnar Vilhjálmsson, (2009), Direct household expenditure on healthcare in Iceland, *Læknablaðið* (The Icelandic Medical Journal), Forthcoming.

Most of those who exceeded the payment ceiling for municipal healthcare costs or medication costs were over the age of 75, but some middle-aged groups also exceeded the ceiling for medication costs. Categorised by income levels, the majority of those who exceeded ceilings were from low-income groups. Information on the accumulation of costs towards ceilings is not available by gender. There is no ceiling for costs accumulated from services of private healthcare specialists. NHI reimbursements for specialist care nowadays counts for about 25% of the total costs compared with about 40% in the 1990s. At the household level, the share of households that use private specialist services decreased from 33% to 22% between 1990 and 2006 in the lowest income deciles and increased from 59% to 64% in the highest income deciles. At the individual level, the women's share of the use of private specialist services also increased according to income level. Their use of the services was, however, much higher than men's in all income levels, and the income level affects men's use of private services very little if at all⁽³³²⁾. The main reason why women use private specialist services more than men is because specialist services in gynaecology are available mainly in the private sector.

In Italy, since the nineties user co-payments both for medicines and health services have been increasing, together with private insurance coverage. Private insurance coverage allows services to be obtained through private

⁽³³²⁾ Haataja, Anita et al. (2008), Yksityisiä terveyspalveluja käyttävät kaikki väestöryhmät. Toiset enemmän kuin toiset [All population groups use private specialists, some however more than others, only in Finnish], *Sosiaalivakuutus* 6/2008, 34–35.

providers who are not accredited by the NHS, which usually ensures easier, quicker access to services and often more comfortable healthcare settings.

In the UK, the NHS offers universal healthcare, free at the point of need and access. In theory, the only potential financial barrier to effective treatment is the cost associated with prescriptions in England. The cost from 1 April 2009 for a single prescription is GBP 7.20 or GBP 104.00 for a 12-month prepayment certificate (PPC). However certain categories of patients are exempt from prescription charges. These include pregnant women and patients on low incomes, many of whom are women⁽³³³⁾. In January 2009 the government announced a plan to exempt patients with long-term conditions, starting with cancer patients. In Wales, prescription charges were scrapped altogether on 1 April 2007 and in 2007 the Scottish executive announced plans to reduce charges annually with the aim of phasing them out completely by 2011. In addition, the government has recognised that the traditional 'one-size-fits-all' approach of the NHS is not working and that service provisions need to become more responsive to the needs of disadvantaged communities, through specific programmes such as the Health Inequalities Public Service Agreement started in 2004⁽³³⁴⁾.

Source: EGGSI network national reports, 2009.

⁽³³³⁾ Due to the gender pay gap in the UK, more women than men are on low incomes.

⁽³³⁴⁾ Department of Health (2003), *Tackling Health Inequalities: A Programme for Action*, London.

The largest group of European countries includes those which finance healthcare mainly through compulsory social insurance contributions, usually the contributions of employees and the self-employed. Continental countries (Austria, Belgium, France, Germany, Luxembourg, and the Netherlands) are included in this group, as are most eastern European countries (the Czech Republic, Estonia, Hungary, Lithuania, Poland, Slovakia and Slovenia). In these countries, the welfare system is largely based on the (male) breadwinner model, with insurance coverage based on the occupational condition of the family breadwinner and derived rights for family dependants (spouse and children). The system of derived rights covers non-employed married women, but penalises single mothers, divorced and single women, as they are not co-insured within the family.

In some of the continental countries, as in France (since the reform of 2000) and the Netherlands (after the 2006 reform) there is a mixed system, with the mandatory social contribution mechanism

supplemented by basic universal tax-based coverage. The Netherlands, since the 2006 health insurance reform, has implemented a dual system composed of: (i) compulsory, individualised basic health insurance system for every adult citizen (children up to 18 years old are free of charge, being insured via one of the parents), regardless of occupational status; (ii) coverage against long-term care costs (non-insurable costs) financed by contributions of the working population.

In many of these countries, a large share of the population is covered by supplementary private insurance schemes, which in the Netherlands also cover primary care and thus complement public insurance. In Germany, supplementary private insurance schemes cover specialised care.

Some of these countries have increased the number of cost-sharing schemes with negative effects on gender and income inequalities in accessing healthcare services.

Box 2-18 — Recent trends in some continental countries

In Austria, recent health reforms have primarily dealt with cost containment, leading to the increasing individualisation of health costs. According to a study carried out by the Austrian Federal Institute for Health Planning⁽³³⁵⁾, these reforms have reduced access to healthcare for low-income groups. Cost containments have a regressive effect, since the less one earns the more — proportional to income — one has to pay. For women, the at-risk-of-poverty threshold is higher than for men (13% relative to 11%)⁽³³⁶⁾. In particular, women above the age of 65 have the highest percentage (19%) due to the generally low old-age pension payments for women; also single mothers and homeless women are negatively affected. Therefore, elderly persons, in particular women, and chronically ill people, as well as people with a lower income, are financially burdened by cost containment for health services.

In Germany, with the 2007 health reform, all citizens are obliged to be insured. Almost 88% of the population has mandatory health insurance, while another 9.7% is insured by a voluntary private health insurance scheme. Men are more often insured by private health insurance schemes than women⁽³³⁷⁾. This can be explained by differences in income — more often men earn an income above the income threshold for public health insurance. In addition, contributions to private schemes do not follow the principle of solidarity, but gender- and age-specific risks which may penalise women who have gender-specific pregnancy and childbirth 'risks' and live longer than men. Because of the gender pay gap and lower average income, women are more often concerned by the fact that more and more health risks are not fully covered by the public health insurance scheme.

⁽³³⁵⁾ Federal Ministry for Women and Health (2006), Men's Health Report Austria 2005, Vienna. http://www.oebig.org/upload/files/CMSEditor/1._Oesterreichischer_Maennergesundheitsbericht.pdf

⁽³³⁶⁾ Austrian Federal Institute for Health Planning (Österreichisches Bundesinstitut fuer Gesundheitswesen, ÖBIG). <http://www.goeg.at/de/OEBIG.html> and Federal Ministry for Women and Health (2006), Men's Health Report Austria 2005, Vienna. www.oebig.org/upload/files/CMSEditor/1._Oesterreichischer_Maennergesundheitsbericht.pdf

⁽³³⁷⁾ Bundesministerium für Familien, Senioren, Frauen und Jugend, BMFSFJ (2005), Gender-Datenreport, 1. Datenreport zur Gleichstellung von Frauen und Männern in der Bundesrepublik Deutschland, Berlin. <http://www.bmfsfj.de/bmfsfj/generator/Publikationen/genderreport/01-Redaktion/PDF-Anlagen/gesamtdokument,property=pdf,bereich=genderreport,sprache=de,rwb=true.pdf>

In France the 2000 reform introduced universal coverage through CMU and free complementary private health insurance for people with low incomes, while the 2004 reform increased the patient's financial participation in medical consultations or interventions. Women consult doctors more often and declare that they renounce consultation for financial reasons more often than men⁽³³⁸⁾.

In Liechtenstein with the health reform of 1 April 2000, several cost-control and cost-reduction measures in the health insurance sector were introduced and the insured must choose between the general practitioner ('family doctor') system (GP) and a free choice of doctors. Insured persons on low incomes, minors and the elderly are granted a reduced premium rate. These reductions, however, are only granted when the insured person joins the family doctor scheme. Pensioners on low incomes also have the possibility to avail themselves of supplementary benefits funded through general taxes in addition to their pension. Expenditure on health insurance premiums and health costs (doctor and dentist costs, etc.) is also taken into account within the context of such supplementary benefits.

In the Dutch healthcare system, considering the individual costs for all diseases, women paid more than men on an individual level in 2005: EUR 2333 against EUR 1915⁽³³⁹⁾. There are also large differences in insurance coverage, which can be ascribed to age and country of origin. In 2006, the Dutch policy on curative healthcare and long-term healthcare changed drastically with a new Health Insurance Act that came into effect on 1 January 2006. Initially, it had a (limited) negative financial impact on the lowest income groups, especially on vulnerable groups such as the chronically ill. Income compensations were thus introduced for the lowest income groups and for the chronically ill. In order to curb the rising costs of healthcare, Dutch citizens were asked to decrease their demand for healthcare as much as possible. Further curbing of the costs was achieved by an implementation and increase of out-of-pocket payments. The minimum amount of out-of-pocket payments for each Dutch citizen, male or female, is EUR 150 a year.

Source: EGGS network national reports 2009.

⁽³³⁸⁾ Insee (2008), Femmes et hommes, regards sur la parité, La documentation française, Paris.

⁽³³⁹⁾ Dutch National Institute for Public Health and the Environment (RIVM). <http://www.kostenvanziekten.nl>

In Belgium, France, the Netherlands, cost-containment measures have been integrated with special measures extending entitlement to publically financed healthcare, such as exemptions and caps to

out-of-pocket payments (as in Belgium) or extending insurance coverage (as in France and the Netherlands) to support healthcare access for low-income and disadvantaged groups.

Box 2-19 — Measures to reduce financial barriers in Belgium and France

In Belgium, recent measures have been geared towards a reduction of cost sharing for groups at risk. The BIM (*Bénéfice de l'intervention majorée*)⁽³⁴⁰⁾ sets a higher rate for the reimbursement of medical services for certain social categories as beneficiaries of the '*revenu d'intégration social*' or for households whose annual income does not exceed a certain threshold (maximum annual income of EUR 2 707 — 1/9/2008). The MAF (Maximum à facturer) sets a maximum amount of annual expenditure per family on healthcare that varies according to household income. However, their impact on improved access to health, in particular for women of lower social groups, has not been evaluated. In addition, the threshold of EUR 450 per year to be charged to patients is still quite high and can represent a substantial part of the household budget. The *dossier médical global initiative* (DMG — Global medical file), introduced in 1999 and available to the whole adult population, reduces medical costs for people opting for it and gives them access to free cancer screening every three years. This measure is an important complement to reduce financial barriers to healthcare. However, this initiative is not well known: there are no data by sex, but people from the lower income groups have 8% less chance to have a DMG⁽³⁴¹⁾.

In France, derived rights for the dependant spouse cover some inactive or unemployed married women without individual entitlement. These rights, however, are becoming more and more uncertain, due to the combination of increasing employment flexibility and the rise of break-ups in unions and marriages. This explains why several 'universal' rights linked to citizenship have been developed in the French system for those, essentially women or immigrants, who do not benefit from individual employment entitlements or from derived rights to social security. Individuals who lose their entitlements may usually keep their rights to social protection for one year. After that period, they may benefit from 'universal rights' under means-tested conditions. In 2000 the government introduced Universal illness coverage (*Couverture maladie universelle* — CMU) to support individuals who have no other entitlement to the social security system. CMU gives access to basic social security coverage (basic CMU), and eventually to complementary coverage (mutual health

insurance funds), to individuals who have no entitlements or who have lost their rights to the social security, under means-tested conditions. Since 1 January 2005, additional help for accessing complementary coverage (CMUC) has been proposed to individuals belonging to a modest household but not eligible for CMUC (because they exceed the income threshold). Statistical surveys show that women and young people represent the majority of the 4.3 million (2007) CMUC beneficiaries. Manual workers and clerks are also over-represented as well as precarious workers at high unemployment risk. Single parent families (essentially single mothers) represent a large and increasing part of the CMUC beneficiaries. Statistical surveys also show that CMUC beneficiaries more often declare that they have renounced dental or optical care during the past 12 months for financial reasons (women more than men) than people benefiting from private complementary insurance, but less than people who have no complementary health insurance coverage at all, showing that the CMUC is effective in reducing the giving-up of healthcare. The highest renouncement rate to dental or optical care is for women without complementary insurance coverage: 40% renounce healthcare (versus 29% for men)⁽³⁴²⁾. Another obstacle that prevents them from accessing healthcare is the refusal of care from health professionals: 15% of CMU beneficiaries declare they have experienced such a refusal, mainly from dentists or specialised doctors⁽³⁴³⁾.

Since 1 January 2000, another measure to ensure health protection was implemented for foreigners who are not stable or regular residents in France. The Medical state aid (*Aide médicale d'Etat* — AME) complements the CMU to give illegal foreign immigrants access to free medical care and hospitalisation under residence (the person must have been in France for at least three months) and resource conditions. According to a recent survey⁽³⁴⁴⁾, in the Parisian Region, AME beneficiaries who are 'in contact' with the healthcare system (who consult a doctor or are hospitalised) are mostly educated young adults (70% aged 20–39) who have been residing in France for less than five years.

Source: EGGSI network national reports 2009.

⁽³⁴⁰⁾ The basic principle of compulsory healthcare insurance is that patients pay care providers directly, at tariffs agreed. Health mutuals reimburse patients partially or wholly according to an agreed rate of intervention, excluding some categories of medical costs or providers. The reimbursement is depending on the income level, and is higher for those with a low income — the *bénéfice de l'intervention majorée* (BIM) (increased intervention benefit).

⁽³⁴¹⁾ Mutualité chrétienne, Inégalités sociales de santé: observations à l'aide de données mutualistes, MC Informations 233, septembre 2008.

http://www.mc.be/fr/109/info_et_actualite/mc_informations/index.jsp

⁽³⁴²⁾ Boisguérin, B. (2009), Quelles caractéristiques sociales et quel recours aux soins pour les bénéficiaires de la CMUC en 2006, Etudes et résultats, Drees, No 675, January.

⁽³⁴³⁾ The explanation may be that doctors have to comply with the Social security tariff for CMU beneficiaries and sometimes experience long delay in reimbursement on the part of social security. Boisguérin, B. (2004), Etat de santé et recours aux soins des bénéficiaires de la CMU, Etudes et résultats, Drees, No 612, December.

⁽³⁴⁴⁾ Boisguérin, B., Haury, B. (2008), Les bénéficiaires de l'AME en contact avec le système de soins, Etudes et résultats, Drees, No 645, July.

A mandatory social insurance contribution system is also present in most eastern European countries (the Czech Republic, Estonia, Hungary, Lithuania, Poland, Slovakia and Slovenia), with Lithuania and Poland having switched from tax-based to social insurance in the mid-nineties⁽³⁴⁵⁾. During the nineties, all these

countries also introduced legislation allowing for private insurance schemes and out-of-pocket payments. In some of these countries, private expenditure accounts for a large share of total spending, so that access to quality healthcare is expensive and largely affected by income levels and occupational positions.

Box 2-20 — Financial barriers in some eastern European countries

Among the Baltic countries, the Estonian healthcare system is mainly funded by solidarity-based mandatory health insurance contributions in the form of earmarked social payroll tax. Overall, at the end of 2006, 95% of the population was covered by mandatory health insurance, and Estonia appears to be the most inclusive among the Baltic countries, even if it does not adequately cover non-registered, unemployed adult men and women. According to the EGGSI national report, 8.2% of women in the 45–54 age bracket are not insured, nor are 67.3% of unemployed men and 54% of unemployed women⁽³⁴⁶⁾. Since the beginning of 2003, voluntary coverage has been extended to those who might otherwise remain uninsured. Private expenditure accounts for approximately a quarter of all health expenditures, mostly in the form of co-payments for pharmaceuticals and dental care. The share of private funding (out-of-pocket payments and voluntary insurance) has increased from 19.6% of the total expenditure on healthcare in 1999 to 25.6% in 2006⁽³⁴⁷⁾. By 2005, the incidence of healthcare services in total expenditures had become equal in the case of the poorest and the richest income deciles. While poorer (and usually older) residents spend their money primarily on buying medicine, the healthcare expenses of wealthier (and usually younger) residents are mainly related to dental care and spa services⁽³⁴⁸⁾. However, since 2007, all registered unemployed people who participate in active labour market policy measures are covered by health insurance. In 2002, 7.4% of inhabitants had high healthcare expenses (above 20% of the household budget), 1.4% of inhabitants were at risk of poverty due to healthcare expenses⁽³⁴⁹⁾. Older persons are especially at risk of high healthcare expenses⁽³⁵⁰⁾.

In Poland the role of NGOs is relevant to financially support access to healthcare services, especially for pregnant women and children. Public healthcare is financed through mandatory health insurance contributions which cover a large part of the total population. However, actual coverage is not complete, and it is slightly biased in favour of men. The main groups not covered include: homeless people (mostly men), except for those under special social programmes, unregistered people, unemployed people with no family relations to the insured person (mostly women), adults who never worked (mostly women) or studied (gender neutral) or live in families without insurance coverage. Voluntary private health insurance is available but not widespread. In most cases it is offered and (co-)financed by employers and its use is two times higher among men than women⁽³⁵¹⁾. Specialised services (including many dental and ophthalmological services) are not provided for at all under public health insurance. While, basic healthcare during pregnancy and birth is available to all women, some procedures, such as anaesthesia during delivery, are not included in the universal health insurance, and must be financed by individuals. In order to overcome financial barriers in accessing healthcare, NGO projects support the financing of selected procedures or diseases not covered by the universal health insurance, especially for children and women of reproductive age, female victims of domestic violence and the elderly. This attention to women's needs reflects a well-organised, self-supporting movement of women in Poland⁽³⁵²⁾. On the other hand, there are very few government (central, local) or non-government projects concentrating on the financial aspects of men's health.

Among eastern European countries, Slovenia presents the lowest inequalities in health insurance coverage. The public scheme covers employees, the self-employed, farmers, recipients of cash benefits (including pensioners) but excludes persons who do not have permanent residence in Slovenia (e.g. asylum seekers, foreigners with temporary residence). The latter are, however, provided with emergency healthcare. There are also specific health services for people without documents and the homeless

⁽³⁴⁶⁾ Koppel, A. et al. (2008), Estonia: Health system review, *Health Systems in Transition*, 2008, 10(1): 1-230.

⁽³⁴⁷⁾ Haigekassa (2007), Annual Report 2007, Estonian Health Insurance Fund, Tallinn.
http://www.haigekassa.ee/files/eng_ehif_annual/EHIF_Annual_Report_2007.pdf

⁽³⁴⁸⁾ Aaviksoo, A. (2009), Health and quality of life, In: Eesti Ekspressi Kirjastuse AS (2009), *Estonian Human Development Report 2008*.
http://www.kogu.ee/public/EIA2008_eng.pdf

⁽³⁴⁹⁾ Vörk, A., Jesse, M., Roostalu, I., Jüristo, T., (2005), Eesti Tervishoiu Rahastamissüsteemi Jätkusuutlikkuse analüüs. Poliitikauringute Keskus Praxis, Tallinn.

⁽³⁵⁰⁾ Habicht, J., Xu, K., Counffinal, A., Kutzin, J. (2005), Out-of-pocket payments in Estonia: an object of concern?, HSF Working Document, Health Systems Financing Programme, WHO Regional Office for Europe.

⁽³⁵¹⁾ According to the Central Statistical Office — GUS (2007), *Kobiety w Polsce [Women in Poland]*, r.2. *Zdrowie [ch.2. Health]*, Warsaw.
http://www.stat.gov.pl/cps/rde/xbcr/gus/PUBL_Kobiety_w_Polsce.pdf

⁽³⁵²⁾ See for instance <http://www.oska.org.pl>

⁽³⁴⁵⁾ Thomson, S. Et al. (2009), Financing health care in the European Union. Challenges and Policy responses, *European Observatory on Health Systems and Policies, Observatory Studies series*, No. 17. <http://www.euro.who.int/document/e92469.pdf>

(in some local areas). However, compulsory health insurance covers 100% of cost of treatment only for certain groups (children, pupils, students). Therefore, it is almost obligatory for people to purchase additional health insurance. Elderly women are a particularly vulnerable group due to their high at-risk-of-poverty rate. Since January 2009, Slovenia has funded additional health insurance for low-income groups (i.e. those receiving cash social assistance or are eligible for receiving cash social assistance)⁽³⁵³⁾, offering better access to healthcare to some of the more vulnerable groups of women (elderly women, single mothers). Additional amendments to the Health Care and Health Insurance Act in 2008 may improve access to healthcare for women. Namely, additional cases previously left out have been included in compulsory health insurance. These are linked to childcare — e.g. parents that are on maternity, paternity leave whose employment contract has expired, parents who pay social security contributions and care for a child under 3 years of age, parents who leave employment to care for four or more children, are now included in compulsory health insurance. These are in most cases women, even though the measures are intended for both men and women⁽³⁵⁴⁾.

In Slovakia, since September 2006, user fees for services in the healthcare sector have been lowered. In addition, the private insurance system has been regulated to prevent abuse. Since 2005, providers have been obliged to respect hard budgetary constraints and health insurance companies are obliged to maintain adequate payment discipline,

⁽³⁵³⁾ <http://www.dnevnik.si/novice/zdravje/1042233497>

⁽³⁵⁴⁾ Health Insurance Institute of Slovenia (HIIS)(2007), Compulsory health Insurance in Slovenia today for Tomorrow, Ljubljana. <http://www.zzs.si/zzs/internet/zzseng.nsf>

report adequate levels of solvency and subject themselves to external audits⁽³⁵⁵⁾. Insured persons now have the right to select their health insurance company, which they may change once per year (always from the 1st of January of the following year) by submitting an application to their health insurance company. Healthcare provision is generally paid for by public health insurance.

The Czech government introduced out-of-pocket payments for seeking medical treatment from a doctor, for prescription pharmaceuticals, and for hospitalisation and medical examination, medications and day — hospital admissions in January 2008. Fees are not paid for preventive examinations, mandatory vaccinations, reproductive care, breast cancer screening (mammography), and prescription of hormonal contraceptives. An annual limit of CZK 5 000 has been introduced (lowered to CZK 2 500 as of April 2009) for the payment of fees. The fees are very low, but for very low income families (for example single parents), the fees might mean a barrier in the use of health services⁽³⁵⁶⁾.

Source: EGGSI network national reports 2009.

⁽³⁵⁵⁾ General Health Policy for 2007–10, Slovakian Health Policy Institute, 2008.

<http://www.hpi.sk/hpi/sk>

⁽³⁵⁶⁾ The information is based on qualitative research carried out under the Project Processes and Sources of Gender Inequalities in Women's Careers in Connection with the Transformation of Czech Society after 1989 and after the Accession of the Czech Republic to the EU, Grant Agency of the Academy of Sciences of the Czech Republic No IA700280804. see EGGSI Network National report 2009, Czech Republic.

The third group of countries is represented by some southern and eastern European countries with different institutional models, but a high incidence of out-of-pocket payments and private insurance schemes: Cyprus, Greece, Latvia, Bulgaria and Romania. In these countries, access to healthcare is more constrained by financial barriers than in other European countries and many disadvantaged groups are completely excluded.

High gender and income inequalities in coverage are present in Latvia, and in some eastern European countries (Romania and Bulgaria), which have only recently started developing a modern healthcare system, switching from a tax-based to an insurance contribution system in the mid-nineties and presenting high out-of-pocket payments. According to the 2008–10 National reports on strategies for

social inclusion and social protection, the Baltic countries, Bulgaria and Romania have increased the public resources aimed at improving access to and quality of care. There are however concerns that the economic crisis is halting this trend, reducing the public resources available for healthcare⁽³⁵⁷⁾.

Cyprus and Greece are the European countries that most rely on out-of-pocket payments. Cyprus is also the only country in Europe still without a universal healthcare insurance system, while Greece, even if it has universal coverage, has a very fragmented system with a high incidence of out-of-pocket payments and private health insurance schemes. While these schemes provide access to good-quality services and reduce waiting times, they also increase inequalities in access to healthcare.

⁽³⁵⁷⁾ European Commission (2009), Proposal for the Joint Report on Social Protection and Social Inclusion 2009, COM(2009) 58 final, SEC(2009) 141. Brussels.

<http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2009:0058:FIN:EN:PDF>

Box 2-21 — Financial barriers in Cyprus, Greece, Latvia, Bulgaria, and Romania

In Cyprus approximately only 65–70% of the population has access to free care and 5–10% has access at a reduced rate⁽³⁵⁸⁾. However, different qualifying conditions for health coverage (free care without income test for some and means-testing for others) result in inequities in access being an inherent part of the system. Exacerbating these inequities is the limited capacity of the public health system to provide services even for those that are eligible for care. Total health expenditure during the 2000–06 period was one of the lowest in the EU-27 and the public share of health spending is the EU's lowest after Greece, with the remaining private share being funded mainly by out-of-pocket payments. Women are more likely to suffer the effects of these inequities, given that they have fewer financial resources, constitute the majority of single parent families, and are at a higher risk of poverty in old age. Other vulnerable groups are women with disabilities and migrant women.

The Greek National Health System (NHS) was created in 1983 with the aim of insuring the entire Greek population, thus contributing to the achievement of the goal of equity in health and healthcare. Even though the expectations of the NHS were very high at the time of its creation, gradually its efficiency was questioned as long as the private health sector was expanding. One of the basic characteristics of the Greek NHS is the co-existence of numerous health funds alongside the coverage of the entire population by a public health system, which is often referred to as the 'Greek Paradox'. Greece is considered to have the most 'privatised' health sector in Europe, with highest incidence of private and out-of-pocket payments as well as 'unofficial' or 'under-the-table' payments in Europe⁽³⁵⁹⁾, whereas private health insurance is not at significant levels⁽³⁶⁰⁾. High private health expenditure is believed to be directly linked to increased levels of dissatisfaction from the NHS⁽³⁶¹⁾. The significant fragmentation of the system is believed to negatively affect the performance of the National Health System in terms of equity. A study⁽³⁶²⁾ conducted in 2003 shows that there are income-related inequalities in the utilisation of 16 basic health services and prevention tests (including diabetes tests, breast examinations, breast screening and Pap tests). With the exception of hearing and osteoporosis tests, the utilisation of the other basic services is largely affected by income levels. The income elasticity of all 16 services is 50% higher for women compared to the rest of the population, so that gender-related income inequalities are more severe

than other income inequalities in health access. The only available chance for women and men (who are not covered by any social security scheme) to tackle financial barriers to the healthcare system is to get a 'certificate of lack of means', which provides access to public healthcare services.

In Latvia healthcare expenditure is still very low as compared to the EU average (6.4% of GDP in 2005 relative to the EU average 9%) and the public system covers only 57% of total expenditures⁽³⁶³⁾. Public insurance only covers basic health services, but not drug prescriptions, dental services, rehabilitation services, etc. Out-of-pocket payments and private insurance are becoming a relevant component of funding and Latvia is one of the European countries with a higher share of private financing. There are no disaggregated data indicating the proportion of insured men and women; however women are less likely to be covered by additional private insurance schemes, as they are not usually employed in large private companies. To protect low-income groups, some exemptions from co-payments have been introduced in recent years, but they have been difficult to maintain in the recent crisis situation.

In Bulgaria there is a combination of low health insurance rates and a large number of non-insured persons. The healthcare system is financed by mandatory contributions to the National Health Insurance Fund (NHIF), central government funding, voluntary health insurance with private health insurance funds, and co-payments from patients. Health insurance mainly covers primary and hospital healthcare services. A serious drawback of the system is the limited access of patients to specialist medical services based on prior authorisation from their GP on the basis of a limited number of 'tickets' allocated by the NHIF. On numerous occasions, patients are obliged to pay out-of-pocket for these services or they simply do not get them. Specific social groups (both men and women) face additional disadvantages based on their economic status, ethnic origin or disability. According to the Law on Health Insurance, registered unemployed and people receiving social benefits are insured by the state through the budget. The number of people with no health insurance is estimated at 1 million (the total population is 7.6 million): they mainly get emergency care treatment. The Roma people, who for different reasons are not among the unemployed or do not receive social benefits, lack health insurance rights and are obliged to pay for medical check-ups, hospital treatment and medicines. According to the Ministry of Health care estimates, almost half of all Roma are not covered by health insurance. The legislation is not applied so rigorously and usually Roma are not denied access to health services in these cases. In comparison with the 10 Member States that joined the EU in 2004, Bulgaria has the lowest share of public healthcare expenditures on GDP — 4.8–5% on average. In 2002 the share of the people unable to pay for necessary medical care and drugs, reached 47% among

⁽³⁵⁸⁾ WHO (2004), 10 Questions about the 10, Report written by Albena Arnaudova, Copenhagen.
<http://www.euro.who.int/Document/E82865.pdf>

⁽³⁵⁹⁾ Liaropoulos, L., Tragakis, E. (1998), Public/Private Financing in the Greek Health Care System: Implications for Equity, Health Policy, Vol. 43, pp. 153–169.

⁽³⁶⁰⁾ Liaropoulos, L., Tragakis, E. (1998), Public/Private Financing in the Greek Health Care System: Implications for Equity, Health Policy, Vol. 43, pp. 153–169.

⁽³⁶¹⁾ Venieris, D., Papatheodorou, Ch. (2003), Social Policy in Greece, Athens.

⁽³⁶²⁾ Mergoupis, Thanos (2003), Income and Utilization of Health Services in Greece, In: Venieris D., Papatheodorou C., (eds.), Social Policy in Greece, Challenges and prospects.

⁽³⁶³⁾ OECD data (OMC indicator HC-C3), presented in European Commission — New common indicators from 2006 for the Open Method of Coordination (OMC), Health and Long-term care, July 2008.

Bulgarian citizens of Turkish origin and 62% of Roma origin. An additional financial barrier is the relatively high cost of medication. As compared to the rest of the EU countries, Bulgarian citizens pay the highest proportion for medications (56%) out of their pockets, while the relative share of the public spending is only 44%⁽³⁶⁴⁾.

In Romania, since the Health Reform Law in 2006, private insurance companies have been allowed to offer supplementary or complementary insurance⁽³⁶⁵⁾. Those who opt for voluntary health insurance are not excluded from participating in the statutory health insurance scheme. Pregnant women and postpartum mothers have special rights within the social health insurance system. They are insured without paying the insurance premium, and if they do not have an income, or if their income is below the minimum national average, they are entitled to free of charge outpatient treatments and transport to the hospital for delivery or emergencies. Health insurance does not cover all healthcare services. Specialised care must be paid for directly by the patients or through other sources of payment. Informal payments are estimated to account

for over 40% of the total out-of-pocket expenditures⁽³⁶⁶⁾. Insurance coverage rates are still low: in 2005, an estimated 7% of the population was not registered with a family doctor and consequently could not benefit from any public health services. A survey carried out in 2000⁽³⁶⁷⁾ showed that only 34% of the Roma were covered by the health insurance fund, compared to the national average of 75%. Also, many people with poor economic status cannot afford to pay the monthly premium, due to insufficient income or resources. The 2008–10 NSR⁽³⁶⁸⁾ provides for additional resources to improve access and quality of care; however it is not clear if these provisions will be maintained given the gravity of the current economic crisis. A free basic health service package for deprived population groups has been defined, together with projects for health services for disadvantaged groups, support to private and public providers of medical and social services addressing disadvantaged groups (the Roma, street children, families on low incomes, elderly people) and access to essential medicines.

Source: EGGSI network national reports 2009.

⁽³⁶⁴⁾ Data for 2007 from the Association of the Research-Based Pharmaceutical Manufacturers in Bulgaria.

⁽³⁶⁵⁾ European Observatory on Health Systems and Policies (2008), Healthcare systems in transition, Vol. 10, No 3, Romania Health System Review.
<http://www.euro.who.int/Document/E91689.pdf>

⁽³⁶⁶⁾ National Statistics Institute (2007), Romanian Statistical Yearbook 2007, Bucharest.

<http://www.insse.ro/cms/rw/pages/index.ro.do>

⁽³⁶⁷⁾ Zamfir, C., Preda, M. (2002), Romii in Romania [Roma in Romania], Bucharest.

⁽³⁶⁸⁾ National Strategic Report for Social Inclusion and Social Protection, 2008, Romania.
http://ec.europa.eu/employment_social/spsi/docs/social_inclusion/2008/nap/romania_en.pdf

2.2.2. Cultural barriers

The distinct roles and behaviours of men and women in a given culture, resulting from gender norms and values, give rise to gender differences and inequalities in access to healthcare, as well as in risky behaviour and health status⁽³⁶⁹⁾.

The first relevant element to be considered while analysing cultural barriers is connected with gender stereotypes. On the one hand, women deal with difficulties in accessing healthcare due to prejudices concerning women's health-related behaviour, or, in certain ethnic groups, customs and habits regarding their role in family and social life. Some examples of prejudices and customs are contained in various EGGSI national reports.

- In Sweden a project called 'Ambulance Care'⁽³⁷⁰⁾ showed that women use ambulances more than men. This could be a result of the fact that more women live alone than men, that women live longer and that they might not have access to a car or have a driver's licence to the same

extent as men. But the most interesting result of the study was that it was observed that when women gave an SOS-alarm, they were generally given a lower priority than men, meaning that it took longer for the ambulance to arrive. One reason for this might be that women's symptoms are not taken as seriously as men's, but maybe also men might only call when they are seriously ill while women call more often. The results were used to raise consciousness about gender issues in the staff and formed the basis for discussions in the organisations involved in ambulance medical care.

- Another example comes from Poland where stereotypes make access to some healthcare procedures difficult for women. This regards, for instance, treatment of alcohol addiction or alcohol-related diseases. Since these problems are perceived as male-related (in fact, they affect mostly men in Poland), women may be deprived of proper treatment. Some psychiatric hospitals have proved completely unprepared for the admission and treatment of women⁽³⁷¹⁾.

⁽³⁶⁹⁾ WHO, Gender, Women and Health.
<http://www.who.int/gender/en/>

⁽³⁷⁰⁾ Ambulansforum, Sweden.
<http://www.ambulansforum.se/>

⁽³⁷¹⁾ Gazeta Wyborcza (2008), Feministki: w szpitalu dyskryminują kobiety, November 11.
http://miasta.gazeta.pl/radom/1,48201,5888267,Feministki_w_szpitalu_dyskryminuja_kobiety.html

- In Romania family opinion is particularly important in the demand for contraceptives and family planning advice. Resistance by a husband and cultural opposition to the use of contraception are important detriments to the seeking of medical advice. Roma adolescents, whose families adhere to traditions that equate a girl's virginity with family honour and place the responsibility for sex education on a mother or sister-in-law, may have particular difficulties in accessing information on sexual health. Cultural conventions about the proper treatment of health issues may also inhibit access. Women often accept symptoms of genito-urinary illness as part of life and may be embarrassed to seek medical care. In many settings, 'modern' and 'traditional' health services still compete with each other. Poor population groups are especially likely to turn to traditional medicine.
- In Cypriot society, with traditional beliefs that reinforce patriarchal attitudes toward women, gender stereotypes as well as societal expectations with regard to gender roles contribute to creating an atmosphere where domestic violence is largely tolerated. As a result of this, a general culture of victim blaming exists in all social classes, and this also seems to be the case among health professionals. In fact, according to a study on the attitudes of health professionals and domestic violence, health professionals revealed a general lack of awareness of the causes and consequences of domestic violence and tended to justify the actions of perpetrators and transfer responsibility to the victims⁽³⁷²⁾.

On the other hand, men also have to face stereotypes in accessing healthcare and prevention programmes. As already mentioned earlier, osteoporosis, for instance, is perceived as a female disease, and it might be less obvious that men should be treated for osteoporosis as well, as shown in some EGGSI national reports. Certain education and health prevention programmes, especially anorexia and eating disorders, are targeted mostly at women, only occasionally mentioning men. Gender-related cultural barriers may also reflect stereotypes regarding lifestyle, where for example, men are expected to be in good shape, dedicated to sport and fitness, etc. The following present two examples from EGGSI national reports in greater detail.

- Although research is scarce, in the UK, evidence suggests that men and women make very different use of primary care⁽³⁷³⁾. Men have a lower

propensity to seek help on health issues from primary care services. They tend to go to general practitioners later and are more likely to use the Accidents and Emergency Department. The cultural explanations given for this are that men have different risk perceptions and are more likely to attribute symptoms to less threatening causes and that they are reluctant to consult with GPs on trivial matters as this may appear 'wimpish'⁽³⁷⁴⁾ or emasculating⁽³⁷⁵⁾. Other studies recommended that in order to increase men's use of health information and services, they could be made more male-friendly, anonymous and convenient. This could be achieved through increased use of NHS Direct⁽³⁷⁶⁾, pharmacists, occupational health and online advice⁽³⁷⁷⁾.

- In Poland, for example, survey data show that men avoid visiting doctors more often than women⁽³⁷⁸⁾. Expectation that a male should be fit and healthy may be one of the reasons for the lower rate of medical care use by men as compared to women. The report also highlights an additional male stereotype: some health-threatening behaviours by men are accepted or at least tolerated, such as drinking alcohol or even occasional risky drinking during special events and holidays. This is often indicated as one of the main causes of transport accident rates and the high male mortality rate due to (transport) accidents.

Women use healthcare services frequently in relation to maternity care and the delivery of children. Throughout their lives and due to their reproductive role, women go through a process of socialisation in which the healthcare system becomes much more a part of their life experience than for men. Also, women live longer and they more frequently use inpatient hospitalisation than men (see Figure 2-7). According to the Iceland EGGSI report, the fact that men are less familiar with the healthcare system, since they miss the socialisation process women experience, may play a role in explaining the differences in accessing healthcare.

⁽³⁷⁴⁾ Banks, I. (2001), No man's land: men, illness, and the NHS, *British Medical Journal*, No 323, 3 November.

⁽³⁷⁵⁾ Wilkins, D., Payne, S., Granville, G., Branney, P. (2008), *The Gender and Access to Health Services Study*, Department of Health, London.

⁽³⁷⁶⁾ NHS Direct offers 24-hour advice and support by telephone and other multimedia channels. See <http://www.nhsdirect.nhs.uk> EGGSI Network National Report 2009, UK.

⁽³⁷⁷⁾ Banks, I. (2001), No man's land: men, illness, and the NHS, *British Medical Journal*, No 323, 3 November, pp. 1058–60.

⁽³⁷⁸⁾ GUS (2008), *Podstawowe dane z zakresu ochrony zdrowia w 2007 r.*, Warsaw, GUS (2007), *Kobiety w Polsce* [Women in Poland], r.2. *Zdrowie* [ch.2. Health], Warsaw; GUS (2007), *Ochrona zdrowia w gospodarstwach domowych w 2006 r.* [Healthcare in households in 2006], Warsaw.

⁽³⁷²⁾ Apostolidou, M., et al. (2008), *Attitudes of Health Professionals on Violence in the Family*, United Nations Development Programme, Cyprus.

⁽³⁷³⁾ Campbell, J.L., Ramsey, J. and Green, J. (2001), Age, gender, socioeconomic, and ethnic differences in patients, assessment of primary health care, *Quality in Health Care*, No 10.

Apart from gender stereotypes, the following issues should also be taken into consideration when analysing cultural barriers in accessing healthcare:

1. social status and level of education;
2. cultural differences inherent in ethnicity and migration issues (that involve not only language skills but also traditions and norms of hygiene);
3. religious practices;
4. prejudice concerning sexual orientation;
5. working culture.

These issues are discussed in more detail below, relying on information from the EGGSI national reports.

Social status and low level of educational

Social status represents a major source of inequality in access to healthcare. Eurostat *Statistics in focus 24/2009*⁽³⁷⁹⁾ investigated the relationship between self-perceived health and unmet medical needs, correlated with demographic and socioeconomic variables. The explanatory factors considered were gender, age group, income, country of residence, level of education and activity status. The results show that there is a direct correlation between the probability of reporting bad/very bad health or unmet medical needs and some of these factors:

- the probability rises considerably when the level of income decreases ;
- the probability rises considerably among inactive and unemployed people;
- the probability decreases when the level of education raises.

So the probability of reporting bad health and unmet medical needs increases with the decrease of socioeconomic conditions such as the level of income, the level of education, and activity status, while from a gender perspective it should be noted that the probability of reporting bad/very bad health is less frequent among women, while the probability of unmet medical needs is a bit more frequent among women than men.

⁽³⁷⁹⁾ Eurostat (2009), Perception of health and access to healthcare in the EU-25 in 2007, by Baert, K. and de Norre, B., Statistics in Focus, No 24/2009, Luxembourg.
http://epp.eurostat.ec.europa.eu/cache/ITY_OFFPUB/KS-SF-09-024/EN/KS-SF-09-024-EN.PDF

Several EGGSI national reports have also described the incidence of social status in the use of healthcare and in the perception of health. For example, in Romania educational attainment and income have been reported as relevant predictors of the use of healthcare, due to missing information or difficulties of access to care. In Hungary this has been reported as particularly evident in take-up rates on breast cancer and cervical screenings (which is lower in women with a low level of education, the unskilled, the Roma, the inactive population, or the poor, particularly in remote, underdeveloped and rural areas). In Portugal, socioeconomic conditions have been reported as particularly determinant in relation to age: a large percentage of older women (over 65 years old) have low educational level, which means a more difficult access to and acquisition of information on topics relevant to their well-being. This may explain why many in this age group still use domestic healing practices and home remedies to deal with their illnesses.

Cultural differences

A rather important area where cultural barriers play a relevant role in accessing healthcare is connected with immigration, in terms of cultural and linguistic differences with the host country, religious beliefs and practices, and difficulties linked to the legal and social situation of immigrant populations. This issue presents two different points of view: the side of the patients and the side of healthcare providers. Some relevant elements to be considered from the side of the patients and their behaviours have been described in EGGSI national reports and summarised as follows.

- *Differences in attitudes towards health and healthcare*: a consideration emerging from the Liechtenstein report, for example, is that 'socially disadvantaged people, of whom many are foreign-language migrants, are exposed to higher health and disability risks. They generally make less use of preventive check-ups and have poorer knowledge of health and risk factors and have different cultural understandings of health, sickness, and hygiene compared with the Liechtenstein population. Culturally different views than those prevalent in Liechtenstein exist, for instance, with respect to the care of infants and children, but also with respect to nutrition: foreign-language migrants are likely to exhibit less healthy behaviour than the native population'⁽³⁸⁰⁾. Dutch general practitioners report unclear health-seeking behaviour and so-called non-compliance behaviour (disregarding doctors' advice) of men and women from ethnic minorities. A remarkable

⁽³⁸⁰⁾ Marxer, Wilfried (2007), Migration und Integration — Geschichte — Probleme — Perspektiven: Studie der NGO-Arbeitsgruppe Integration (co-author Manuel Frick), Benden.

research finding is that second- and third-generation migrants experience more difficulties regarding access to qualified healthcare than first-generation migrants. This implies that language is not such a problem, as second- and third-generation migrants usually speak Dutch, meaning the problem is the difference in cultural background⁽³⁸¹⁾.

- *Differences in the role and relevance attributed to genders*, in some cases with the legitimisation of the use of violence against women. In recent years, issues of violence against immigrant women have become the centre of public attention concerning female genital mutilation (FGM), forced marriage and trafficking in women and girls: examples have been reported in the Norwegian and Austrian EGGSI national reports⁽³⁸²⁾. In Norway the National action plan to reduce domestic violence 2008–11 includes the protection of victims, treatment programmes for those who batter, increased knowledge of domestic violence within healthcare, prevention strategies and an increased focus upon research and development⁽³⁸³⁾. The Action plan to combat female genital mutilation 2008–11 clearly places the responsibility for efforts to struggle against the practice of female genital mutilation with national, regional and local authorities. In Austria, special attention is given to traditionally influenced violence against immigrant women, e.g. female genital mutilation (FGM), forced marriage and trafficking in women and girls. In 2005 the Vienna Women's Health programme supported the establishment of a counselling centre for women's health and genital mutilation⁽³⁸⁴⁾.
- *Differences in educational attainments of women*: ethnic minority women are often characterised by low educational levels, and in particular within Roma communities, high rates of illiteracy and poor school attendance by the children, which hampers their access to services.

From the side of healthcare providers the impact of cultural differences in the access of healthcare can be summarised by some examples presented in the EGGSI national reports.

- In Portugal, access to health services by immigrants and ethnic minorities, though recognised as a right for all those who are legally registered in Portugal, can often be hampered because of the lack of preparation and adjustment to cultural diversity on the part of health professionals and this creates a gap between immigrants and healthcare services: the immigrant population is not familiar enough with actual Portuguese health services, making them suspicious and afraid and the difficulty in understanding and speaking Portuguese makes communication harder between immigrants and technicians.
- Both Dutch healthcare professionals and healthcare users from a different ethnic background report mutual lack of knowledge, ignorance and misunderstanding as bottlenecks in access to healthcare. In Bulgaria, lack of knowledge, ignorance and non-consideration by general practitioners and other health specialists of the cultural differences and traditions of people of Roma and Turkish origin worsen their contact with these patients. This often leads the poorly and less-educated of these groups to resort to methods of self-treatment.
- In many cases migrants and Roma people are described as subject to negative attitudes/racism/discrimination of some healthcare workers and hospitals. This can be seen most overtly in the case of Roma women. Roma women face at least two main obstacles concerning the health services, i.e. the poor access to the services due to the difficulty in obtaining information, and discrimination by those who work in the healthcare system. It is particularly women living in the remote parts of the countries and small villages who do not have sufficient access to the healthcare services. As in the case of other European countries Roma women in Hungary have access to these services in the case of childbirth and of urgent situations. Roma women however suffer from forced segregation even in hospitals, in rooms where there are only Roma women. In Romania the EGGSI national report describes stigma and discrimination as relevant limits in the access to healthcare for the Roma people. The refusal may be direct discrimination and takes many forms, including denial of entry into medical facilities, setting limits on when a patient can be seen and denial of assistance to family members or visitors. Although existing legislation on equal opportunities and non-discrimination is reinforced, there are circumstances when members of Roma communities may be subject to verbal abuse, delayed care, segregation, or outright denial of services on grounds of their ethnicity. Roma women are disproportionately affected by such treatment given their generally higher interaction with health

⁽³⁸¹⁾ Keuzenkamp, S., Merens, A. (2006), Sociale Atlas van Vrouwen uit Etnische Minderheden, Social and Cultural Planning Office (Social Map on Women from Ethnic Minorities), Den Haag.

⁽³⁸²⁾ In 2005 the Vienna Women's Health programme supported the establishment of a counselling centre for women's health and genital mutilation cited in Vienna Women's Health Report 2006.

⁽³⁸³⁾ Justis og politidepartementet, Vendepunkt Handlingsplan mot våld i nære relasjoner 2008–11.

<http://www.regjeringen.no/upload/JD/Vedlegg/Handlingsplaner/Vendepunkt.pdf>

⁽³⁸⁴⁾ City of Vienna 2006, pp. 384–398.

services as mothers and carers for other family members. Poor communication between health professionals and Roma health system users limits access to information on health issues. Moreover, the Bulgarian report highlights that residential segregation puts the Roma at a greater physical distance from healthcare facilities, and they often live in areas without a general practitioner.

One of the greatest barriers for migrant men and women in accessing health services are the language difficulties between migrant patients and health personnel. Difficulties in verbal communication, however, not only include language barriers but also misunderstandings due to cultural differences in interpreting health and illnesses. As described in the Austrian EGGSI report, 'the results of these difficulties in communication between migrant patients and health personnel are wrong diagnoses, inefficient treatment and long "care history" of patients. In particular in sensitive areas of medical treatment such as gynaecology and obstetrics very few personnel with migrant background can be recruited. Furthermore, there are incisive information deficits by migrants about the services of the Austrian health system. The deficient information about the Austrian healthcare system and the deficient provision of health programmes for this particular population group result in a lacking utilisation of preventive, psycho-social and rehabilitation measures'. In Germany, where legal migrants are medically insured and thereby have access to general medical treatment, a great number of female migrants who live in traditional family structures are reported to need language assistance from relatives when they see a doctor. In certain cases, they are accompanied by representatives of organisations offering social assistance for migrants. Many women prefer doctors where the staff is able to speak the same language as they do, in order to be more independent and to protect their privacy. Due to language problems, some women refrain from seeing a doctor even if necessary — and do not make use of preventive check-ups (dentist, gynaecologist, etc.). Within the National action plan for integration (*Nationaler Aktionsplan für Integration*), the federal states agreed on better integration for migrants and people with a migration background in the health system through an 'inter-cultural' opening⁽³⁸⁵⁾, with the support of integration counsellors.

⁽³⁸⁵⁾ Bundesministerium für Gesundheit, BMG (2007), Mitglieder, mitversicherte Angehörige und Krankenstand, Jahresdurchschnitte 1998 bis 2007, Berlin.

Religious practices

Religious beliefs may affect access to healthcare both in the case of immigrants and in the case of nationals, for different reasons. For example, in Belgium hospitals face refusals from women of some ethnic minorities (or their partners/husbands) to be treated by a male gynaecologist even when an urgent intervention is needed. In this case, intercultural mediation services, available in public hospitals⁽³⁸⁶⁾, can help to deal with difficulties posed by cultural differences. Cyprus has always had a significant Muslim minority, which is growing given the influx of immigrants and workers from many countries with Muslim populations. These changes call for the need to offer services that are culturally sensitive and offer options that do not clash with an individual's culture and value system (e.g. female gynaecologists for Muslim women). Also, Maltese NGOs report that, due to their religious beliefs, Muslim women may find it unacceptable to be examined by male medical doctors, and often request the assistance of female social workers⁽³⁸⁷⁾ when in need of healthcare, but this may not always be granted in Malta's state hospitals. In the Netherlands, considering that the Islamic tradition does not allow women to talk to men they are not married to, a care-consultant who is equipped with knowledge and experience with different cultures mediates between the healthcare user and healthcare provider. However, the care-consultant cannot replace a medical professional. Therefore, it is still necessary to develop intercultural competences among healthcare professionals.

Other concerns have been presented in the EGGSI national reports for Cyprus and Poland. In Cyprus, emergency contraception is provided by the Cyprus Family Planning Association (CFPA) and by pharmacies without prescription. Nevertheless, the CFPA has received several reports and complaints by women who were refused to be provided with the pill by pharmacists, who insisted on requesting prescription, either due to ignorance of the regulation or on the basis of conscience issues. In Poland, 89% of the population is Catholic⁽³⁸⁸⁾ and the Church has a visible impact on sexual (conception, birth control, in vitro fertilisation) and ethical education at schools as well as on political parties and political life. The Catholic Church stance on abortion, birth control and fertilisation methods also affect doctors' behaviour and their readiness to implement certain medical procedures⁽³⁸⁹⁾.

⁽³⁸⁶⁾ According to the EGGSI network national report 2009, Belgium, the Federal Ministry in charge of Health is financing such services in hospitals.

⁽³⁸⁷⁾ Draws on an interview with the Organisation for the Integration and Welfare of Asylum Seekers (OIWAS) in February 2009.

⁽³⁸⁸⁾ Central Statistical Office Poland (2008), Concise Statistical Yearbook, Warsaw.

<http://www.stat.gov.pl>

⁽³⁸⁹⁾ Public Opinion Research Centre (2008), Acceptability of in vitro fertilization.

<http://www.cbos.com.pl>

Sexual orientation

A specific cultural issue that affects access to healthcare is linked to sexual orientation. Gay and lesbian organisations frequently report discrimination in healthcare access⁽³⁹⁰⁾. Lesbian women for example, often remain 'invisible' in the public health system; their sexual orientation is not addressed. This is due to the fact that both medical staff and health researchers have little knowledge about the lifestyles, health requirements and specific health risks of lesbian women. It remains to be seen whether lesbian women have specific health risks and illnesses, whether they participate in early detection examinations less frequently than other women. In this regard, in Austria in October 1998, an Anti-discrimination unit for same sex lifestyles was established by the Vienna city administration. This was the recognition of the fact that lesbian, gay and transgender lifestyles have so far not yet been sufficiently perceived and recognised. In Austria, there are no other specific institutions for the promotion of sexual health for lesbian women, gynaecological health services such as family planning institutions, prenatal services or birth clinics are predominantly focused on the needs of heterosexual women. Therefore, lesbian

women utilise such service provisions less often, also due to fear of being stigmatised or discriminated by the health personnel.

Working culture

An additional cultural barrier that is worth mentioning mainly affects men and relates to the flexibility of services. An explanation given in the UK for men's lower use of primary care services is that the opening hours are incompatible with the long working hours that characterise the UK labour market. Men are unable or uninclined to access primary care services because they are more likely than women to work full-time and to work more than 45 hours per week⁽³⁹¹⁾. In some cases, similar difficulties have been reported for single mothers in accessing healthcare, due to reconciliation problems.

Good practice examples in overcoming cultural barriers

There are a number of specific programmes organised throughout Europe to overcome cultural barriers. In most cases, there is a general strategy addressing intercultural barriers, but some peculiarities emerge.

Box 2-22 — Good practices in some European countries

Italy — Department of Prevention Healthcare for Migrants

Among the existing local experiences of healthcare specifically targeted at migrants, San Gallicano hospital in Rome is particularly interesting, where there is the Department of Prevention Healthcare for migrants (legal or not), ethnic minorities and the homeless. A specific service for female health promotion offers immigrant women gynaecological and oncological examinations. Most of the doctors are female and a translation service is provided.

Liechtenstein — A programme to improve communication and integration of the healthcare system

In Liechtenstein, the Working Group against Racism, Anti-Semitism, and Xenophobia stated that foreigners and Liechtenstein citizens are treated and provided with medical care equally⁽³⁹²⁾. However, the health expert group (part of the Working Group against Racism, Anti-Semitism, and Xenophobia) points out that physicians often lack cultural background knowledge to be able to grasp and appropriately react to the whole range of foreigners' health problems: communication difficulties with foreign-language patients make treatment in doctor's offices and hospitals more difficult. The frequently used solution of

using family members as translators conflicts with doctor-patient confidentiality. The fact that foreign-language migrants are mainly present in the Liechtenstein healthcare system as patients and not as professionals aggravates the language problem.

Based on the results of the 2007 integration report, the following measures have been initiated in Liechtenstein:

(a) In order to improve communication and integration of the healthcare system, the Director of the Office of Public Health became a member of the Working Group against Racism, Anti-Semitism, and Xenophobia.

(b) Physicians were provided with a list of interpreters, an overview of all contact offices and persons for cultural communication in Liechtenstein and Switzerland, and the revised Ordinance on the Movement of Persons. In addition, the Health and Integration Office of Caritas Switzerland in Chur offered to serve as a contact point and clearing house. Accordingly, physicians in Liechtenstein can also make use of the list of interpreters provided by Caritas.

(c) Physicians were introduced to the existing overview of integration services in Liechtenstein in the updated social encyclopaedia on the Internet. The Information and Contact Centre for Women's brochure in different languages was also sent to doctors' offices.

(d) Since July 2007, the National Hospital in Vaduz uses the telephone interpreter service TeleLingua when communication

⁽³⁹²⁾ Working Group against Racism Anti-Semitism and Xenophobia (2007), Integration of the foreign population in Liechtenstein, Vaduz.

⁽³⁹⁰⁾ As an example see Ireland Gay Health Forum. <http://www.irishhealth.com/article.html?id=15671>

⁽³⁹¹⁾ Wilkins, D., Payne S., Granville, G., Branney, P. (2008), The Gender and Access to Health Services Study, Department of Health, London.

difficulties arise between doctors or nurses and foreign-language patients. Nine of the most commonly used foreign languages are available. In emergencies and for shorter conversations, the telephone service is an uncomplicated alternative to the presence of interpreters. In this way, doctors and nurses no longer have to rely on the family members of the patients who may speak German, but who often lack the necessary expertise and for whom the translation is too difficult.

Romania — The National programme for health assistance at community level

A national network of health mediators has been created, facilitating contact between health personnel and Roma communities; mediators are Roma representatives (especially women) trained and hired at District Public Health Authorities. Roma health mediators prove to be influential in identifying discriminatory behaviour and helping healthcare workers to dispel prejudices that cause inferior and degrading treatment. They also help in raising awareness in Roma communities about rights, complaint mechanisms and alternative sources of healthcare.

Slovenia — National programme for the Roma community

In Slovenia, where the group that stands out as the most vulnerable in terms of cultural (and language) barriers to accessing healthcare is the Roma population, a National programme of measures for Roma is under preparation, which also includes measures to reduce health inequality in the Roma community.

Sweden — A programme dedicated to overcoming cultural barriers

A programme promoted by the Centre for Clinical Research Västerås of the University of Uppsala dedicated to overcoming cultural barriers was initiated by Asylhälsan (Asylum Seekers Health Care) with participation in an Equal project on Asylum seekers in the region of Uppsala and Västmanland carried out by the non-governmental organisation of UP AROS ASYL⁽³⁹³⁾. The overall objective of the programme was to reach Arabic-speaking women and provide information of self-care as well as to develop competencies at the county council to better treat and understand their needs.

Source: EGGSI network national reports 2009.

⁽³⁹³⁾ UP AROS ASYL (n.y.), Asyl- och Integrationshälsan, slutrapport. <http://193.13.74.89/d2/public/153/071025Asylhalsan.pdf>

2.2.3. Geographical and physical barriers

Even if in most European countries access to (basic) healthcare is a universal right, geographical disparities (such as distance from hospitals and healthcare centres, as well as lack of accessible transportation systems) and physical barriers (such as facilities for the disabled) in the delivery of care may prevent actual access. These barriers affect especially women living in rural or mountainous areas, or disabled and elderly women. The following section explores these difficulties.

Geographical barriers

Geographical variations in coverage and provision are a relevant barrier to accessing healthcare. 'Supply is typically greater in bigger cities and more densely populated areas, whilst there is a lack of GPs or family doctors and certain basic specialist services in small, rural and remote areas. Hospitals are often unevenly distributed and as a large proportion of medical staff is concentrated in hospitals this exacerbates geographical disparities. Geographical features (islands, mountains) may be an explanation for some Member States but in others (e.g. Finland, Spain, Denmark, Italy) disparities are the result of a decentralised decision-making process giving regional and local authorities policy discretion and permitting regional differences in funding. While allowing services to adapt to local circumstances, local decision-making has led to varying treatment and coverage as well as to variations in staff levels. It

should also be noted that care provision within cities can be equally mixed, exhibiting variations between richer and poorer neighbourhoods'⁽³⁹⁴⁾.

Geographical barriers are first of all a problem due to the territorial configuration of the country. Some countries suffer greatly from this aspect.

In Greece inequalities in health can have a geographical dimension, as the lack of health services in some rural or remote regions can result in different health outcomes. The Greek National Health System, consisting of numerous hospitals and health centres across the country, covers the majority of the Greek regions. Nevertheless, significant disparities between regions exist in terms of the number of doctors and hospital beds per 100 000 inhabitants, mainly due to the specific geographical configuration of the country.

Another frequent problem is the unequal distribution of assistance throughout a country due to the political and administrative configuration of the healthcare system. The main reasons for disparity are linked for example to federal structures, allowing consistent autonomy to local areas for the organisation of the health system, or to specific choices made in order to rationalise and improve the quality or the efficiency of the health system.

⁽³⁹⁴⁾ European Commission (2007), Joint report on social protection and social inclusion — Supporting document, SEC(2007) 329, Brussels.

In the following table several examples across Europe are reported:

Box 2-23 — The unequal geographical distribution of healthcare in some European countries

Austria

The density of practising physicians is subject to considerable variation across the country. Rural regions such as the Land of Burgenland in the east (32 physicians per 100 000 inhabitants), Vorarlberg (345 per 100 000) or Upper Austria (362 per 100 000) have the lowest density.⁽³⁹⁵⁾ In contrast, Vienna, the federal capital and the largest city by far, has 700 practising physicians available per 100 000 inhabitants and thus more than twice as many as the abovementioned, largely rural areas. In a 'location plan' which is drawn up by the health insurance funds and the physicians' chambers, the number and the provincial distribution of self-employed physicians is specified. The aim of this regulatory measure is to avoid imbalance in the provision of healthcare.

Belgium

In Belgium, recent measures promote the presence of general practitioners in less well-off zones through financial incentives, in order to have 'care zones' with facilities accessible within a radius of 20 km. This relates mainly to preventive and diagnostic care. Meanwhile, an emerging concern is the policy to have 'reference services' within a limited number of hospitals (such as for advanced device) with the aim of lowering health costs and increase efficiency of care. Accessing such 'reference services' can be more problematic for people living in more isolated zones or for people who have to rely on public transport. This 'geographical accessibility' would be an important aspect to consider when monitoring the policy⁽³⁹⁶⁾.

Cyprus

The main problem is the lack of provision for certain specialised services in (accessible) health centres across the island. Thus, women seeking specialised preventative care and treatment may be unable to do so due to the lack of available specialised healthcare in rural areas, as most rural health centres provide only primary care. For example, women invited to undergo breast cancer screening tests must visit main district hospitals, and although a mobile unit was donated to the Ministry of Health by Europa Donna Cyprus, it is not currently in use. In relation to sexual and reproductive health and family planning, public hospitals, both general hospitals in the main cities, as well as regional hospitals or healthcare centres, usually offer only limited services, mostly related to pregnancy and reproductive health. For women living in rural areas, this may complicate matters even further, since they may have to travel longer distances to access private clinics in urban or semi-urban centres.

Estonia

In rural areas, the distance to the closest healthcare facilities is much greater than in urban areas. Some 43% of rural

households have medical aid further than 5 km compared to 1.4% in urban areas in 2007⁽³⁹⁷⁾. In 2008, a study⁽³⁹⁸⁾ showed that going to a family doctor was not easy for 13% of the population: the main reasons were the distance from home and the dependence on public transportation (58% did not find it easy) which is not always affordable or suitable.

Hungary

The 2006 Health Service Reform was aimed at rationalising the system. People now have to travel farther, and it takes more time and more money. This affects women, who travel more often by public transport than men do, and especially elderly women, who are often more dependent on family members' help. This situation is particularly true for people who have disadvantaged social positions in general, due to the elevated costs. The 2008 National Strategy Report on Social Inclusion and Social Protection cited these difficulties to some extent by emphasising that deficient service coverage meant serious disadvantage to old people living in small settlements⁽³⁹⁹⁾.

Italy

In Italy, geographical barriers are strictly related to strong disparities between northern and southern regions that are paramount when considering quality healthcare services and the diffusion of prevention programmes. The prevalence of screening programmes show a great difference between north-central and southern Italy. In the north-central regions of the country, the extension of mammographic and cervical screening programmes is nearly 100% and the extension of colorectal programmes is over 50%. In the southern regions, the figures are considerably lower. This difference tends to grow if we also consider compliance to invitation. Compliance is higher in the north-central Italy compared to the southern part of the country. The combination of these two parameters (invitation and compliance) increases the inequality in early diagnosis between north and south.

Portugal

Pregnant women constitute a group for whom geographical barriers are considered highly penalising, particularly at the time of delivery. The problem has to do with the new organisation of health services, committed to the concentration of hospital services, with the closure of many hospitals, which means that many pregnant women have to look for help at the time of delivery in locations far from their homes. In the last two years (corresponding to the closure of maternity wards), the number of deliveries made in ambulances has increased, with the associated risks to mother and child. This reflects the effect that the

⁽³⁹⁵⁾ Hofmarcher, M., Rack, H. (2006), Austria: Health system review, Health Systems in Transition 2006, No 8(3).

⁽³⁹⁶⁾ Since recently, travel costs can be reimbursed for cancer patients by the compulsory insurance.

⁽³⁹⁷⁾ National Statistic Institute, Estonia. <http://pub.stat.ee>

⁽³⁹⁸⁾ Faktum e Arikov (2008), Patsientide hinnangud tervisele ja arstiabile, Tallin. <http://www.haigekassa.ee/uploads/userfiles/Patsientide%20rahalolu%202008.pdf>

⁽³⁹⁹⁾ National Strategy Report on Social Protection and Social Inclusion 2008–10 (NSR), Hungary, Budapest, 2008.

actual policies of the closing down of maternity units has on women. Moreover, the concentration of the population in certain areas of the country leads to organisational choices that end up providing uneven services. This is the case for uterine cancer screening, available to women living in the metropolitan area of the country's capital, Lisbon, but it is not available to women living in other areas.

Romania

Rural residents typically have smaller incomes and lower levels of education and are more likely to be uninsured. Specific problems of access to healthcare by women in rural areas include the lack of healthcare providers, particularly for primary healthcare and obstetricians, due to recruitment and retention issues. Relatively impoverished populations, lack of facilities and physicians for back-up arrangements make obstetrical practice in rural places unattractive. As a result, rural women face more challenges related to childbirth and must seek prenatal care and delivery outside of their county of residence. An increase in distance and travel time to prenatal care facilities decreases the use of such care, leading to relatively poor outcomes.

Spain

Territorial disparities are probably one of the most worrisome consequences of the federal administrative organisation. The Spanish health system is entirely made up of individual regional systems, which the central government guarantees access to under equal conditions as well as legislating major public health issues. However, according to the last health survey published by the National Institute of Statistics, gender disparities in terms of access to health services are not equally distributed among Spanish regions. The share of the population who suffered from some kind of impediment to accessing the health system is always higher among women (except for the case of Castilla-La Mancha), but some regions show particularly worrying gaps according to gender: La Rioja, Galicia, Valencia, and Catalonia⁽⁴⁰⁰⁾.

Sweden

In Sweden, 21 county councils and regions are responsible for supplying their citizens with healthcare services. The population in these 21 areas ranges from 60 000 to 1 900 000⁽⁴⁰¹⁾. Within the framework of national legislation and varying healthcare policy initiatives from the national government, the county councils and regions have substantial decision-making powers and obligations

⁽⁴⁰⁰⁾ National Institute of Statistics, National Health Survey 2006.

⁽⁴⁰¹⁾ SKL and Socialstyrelsen (2008), Quality and Efficiency in Swedish Health Care, Regional Comparisons 2007, Stockholm.

towards their citizens. There are only small differences in accessing medical care in different geographical areas.

UK

A major issue in the UK concerns the variation in service delivery according to location. There are geographical variations in all aspects of healthcare, for example, treatment and death rates in hospitals, cancer survival rates, or access to drugs to treat multiple sclerosis or Alzheimer's disease, cancer screening programmes. For women, this is particularly important regarding the availability of contraception, IVF fertility treatment, abortion and breast cancer survival rates. In 1999, the National Institute for Health and Clinical Excellence (NICE) established which treatment drugs should be widely available for free on the NHS. Where drugs are not available, doctors can apply to local health boards or Primary Care Trusts (PCTs) for exceptional funding for individual patients. Treatment therefore depends on a doctor's inclination to make the case for individual patients (or 'candidacy', which is gendered) and on the criteria of a local health board. Differences usually exist between deprived and more wealthy geographical locations. A further geographical barrier relates to access to care in rural rather than urban locations. Access to healthcare is lower for rural populations: 19% of people in England and 40% in Wales and Scotland⁽⁴⁰²⁾. Mortality rates in road traffic accidents, asthma and cancer are worse in rural areas. Cancer is diagnosed later and intervention for cardiovascular disease is lower⁽⁴⁰³⁾. Increasingly, NHS health services are being centralised within large, specialised hospitals. Patients can lose out when health services are provided in such a way and public transport links are poor. Distance to services makes uptake for health services particularly hard for people in rural communities. This may affect women more, as they are more likely than men to rely on public transport. There is also evidence that ethnic minorities in rural locations (e.g. Scotland⁽⁴⁰⁴⁾) experience multiple disadvantages. Women from these groups might be particularly affected by a lack of female practitioners⁽⁴⁰⁵⁾.

Source: EGGSI network national reports 2009.

⁽⁴⁰²⁾ Baird, A. G., Wrights, N. (2006), Poor Access to Care: rural health deprivation?, *British Journal of General Practice*, August, pp. 567–8.

⁽⁴⁰³⁾ Baird, A. G., Wrights, N. (2006), Poor Access to Care: rural health deprivation?, *British Journal of General Practice*, August, pp. 567–8.

⁽⁴⁰⁴⁾ Scottish Executive, Fair for All.

<http://www.scotland.gov.uk/library3/society/ffar-15.asp>

⁽⁴⁰⁵⁾ Campbell, J.L., Ramse, J., Green, J. (2001), Age, gender, socioeconomic, and ethnic differences in patients, assessment of primary health care, *Quality in Health Care*, No 10, pp. 94.

Another problem is the difficulty in accessibility due to the lack of public transport. This is the case in Cyprus where scarce public transportation limits autonomous access to healthcare services for individuals who do not have their own means of transportation, and may even to some extent compromise confidentiality. Groups especially affected by this are elderly women, and immigrant or foreign workers living in Cyprus.

The smallest countries (Liechtenstein, Luxembourg and Malta) tend not to have these kinds of problems, nor does Slovenia, where a good geographical coverage of healthcare throughout the country exists. Only 0.3% had unmet needs for medical examinations in 2006, which is far below the EU average (at 7.6%)⁽⁴⁰⁶⁾. In addition, only 0.2% had unmet medical needs due to access problems (too expensive, too far to travel, long waiting

⁽⁴⁰⁶⁾ Eurostat data based on EU-SILC survey, 2006.

list). In the Netherlands, qualitative analysis and patient experience studies both show that geographical access is not a major problem for the (large) majority of the population⁽⁴⁰⁷⁾. Limited physical access to healthcare may however affect older men and women who might have problems reaching certain healthcare institutes by public transport. The announced restrictions for the reimbursement of mobility costs within the Exceptional Medical Expenses Act could have a negative influence on this issue. On the other hand, many local civil society initiatives within the framework of the Social Support Act have a positive effect, as in many places, especially in rural areas, volunteers are mobilised to standby for the transport of people with specific mobility problems. The physical mobility problems of older men and women are addressed by these local initiatives.

In Poland 39% of the population lives in rural areas (men 40%, women 37.7%) but, as far as the gender composition of the population is concerned, the rural population is more balanced than the urban one. In rural areas, one outpatient clinic serves more than 4 000 people, in urban areas more than 2 220⁽⁴⁰⁸⁾. Clearly, geographical barriers may be more important for the rural than for the urban population. However, according to a 2006 survey, the share of respondents indicating that they renounced medical consultation because of the distance from the health centres was rather low, being somehow lower for men (2.7%) than for women (6%). In general, lack of time, money and distant dates of consultations were much more important, both for men and for women (intensity according to gender was different)⁽⁴⁰⁹⁾.

Box 2-24 — General approach and provisions adopted to address geographical barriers across Europe

Estonia

A good example of a strategy to overcome geographical barriers is the breast cancer screening programme which includes a mammography bus that drives around the southern part of the country to bring the service closer to women in all areas. This is very important in improving the provision of service throughout the country, as the hospitals providing mammography are only available in the three largest towns. As a result, the participation rate in rural areas is quite high. In 2009, the Tartu University Hospital will rent the bus from the Estonian Cancer Society in order to perform about 7 000 mammograms (out of 10 000 performed by Tartu University Hospital).

Moreover, the majority of the population (75%) has the possibility to ask for advice from family doctors by phone, which may help in some cases. There is also a national medical phone line providing medical help 24/7 in Estonian and in Russian. However, only 40% of people are aware of its existence and 12% of people have called it⁽⁴¹⁰⁾.

Poland

There are examples of arrangements intended to overcome geographical barriers in accessing health treatment, targeted especially at the female population. Under the programme 'Early diagnosis of breast cancer', mobile mammography units, special 'Mammobuses' equipped with units for performing mammography screening have been widely used. They function in all regions (voivodships), and the schedule of their operations (places and times) is posted on the Internet and in local healthcare centres.

Romania

The Ministry of Public Health promoted measures such as the planning and allocation of human resources according to the needs of the population and increasing the professional competency of medical personnel; offering incentives for family doctors to relocate towards isolated rural areas (economic and accommodation incentives); developing the infrastructure for health service providers and providing medical equipment; reducing the differences in medical practice by elaborating guidelines and clinical protocols (i.e. clinical guidelines for obstetrics and gynaecology have been approved). Decentralisation of health services is an ongoing process and ensuring adequate resources for the provision of healthcare is essential to facilitate the access to health services for people living in poor communities/regions.

As an example of good practice, it is worth mentioning a measure promoted by the Ministry of Public Health that proved to be successful: the creation of a network of community nurses, including the provision of appropriate training for them, in order to create a link between primary healthcare and community social services. The network of community nurses contributes to reducing the barriers in accessing health units for many elderly or disabled women and men with mobility problems (especially those living in rural areas).

Concerning in particular Roma Communities, within the National Programme for Health Assistance at Community Levels, a national network of health mediators (Ministerial Order No 619/2002 approving the health mediator profession and related technical norms) was created to facilitate contact between health professionals and Roma communities; the mediators are Roma representatives (especially women), trained and hired by District Public Health Authorities. Roma health mediators proved to be influential in identifying discriminatory behaviour and helped healthcare workers dispel prejudices that cause

⁽⁴¹⁰⁾ Faktum e Arikov (2008), Patsientide hinnangud tervisele ja arstiabile, Tallin.
<http://www.haigekassa.ee/uploads/userfiles/Patsientide%20rahulolu%202008.pdf>

⁽⁴⁰⁷⁾ Westert, G.P., van den Berg, M.J., et al. (2008), Dutch Healthcare Performance Report, Bilthoven.

⁽⁴⁰⁸⁾ GUS (2008), Demographic Yearbook 2007.

⁽⁴⁰⁹⁾ Główny Urząd Statystyczny [Central Statistical Office], GUS (2007).

inferior and degrading treatment. They also helped in raising awareness in Roma communities about rights, complaint mechanisms and alternative sources of healthcare.

UK

There are initiatives to improve transport access in rural locations and to promote alternative service access, for example, via NHS Direct and the Internet. Mobile services,

for example, mobile mammography screening units, have successfully been delivered in rural communities⁽⁴¹¹⁾.

Source: EGGSI network national reports 2009.

⁽⁴¹¹⁾ Baird, G. A., Wrights, N. (2006), Poor Access to Care: rural health deprivation?, *British Journal of General Practice*, August, pp. 568.

Physical barriers

Many EGGSI national reports specify that barriers preventing the disabled to access health structures appear to be gender neutral: these are the barriers that reduce the accessibility to preventive medical services and treatments. Not much literature and debate exists on this issue, which deserves much more attention than it has been given so far.

A specific case has been reported in the Cyprus EGGSI national report: women with disabilities experience physical barriers in accessing gynaecological healthcare, despite the fact that all public hospitals have a minimum level of access for physically disabled persons; moreover difficulties in accessing information on family planning and sexual and reproductive health result in the reduced provision of primary and preventative care (such as breast cancer screening, Pap smears etc.).

Box 2-25 — A good practice in Austria

In Austria during 2003, the Year of Disabilities, a number of initiatives and projects for women with disabilities were launched. The Vienna Women's Health programme carried out a project for removing barriers in access to gynaecological treatment. Issues of sexual and reproductive health (contraception, pregnancy, sexual abuse) for women with disabilities have been discussed only marginally for a long time, although they are equally relevant for them as for women without disabilities. Much information and awareness-building is still needed, e.g. in training medical and nursing staff. The Vienna programme for women's health has carried out a project 'barrierefrei. Gynäkologische Vorsorge und Versorgung behinderter Frauen'⁽⁴¹²⁾ since 2003, to evaluate the experiences of physicians in the

treatment of women with disabilities. Two thirds of the interviewed physicians envisage an improvement of the situation if the additional expenditure of time for dressing and for the examination was paid, 44% signalled the need for subsidies to renovate their surgeries, 40% asked for financial support to buy specific equipment to treat disabled persons, 42% requested regular training in disability issues. The organisation 'Bizeps — centre for self-determined living' published a brochure on facilities for disabled persons in hospitals and other health institutions. The brochure is written for disabled persons as well as physicians and other health professions. A list with disability-friendly surgeries and hospitals where personnel is competent in sign language is available.

⁽⁴¹²⁾ Bizeps info — Barrierefrei Gynokologische Vorsorge und Versorgung behinderter Frauen.
<http://www.bizeps.or.at/news.php?nr=4341>

Source: EGGSI network national reports 2009.

3. Gender differences in access to long-term care (LTC)

This chapter is aimed at examining gender differences in access to Long-term care (hereafter LTC) and existing programmes and policies addressing barriers to access. In order to place these issues in a general framework, it is helpful to provide an overview on similarities and differences in LTC systems among European countries.

Within the European Union, different LTC schemes coexist, in terms of the extent of provision, benefits and services provided and institutional settings. Nevertheless, there are common grounds among Member States, in particular from a gender perspective. In most European countries, women are the majority of both the beneficiaries and the care suppliers. In some countries the greater number of women among LTC beneficiaries is due to their longer lifespan: the death of their husbands leave them alone at home and when their health conditions do not allow their remaining at home unattended, the only alternative for them is institutionalisation. Regarding the role played by women as care providers, they are the main caregivers, usually supplying unpaid, informal care which often impacts on their quality of life.

Concerning barriers in access to LTC, EGGSI National reports show that women are affected by cultural and financial barriers more than men, in particular when they are of ethnic minority: a specific section below further explores this issue. Examples of provisions to overcome these barriers have been implemented by some EU Member States. Existing programmes are mainly aimed at removing financial disadvantages, improving the quality of care and supporting informal care providers. As women are very often informal care givers, programmes aimed at giving support to informal care providers have a relevant gender impact in terms of quality of life and remuneration for women's informal work: some countries have introduced forms of payment for caregivers, such as Italy, or other types of support (see the cases of the Netherlands and Liechtenstein below).

3.1. Overview of existing LTC service provisions

According to the OECD, LTC can be defined as a range of health and social services provided to individuals in need of permanent assistance due to physical or mental disability for short or long periods. LTC includes

rehabilitation, basic medical services, home nursing and empowerment activities⁽⁴¹³⁾. In short, LTC consists of a wide set of different services provided to people who are dependant in conducting the Activities of daily life (ADLs)⁽⁴¹⁴⁾ or Instrumental activities of daily living (IADLs)⁽⁴¹⁵⁾.

All over the EU, various provisions concerning LTC have been allocated. Service provision can be distinguished on the basis of two variables: those who provide care and the place where care is provided. Concerning the first variable — care providers — a difference must be recognised between formal and informal care. With reference to the second variable — where the care is provided — a distinction has to be made between institutional care and care at home. Institutions include nursing homes, residential care homes and old-age homes where there is a permanent presence of care assistants. Care at home may include care provided in houses and apartments that are not built specifically for persons needing LTC, as well as adapted housing, group living arrangements and wherever there are no permanent care assistants⁽⁴¹⁶⁾.

The mix of benefit types — formal/informal, economic support/direct provision of services and institutionalisation/care at home — varies among European countries, reflecting the organisational features of each system more than population structure and demographic developments. In particular, these variations reflect different national approaches to familial solidarity (incidence of informal care and support for carers)⁽⁴¹⁷⁾.

In the last 15 years, European countries have experienced reforms aimed at removing inequalities in access to LTC and at improving the quality of care. These reforms

⁽⁴¹³⁾ Council of the European Union (2008), Joint Report on Social Protection and Social Inclusion, Brussels.

⁽⁴¹⁴⁾ ADLs are activities that a person must perform every day such as bathing, dressing, eating, getting in and out of bed, moving around, using the toilet, and controlling bladder and bowel.

⁽⁴¹⁵⁾ IADLs include preparing own meals, clearing, laundry, taking medication, getting to places beyond walking distance, shopping, managing money affairs and using the telephone/Internet.

⁽⁴¹⁶⁾ OECD (2005), Consumer Direction and Choice in Long-Term Care for Older Persons, Including Payments for Informal Care: How Can it Help Improve Care Outcomes, Employment and Fiscal Sustainability?, Paris.

⁽⁴¹⁷⁾ Council of the European Union (2008), Joint Report on Social Protection and Social Inclusion, Directorate-General for Employment, Social Policy, Health and Consumer Affairs, Brussels. <http://register.consilium.europa.eu/pdf/en/08/st07/st07274.en08.pdf>

present different features across countries as the solutions provided resulted from the traditional LTC framework in a given country. While northern European countries have rationed service provision, continental countries have proceeded to increase the number of people receiving LTC considerably, and Mediterranean countries have basically not changed their delivery system.

According to the Centre for European Social and Economic Policies (hereafter CESEP) ⁽⁴¹⁸⁾, in European countries, the social care model — including LTC — can be placed on a ‘continuum’ with the family care model at one extreme and the state responsibility model at the other ⁽⁴¹⁹⁾. A third model, called the subsidiary model, can be found in the middle.

Some authors call the first model informal care-led model ⁽⁴²⁰⁾. This model is characterised by limited public service coverage. The mix of services is generally imbalanced, with a predominance of institutional services, and involves a certain level of cash transfers. Public intervention is generally aimed more at supporting the incomes of persons in need of care than providing them with the LTC services they need. Public intervention occurs when family support isn’t sufficient or the income of the person is very low and is not sufficient to pay informal caregivers. Typical examples of countries characterised by this model are Portugal, Spain, Greece and Italy, where home care, provided by public institutions, is traditionally underdeveloped.

In the second model, public services are much more developed and public institutions more often provide direct care rather than cash transfers. The underlying objective of this model is to promote a high level of regular employment in the care giving sector and to meet the care needs of those who are not self-sufficient ⁽⁴²¹⁾. This model has historically been adopted in the Nordic countries.

The subsidiary model is typical of the francophone continental area (France and Belgium) and other

central European countries. It relies on the family as the primary, responsible caregiver for the elderly, with intermediate organisations providing services that replace informal care when necessary ⁽⁴²²⁾. These countries are in a middle position with reference to the models previously described.

The UK is in the middle position, more inclined than continental European countries towards the state responsibility model, with widespread service provision, especially in home care and a widespread programme of cash transfers, such as attendance allowances ⁽⁴²³⁾.

Eastern European countries cannot be assimilated to a specific model, despite sharing some common traits. They reveal different characteristics in relation to social policy systems adopted that are strongly influenced by their specific path towards democracy and their experience of market economy.

The balance between health services and social services in LTC provision is another element that varies among Member States. While healthcare provides specific nurse or medical support for health problems, social services aim at making the living conditions more bearable providing supports concerning patients daily care. Yet, the boundary between social and health services is often not so clear.

The provision for health matters is usually regulated through the framework of a national health system (such as Greece, Italy, the Nordic countries and the United Kingdom) or a national social insurance system (such as Austria, France, Germany and the Netherlands), while the social welfare systems to address social care issues are usually administered by regional or local governments. In most countries, the right to health is thus defined quite differently than the right to social care. Different legal arrangements and funding bodies may also produce different accountability and performance management regimens and targets, and these can ultimately constitute major barriers to integration ⁽⁴²⁴⁾.

Considering all these premises, it is clear that different forms of provisions can be found all over European countries according to the institutional framework for LTC. The following box shows different institutional settings in European countries.

⁽⁴¹⁸⁾ CESEP is an independent research consultancy specialising in the development and assessment of employment policies, as well as on policies for ensuring equal opportunities and combating discrimination. CESEP collects and analyses qualitative and quantitative information, and provides econometric testing and modelling. CESEP provides policy recommendations for the integration of disadvantaged groups, the management of European programmes and the evaluation of projects and policies (from CESEP website: <http://www.cesep.eu>)

⁽⁴¹⁹⁾ Ranci, C., Pavolini, E. (2007), *New Trends of Long-Term Care Policy in Western Europe*, paper presented at the APSA Annual Meeting 2007, Chicago, Illinois.

⁽⁴²⁰⁾ Ranci, C. Pavolini, E. (2007), *New Trends of Long-Term Care Policy in Western Europe*, paper presented at the APSA Annual Meeting 2007, Chicago, Illinois.

⁽⁴²¹⁾ Ranci, C., Pavolini, E. (2007), *New Trends of Long-Term Care Policy in Western Europe*, paper presented at the APSA Annual Meeting 2007, Chicago, Illinois.

⁽⁴²²⁾ CESEP ASBL (2007), *Exploring the synergy between promoting active participation in work and in society and social, health and long-term care strategies*, Brussels.

http://ec.europa.eu/employment_social/spsi/docs/social_protection/final_report_en.pdf

⁽⁴²³⁾ CESEP ASBL (2007), *Exploring the synergy between promoting active participation in work and in society and social, health and long-term care strategies*, Brussels.

⁽⁴²⁴⁾ WHO (2008), *Home care in Europe*, Copenhagen. <http://www.euro.who.int/Document/E91884.pdf>

Box 3-1 — LTC institutional settings

Belgium

In Belgium, long-term care is part of the integrated healthcare system. A distinction must be made between the provision of services, which can be: (i) linked to specific needs in healthcare that are performed by care institutions (day care, hospitals or convalescent or old people's homes) that are covered by health insurance benefits; (ii) aimed at helping people who have lost autonomy, either due to illness, disability or old age. These services can take different forms: financial benefits or organised care services. In this area, competences are mainly the responsibility of regions and communities.

Czech Republic

LTC is ensured by two systems: a healthcare system organised by the Ministry of Health which is mainly financed by public health insurance, and social services within the Ministry of Labour and Social Affairs, which in turn is funded primarily by the redistribution of state taxes.

Cyprus

There is no public long-term care insurance system in Cyprus. Under the Public Assistance and Services Laws 1991–2003, a person legally residing in Cyprus whose resources are not sufficient to meet his/her basic and special needs may be entitled to social assistance in kind and/or cash. The social welfare services of the Ministry of Labour and Social Insurance are responsible for the implementation of the above legislation. Welfare Officers assess needs for LTC on an individual basis. LTC is provided directly by government, community or private institutions with state financing.

Denmark

The organisation of long-term care is the responsibility of the municipalities based upon state legislation aimed at helping the elderly to take the best care of themselves. Local municipalities decide whether a person is eligible to receive care.

Estonia

LTC is provided by the Social Welfare Act (*Sotsiaalhoolekande seadus*). Long-term care services are financed by the local government and by the person in need of care or his/her family. LTC is provided as in-kind social service and it is organised regionally. Vocational rehabilitation is provided by the Labour Market Board. Local authorities are responsible for the provision of social rehabilitation (e.g. special transportation for disabled persons, adaptation of the dwelling, personal assistant).

Finland

The main policy aim of long-term care is that as many persons in need of LTC as possible should be able to live independent lives in their own homes, and in a familiar social and living environment. Living at home is supported with rapid-access professional social welfare and healthcare services. The elderly over the age of 75 years are guaranteed an assessment of their service needs by social care professionals. This is important since the vast majority of elderly women live alone, far away from relatives. A home visit programme allows the elderly to be under continuous supervision and in contact with social care professionals. Residential services and different forms of institutional care are provided to people who no longer manage to live at home.

The main types of service provided are (i) home help and home nursing care, meals, cleaning and other services, (ii) sheltered accommodation, (iii) rehabilitation, assistance devices and health services, (iv) services for veterans and (v) institutional care. Even though receiving the services and benefits are needs tested, the prices of municipal services are normally means tested. The fee collected from clients covers less than 10% of the costs of the services. The rest is covered by taxes.

France

In France, existing service provisions for LTC (both cash and kind) have recently changed and become broader. Policies address two distinct categories of beneficiaries: dependant elderly subjects and handicapped adults, covered by different policies. Regarding LTC for the elderly, several cash provisions exist to facilitate access to LTC, according to the degree of autonomy: the '*allocation personnalisée d'autonomie*' (APA)⁽⁴²⁵⁾ for dependant persons and the 'Cleaning aid' for autonomous elderly people who need help in everyday life. Regarding LTC for handicapped persons, a new handicap compensation provision (*Prestation de compensation du handicap*) has been created. As with the '*allocation personnalisée d'autonomie*', the '*Prestation de compensation du handicap*' is personalised and calculated according to the beneficiary's needs.

Germany

There are around 11 000 itinerant nursing services with 214 000 employees, about 10 400 nursing homes with approximately 546 000 employees. The majority (58%) of itinerant nursing services are provided by private suppliers, 41% are provided by non-profit organisations and the share of public services is only 2%⁽⁴²⁶⁾.

Greece

There is no specific branch of the insurance system responsible for granting LTC benefits (both in cash and in kind); these are granted through the system of sickness invalidity and survivors. The typical LTC services are provided by state and by private (both profit and non-profit) organisations.

Hungary

LTC still does not have a separate system: services providing long-term care to people are supplied within the healthcare and social service system. Professional policies pertaining to long-term care are basically shaped by the ministries in charge of health and social affairs.

⁽⁴²⁵⁾ The Personalised autonomy allowance (APA Allocation personnalisée d'autonomie) is addressed to persons aged 60 and more, living at home or in an institution, who are experiencing a loss of autonomy. This allowance is personalised, according to the beneficiaries' needs (degree of autonomy, requested aid and services) and income (but it is not means tested). It is provided with an Aid plan (Plan d'aide): for beneficiaries living at home, a medico-social team visits the patients and assesses their needs and necessary aids to allow them to stay at home (the APA depends on the needs and the resources of the patient); for beneficiaries in an institution, the APA helps beneficiaries to pay for the 'dependency tariff' calculated according to the degree of autonomy/dependency.

⁽⁴²⁶⁾ Backes, G. M., Amrhein, L., Wolfinger, M. (2008), Gender in der Pflege, Herausforderungen für die Politik, Expertise im Auftrag der Friedrich-Ebert-Stiftung, Bonn.
<http://library.fes.de/pdf-files/wiso/05587.pdf>

Italy

LTC in Italy is provided by two separate sectors (healthcare and socially related healthcare) even if integration has increased in the last few years, especially in the northern regions of the country. Both of these sectors are programmed and governed by regions, while local-level healthcare provisions are the responsibility of the Local Health Units and socially related healthcare provisions are the responsibility of the municipalities. With regard to public home care, there are two types of provision: home care assistance (*Servizio di Assistenza Domiciliare* — SAD) and integrated home care assistance (*Assistenza Domiciliare Integrata* — ADI). SAD is supplied by municipalities through specifically trained social workers who identify the needs and plan a tailored assistance project. ADI is supplied by local health units, which provide the patient with nursing and therapeutic care. With regard to residential LTC, a national survey on social healthcare structures shows that just 2.0% of over 65 year olds and 4.0% of over 75 year olds live in a nursing home⁽⁴²⁷⁾.

Liechtenstein

In Liechtenstein an independent care insurance law is lacking. The same is true for a legal definition of the concept of 'requirement for care'. Social protection in the case of need for care is primarily guaranteed by the law regarding sickness insurance and the law regarding accident insurance. There are private organisations and public organisations that provide care services in the home or inpatient services for medical and geriatric care. Private as well as the public organisations are non-profit organisations or non-profit foundations.

Lithuania

There is no official definition of LTC in Lithuania. LTC is granted through several branches: social services, invalidity and sickness.

Provision of LTC benefits are organised at national, regional and local levels. Government adopts long-term national programmes and strategies for the social integration of the disabled. Heads of the counties implement social programmes and projects for the disabled at the county level. Counties establish regional social service institutions when the establishment of municipal ones would not be economical. Heads of Counties are also responsible for the provision of secondary specialised medical treatment.

Municipalities prepare and implement municipal programmes for the social integration of the disabled. They are also responsible for determining the need and the provision of common and special social services for their residents.

Malta

Long-term care benefits are granted under different legislative and administrative measures. Cash benefits are granted under the Social Security Act and are both contributory and non-contributory. Contributory benefits include mainly invalidity pensions and disability pensions; non-contributory benefits consist in disability pensions, pensions for the blind and social assistance for long-term invalids.

Additionally, Agenzija Sapport, a government agency, provides limited long-term care benefits in kind to people with

disabilities. Benefits in kind are granted under the national health scheme and subsidiary legislation is administered by the Department for the Elderly and Community Care. The benefits include free treatment and care at all state hospitals and clinics and free medicines, and are subject to a means test. Free medicine is given to people with chronic diabetes.

Residential care is provided by the state or by non-profit predominantly religious voluntary organisations and by the private commercial sector. The state's provision for residential care can be divided into two categories: high (mostly in quasi-hospital settings) and low support (in smaller residential homes based in the community).

The Netherlands

In the Netherlands, the Exceptional Medical Expenses Act is the basis for the financing and organisation of LTC. Before a person can qualify for care under the Exceptional Medical Expenses Act, it is necessary to establish whether care is really required and, if so, what type of care and how much care is needed. This 'indication' is issued by an organisation called CIZ (Independent assessment organisation), responsible for impartially, objectively and thoroughly determining the care required.

Most care under the Exceptional Medical Expenses Act is provided by institutions. The Exceptional Medical Expenses Act insurance scheme is funded through premiums paid by the people covered by the scheme, by state subsidies and by personal contributions from care recipients. Contributions are collected through the income and payroll tax systems.

Norway

The municipalities are responsible for providing reasonable, high-quality healthcare and social services to everyone in need of them, regardless of age, gender or social background. There are several relevant long-term strategies and programmes i.e. the 2015 Care Plan, the National Strategy for Specialised Health Care 2008–12 and the 2008–12 Dementia Plan. The aim of the 2015 Care Plan is to address the main future challenges in elderly care in a long-term perspective⁽⁴²⁸⁾.

Poland

In Poland, public long-term care (LTC) is administered by the Ministry of Health and the Ministry of Labour and Social Policy. While the former is responsible for healthcare and nursing service provisions, the latter is in charge of providing nursing and daily-living care — but not specialised healthcare — services. These responsibilities may sometimes overlap in part and cooperation is needed. LTC granted within the social security sector involves local government to a large extent. This is not so much the case with healthcare procedures. Both sectors are widely supported by non-governmental organisations.

Romania

Local councils are responsible for service organisation and provide services directly or through partnership contracts with non-governmental and/or religious organisations. Generally, assignment to these care homes only becomes available upon the death of a resident. Referral places (i.e. for a patient to be accepted there after hospitalisation) do not exist.

⁽⁴²⁷⁾ Istat (2003), *L'assistenza residenziale in Italia: Regioni a confronto*, Rome.

⁽⁴²⁸⁾ For further information see the last section of this chapter.

Slovenia

LTC in Slovenia is not uniformly organised or centrally coordinated: it is linked to different systems, mainly in the field of healthcare and social protection.

Spain

In Spain the endorsement of the Law 39/2006 on the Promotion of Personal Autonomy and Care for Dependant Persons, known as the Dependant care law (DCL), has implied a highly remarkable advancement in the field of social protection. In particular this law (DCL) created the National system of dependency (NSD), which is managed by the Territorial council of national system of dependency (NSD), for the arrangement of LTC system. With regard to financial resources, the Dependant care law has established a contribution system for LTC: (i) Central government, which finances a guaranteed minimum; (ii) Regional governments, which provide contributions of an amount no smaller than the one from central government.; (iii) Beneficiaries, depending on their income and wealth, participate in co-payment, common everywhere in Spain, determined by the Territorial council of autonomy and dependence attention system (ADAS).

Sweden

The responsibility for the welfare of the elderly is divided among three governmental levels. At the national level, the

parliament and the government have set out policy aims and directives by means of legislation and economic steering measures. At the regional level, county councils or regions are responsible for the provision of health and medical care. And at the local level, the 290 municipalities are legally obliged to meet the social service and housing needs of the elderly. Services provided by doctors are not included in the care for which municipalities are responsible. Some municipalities have contracted out their elderly care services to private providers and in certain areas the elderly are allowed to choose whether they want help at home or in special housing managed by public or private operators.

UK

Long-term care in the UK is predominantly provided in private households rather than communal or residential homes. Some provisions for care in private homes derive from public services. However, the majority of care provision is from (mostly female) relatives and friends. Over the last 25 years there has been a marketisation of residential and domestic care provision to increase flexibility and choice. Local authorities no longer provide most social care directly. Rather, three quarters of private care services are now in the private for-profit sector.

Source: EGGSI network national reports 2009.

3.2. Overview of existing service provisions for LTC from a gender perspective

In order to outline the existing service provisions for LTC from a gender perspective, there are two key issues to be addressed:

- a. the role of women as informal caregivers;
- b. the increasing demand and use of LTC by women.

The role of women as informal caregivers

As far as existing service provisions for LTC are concerned, a crucial difference from a gender perspective is between formal and informal care. According to the OECD⁽⁴²⁹⁾, the difference between formal and informal care depends on who provides the services. In particular:

1. formal LTC includes care provided in institutions, such as nursing homes, or care provided to recipients living at home by professionally trained care assistants. Formal care is provided by care assistants under an employment contract with LTC-service recipients or agencies providing LTC;

2. informal LTC consists in services provided by someone who provides care without any form of employment contract⁽⁴³⁰⁾.

According to OECD, informal caregivers can be divided into three categories. The first includes relatives, friends or volunteers that do not receive any form of compensation for their engagement. The second category includes informal caregivers that receive cash benefits/allowance as part of cash benefit programmes and consumer-choice programmes. They are usually relatives or friends. The last category includes undeclared/illegal informal caregivers. They are caregivers who receive some form of payments by care recipients but without any form of employment contract⁽⁴³¹⁾.

In conformity with the OECD report, the majority of LTC workers, both formal and informal are women, and this is also what emerges from the EGGSI national reports.

- In Greece 80.9% of help-providers are female and the majority of elderly recipients are also women (with an incidence of 50.7%)⁽⁴³²⁾. Informal caregivers are often middle-aged and frequently the relationship between care providers and care receivers is a child-parent relationship.

⁽⁴²⁹⁾ OECD (2006), Projecting OECD Health And Long-Term Care Expenditures: What Are The Main Drivers? Economic Department Working Papers No 477, Paris, p. 9.

<http://www.oecd.org/dataoecd/57/7/36085940.pdf>

⁽⁴³⁰⁾ OECD (2006), Projecting OECD Health and Long-term care Expenditures: What are the main Drivers? Paris.

⁽⁴³¹⁾ OECD (2009), The Long-Term Care workforce: overview and strategies to adapt supply to a growing demand, Paris.

⁽⁴³²⁾ Triantafyllou, J. et al., (2006), The Family that Takes Care of Dependant Older Persons, Eurofarmare, Athens.

- In Austria about 80% of the required LTC services are rendered by relatives or other private helpers, particularly women.
- In Bulgaria, the active involvement of family members and close relatives in LTC service provision for the elderly puts a lot of pressure on women as caregivers (daughters, granddaughters, sisters, etc.) in terms of time spent, job loss, lower pension, psychological burden. All of these aspects seriously damage women's health. Women take on the majority of responsibility for care, and they are especially subject to problems of reconciliation between work and caring responsibilities and insufficient social security. Existing regulations do not encourage men to take over care responsibilities.

The impact on women of informal care giving is relevant, as shown in Chapter 2: according to the WHO⁽⁴³³⁾ primary caregivers are frequently depressed and

anxious, and are likely to use psychotropic medications to treat their psychological distress.

Given the relevance of informal care in many societies and women's predominance as carers, measures supporting informal carers have a positive gender impact. Support for informal caregivers may include information and training, respite care, tax benefits and payments, regulations of businesses or initiatives by private organisations aimed at making it easier for family members to combine work and care-giving⁽⁴³⁴⁾. With reference to the last issue, 'some governments have mandated that businesses make medical leave available for family members to care for their sick or disabled relatives, and some businesses, on their own initiatives, have sought ways to help informal caregivers'⁽⁴³⁵⁾. A few countries also provide pension credits for caregivers who provide a substantial amount of care, in order to partially compensate for the time spent away from the labour market.

Box 3-2 — Programmes aimed at supporting informal caregivers

France has innovated considerably in recent years: the introduction of national assistance programmes for disabled and dependant people has been accompanied by the development of measures aimed at 'rewarding' caregivers, or at the purchasing of services on the private market. The main programme is the 'allocation personnalisée d'autonomie' (APA), introduced in 2002 for dependant persons over 60. Thanks to the plan, beneficiaries receive cash benefits of up to EUR 1 106 per month. It is a form of 'co-payment' for expenses incurred by beneficiaries. According to the programme, teams of medical and social workers suggest the best kind of assistance for each individual case⁽⁴³⁶⁾.

In Italy some measures aimed at recognising and giving financial support for the social assistance of families have been introduced at the local level, while a national policy is still lacking⁽⁴³⁷⁾.

In the Netherlands a national association for informal carers and volunteers, Mezzo⁽⁴³⁸⁾, provides information and support for informal carers, professionals and local member organisations. There are several local initiatives, often initiated and/or supported by local governments, to support informal carers with information and guidance concerning social security work leave arrangements, tax issues, and also with the provision of temporary replacement or the provision of childcare⁽⁴³⁹⁾.

⁽⁴³⁶⁾ Ranci, C., Pavolini, E. (2007), New Trends of Long-Term Care Policy in Western Europe, paper presented at the APSA Annual Meeting 2007, Chicago, Illinois.

⁽⁴³⁷⁾ Ranci, C., Pavolini, E. (2007), New Trends of Long-Term Care Policy in Western Europe, paper presented at the APSA Annual Meeting 2007, Chicago, Illinois.

⁽⁴³⁸⁾ Information provided by the non-profit making organisation 'Mezzo'.

<http://www.mezzo.nl/>

⁽⁴³⁹⁾ <http://www.mezzo.nl/>

In Liechtenstein, care work which takes place within the family has not yet been legally regulated. It is mostly provided on a voluntary basis, in particular by relatives. The family care federation (*Familienhilfeverband*) performs voluntary work in some cases and is financially supported by the state. A 'social time card' (volunteer work certificate) is issued for those who work on a voluntary basis. Volunteers are able to use the volunteer work certificate to record their accomplishments and how much time they have spent. The idea was that evidence of volunteer work and corresponding training could be important in particular for re-entering the workforce. However, participation in these few activities was not as high as expected. It is unclear whether this was due to a lack of interest or to limited opportunities⁽⁴⁴⁰⁾.

In Finland informal care has been a relevant issue of the policy agenda for many years and some support has been provided: the carer may be entitled to receive an informal/family caregivers' allowance paid by the local government to the carer, who often is a spouse or mother (or other relative). These carers are also entitled to 'free days' from care. The system presents some critical points although the allowance and leave system is better than no compensation at all. Gender problems occur when informal carers are working-age women: there has been little attention and encouragement to promote their return to the labour market. Another relevant problem concerns older carers, who are often in need of care services themselves.

Source: EGSI network national reports.

⁽⁴⁴⁰⁾ Liechtenstein Familienhilfe Verband — allgemeine Prinzipien. http://ec.europa.eu/employment_social/missoc/2006/02/2006_02_li_de.pdf

⁽⁴³⁴⁾ WHO (2003), Key policy Issues in Long-Term Care, Geneva. http://www.who.int/chp/knowledge/publications/policy_issues_ltc.pdf

⁽⁴³⁵⁾ WHO (2003), Key policy Issues in Long-Term Care, Geneva. http://www.who.int/chp/knowledge/publications/policy_issues_ltc.pdf

⁽⁴³³⁾ WHO (2003), Key policy Issues in Long-term care, Geneva. http://www.who.int/chp/knowledge/publications/policy_issues_ltc.pdf

The increasing demand and use of LTC by women

According to Eurostat, by 2060, 30% of the population in the 27 EU countries will be over 65. This means that European countries will move from having four people of working age for every person aged over 65 to a ratio of 2 to 1⁽⁴⁴¹⁾.

Demographic ageing, however, does not necessarily mean an increase in demand of LTC⁽⁴⁴²⁾. It is the increase in life expectancy and the incidence of dependency that creates increase in the demand for LTC. The increase in life expectancy at birth⁽⁴⁴³⁾ has implications on the percentage of healthy life years, and therefore on incidence of dependency: longer lifespan influences needs in terms of LTC (formal and informal). Therefore, this clearly affects women more than men.

What is important to note is that demographic trends are quite different across Europe: the old-age dependency ratio⁽⁴⁴⁴⁾ is projected to be more than 60% in Bulgaria, the Czech Republic, Latvia, Lithuania, Poland, Romania, Slovenia and Slovakia, and less than 45% in Denmark, Ireland, Cyprus, Luxembourg and the United Kingdom⁽⁴⁴⁵⁾. In addition, there are great differences within the European countries in life expectancy and in healthy life years (see Chapter 1, Table 1-1 — 'Life expectancy and healthy life years for EU-27, and Iceland and Norway, 2006'). Nevertheless, in all the countries, women live a shorter percentage of their life in good health than men, so more women need LTC and for a longer period of time.

What emerges from the EGGSI national reports is that there is an increasing demand and use of LTC by women. It is in fact women who are the main beneficiaries of LTC (both of service in kind and benefits in cash) in the majority of the European states, considering their longer life expectancy and their reliance on formal care. Women's reliance on formal care is linked to the fact that they often have no care alternatives in their household. Generally speaking, elderly women are more likely to live alone than men.

⁽⁴⁴¹⁾ European Commission (2009), The 2009 Ageing Report. Economic and budgetary projections for EU-27 Member States (2008–60), Brussels.

⁽⁴⁴²⁾ European Commission (2008), Long-term care in the European Union, Brussels.
http://ec.europa.eu/employment_social/news/2008/apr/long_term_care_en.pdf

⁽⁴⁴³⁾ European Commission (2008), Long-term care in the European Union, Brussels.
http://ec.europa.eu/employment_social/news/2008/apr/long_term_care_en.pdf

⁽⁴⁴⁴⁾ The age-dependency ratio is the proportion between elderly and people in working age in a given country.

⁽⁴⁴⁵⁾ European Commission (2009), The 2009 Ageing Report. Economic and budgetary projections for EU-27 Member States (2008–60), Brussels.

- In Austria, more than two thirds (68%) of recipients of the federal LTC allowance are women. At the end of 2007, a total of 351 057 people received a long-term care allowance on the basis of the Federal Act for Long-Term Care Allowance⁽⁴⁴⁶⁾.
- In Bulgaria women constitute 54% of the patients in specialised establishments for social services in communities (also including home care patronage, day centres for elderly people, adults with disabilities, street children etc.)⁽⁴⁴⁷⁾.
- In Estonia home services were provided to 6428 persons, including 3960 with special needs (i.e. disabled) in 2007. Some 76% of all service receivers were women. Personal assistance service was provided to 22 289 persons with special needs who were assigned a personal carer, and 61% of recipients were women. Concerning the institutionalisation of adults, according to the Ministry of Social Affairs, in 2006, of 4737 recipients, 62% were women⁽⁴⁴⁸⁾.
- In France, regarding LTC for the elderly, women represent the majority of beneficiaries, both at home and in institutions. In June 2008, 1 094 000 persons received APA⁽⁴⁴⁹⁾, among which women represented a majority (seven out of 10). As shown by the age and gender structure of the '*allocation personnalisée d'autonomie*' (APA) beneficiaries, APA beneficiaries are mostly both elderly (85% are at least aged 75 and 45% are at least aged 85) especially when in institutions (55% are aged 85 and more) and female (women represent 77% of the APA beneficiaries aged 75 and more, while they represent 64% of the whole population in the same age bracket)⁽⁴⁵⁰⁾.

⁽⁴⁴⁶⁾ Statistik Austria (n.y.), Social benefits at federal level: Federal Long Term Allowance.

http://www.statistik.at/web_en/statistics/social_statistics/social_benefits_at_federal_level/federal_long_term_care_allowance/index.html

⁽⁴⁴⁷⁾ Information provided by the Center for Women Studies and Policies for the elaboration of the Thematic Report 2008.

⁽⁴⁴⁸⁾ Sotsialaministeeriumi (2008), Sotsiaalvaldkonna arengud 2000–06, Toimetised No 2/2008, Tallinn.

⁽⁴⁴⁹⁾ The Personalised autonomy allowance (APA Allocation personnalisée d'autonomie) is addressed to persons aged 60 and more, living at home or in an institution, who are experiencing a loss of autonomy. This allowance is personalised, according to the beneficiaries' needs (degree of autonomy, requested aid and services) and income (but it is not means tested). It is provided with an Aid plan (Plan d'aide): for beneficiaries living at home, a medico-social team visit the patients and assesses their needs and necessary aids to allow them to stay at home (the APA depends on the needs and the resources of the patient); for beneficiaries in an institution, the APA helps beneficiaries to pay for the 'dependency tariff' calculated according to the degree of autonomy/dependency.

⁽⁴⁵⁰⁾ Espagnol, P., Lo, S.-H., Debout, C. (2008), 'allocation personnalisée d'autonomie et la prestation de compensation du handicap au 30 juin 2008', Etudes et résultats, Drees, No 666, October.

- In Latvia there are more women in the long-term social care centres (on 1 January 2008 there were 4564 men and 5716 women). The average age of women is higher than that of men (in municipal care the average age of women is 78, for men it is 68) ⁽⁴⁵¹⁾.
- In Norway women are in majority of long-term care users. Among users over 80 years old, 3 out of 4 are women ⁽⁴⁵²⁾.
- In Poland, LTC recipients are mostly women, especially as recipients of nursing care. In 2007, there were almost 15000 patients for stationary care and treatment and women represented 65% of the total. The proportion of women in nursing and care amounted to 71% of the total ⁽⁴⁵³⁾.
- In Sweden, 153000 elderly persons in ordinary housing were granted home help services as of 30 June 2008, of which 68% were women and 32% men. In relation to the population aged 65 or older, the share corresponds approximately to 10%. In relation to the population aged 75–94, the share was bigger among women than among men ⁽⁴⁵⁴⁾. Both in the youngest age group (65–74) and the oldest (95+), the share with home help was similar for women and men. Almost 149000 persons were equipped with safety alarms devices ⁽⁴⁵⁵⁾, of which 73% women and 27% men ⁽⁴⁵⁶⁾. Of 94000 persons 65 years and older living permanently in special forms of housing, 70% are women and 30% men.
- In the UK LTC is predominantly provided in private households rather than communal or residential homes: 95.4% of British people aged 65 or over live in private households as opposed to 4.6% who live in communal establishments. Women are, however,

twice as likely as men to live in a communal establishment (5.9% against 2.8%) ⁽⁴⁵⁷⁾.

3.3. Gender barriers to access LTC

All European Member States are committed to ensuring universal access to LTC for their citizens. As the population grows older, the challenges to achieve this goal depend more and more on national health and social policies. Therefore, one's universal right does not necessarily mean universal service. All over European states, access to LTC might be restricted by many kinds of barriers. These include lack of insurance coverage, lack of coverage/provision of certain types of care, high individual financial care costs and geographical disparities in supply. They also include lengthy waiting lists for certain treatments or in certain areas of a given country, lack of knowledge or information and complex administrative procedures ⁽⁴⁵⁸⁾.

Moreover, some barriers may particularly affect women (or men) in a given country for demographic, socioeconomic, cultural or financial reasons. Gender is a cross-cutting issue with reference to barriers to access LTC.

3.3.1. Gender and financial barriers

High private costs which are seemingly higher than in healthcare impose a major financial burden on LTC users and their relatives and act a barrier to access, particularly for low-income groups ⁽⁴⁵⁹⁾.

Many countries have a system of co-payments to access LTC (for example Cyprus, Ireland and Estonia) or voluntary/private complementary insurance. Generally speaking, financial barriers include both restrictions depending on co-payment for low-income groups and differences in access observed for population groups not yet fully covered by social insurance schemes. Policies to reduce the individual direct costs of care include: co-payment exemptions and co-payments based on income; extra financial aid/welfare benefits granted to the elderly dependant, disabled and chronically ill; state coverage of social long-term care for low-income households within a social assistance framework; nationwide standardisation of co-payments; and state subsidies to use private services ⁽⁴⁶⁰⁾.

⁽⁴⁵¹⁾ Data are collected from Social Service Board Annual Report. Website: <http://www.spp.lv>

⁽⁴⁵²⁾ Helse og omsorgsdepartement (2005), St. Meld. Nr.25 (2005–06), Mestring, muligheter og mening. Framtidas omsorsutfordringer. Oslo. <http://www.regjeringen.no/Rpub/STM/20052006/025/PDFS/STM200520060025000DDPDFS.pdf>

⁽⁴⁵³⁾ Główny Urząd Statystyczny [Central Statistical Office] (2008), Podstawowe dane z zakresu ochrony zdrowia w 2007, Warsaw. http://www.stat.gov.pl/cps/rde/xbcr/gus/PUBL_WZ_podstaw_dane_z_zakre_zdr_2007r..pdf

⁽⁴⁵⁴⁾ Statistiska Centralbyrån — SCB (2009) Statistisk årsbok 2008. Stockholm, p. 426.

⁽⁴⁵⁵⁾ Socialstyrelsen (2009) Äldre — vård och omsorg den 30 juni 2008, Kommunala insatser enligt socialtjänstlagen samt hälso- och sjukvårdslagen, Stockholm.

⁽⁴⁵⁶⁾ The aim of municipal care provision is to ensure that older people and those with disabilities are able to live normal, independent lives. This includes living in their homes for as long as possible. They can have access to support of various kinds, such as meals delivered at home, help with cleaning and shopping, safety alarms devices and transportation service. Safety alarms devices are useful to call for help in case the patient is in a dangerous situation.

⁽⁴⁵⁷⁾ Del Bono, E., Sala, E., Hancock, R., Gunnell, C., and Parisi, L., (2007), Gender, older people and social exclusion, A gendered review and secondary analysis of the data, ISER Working Paper 2007–13, Colchester.

⁽⁴⁵⁸⁾ Council of the European Union (2008), Joint Report on Social Protection and Social Inclusion, Directorate-General for Employment, Social Policy, Health and Consumer Affairs, Brussels.

⁽⁴⁵⁹⁾ OECD (2009), The Long-Term Care workforce: overview and strategies to adapt supply to a growing demand, Paris.

⁽⁴⁶⁰⁾ Council of the European Union (2008), Joint Report on social protection and social inclusion, Directorate-General for Employment, Social Policy, Health and Consumer Affairs, Brussels.

Nevertheless, in some countries financial barriers remain an important issue.

- In Bulgaria LTC services are usually provided by close relatives at home. In some cases, Bulgarian citizens pay for them in cash (out-of-pocket) to professional caregivers (retired nurses, rehabilitators, doctors), which is very expensive by Bulgarian standards, above all because there is no specific insurance.
- Spanish citizens do not have sufficient economic support. Among the different economic benefits gathered in the DCL (Dependant Care Law), the payments aimed at financing market services have proved to be insufficient to cover full costs. This could imply certain unwanted effects regarding the proliferation (or preservation) of an informal market, which employs a vast majority of women under deficient labour conditions.

Moreover, financial barriers may be experienced more by women than by men because the average income of older women is much lower than that of older men, and the at-risk-of-poverty rate of older women is higher than that of older men, so many women may find their income insufficient for covering co-payments, private health costs and costs of voluntary insurance.

- In Belgium an analysis of contacts with home-based services shows that women call on these services more frequently than men and the reliance on such services increases with age. Any initiative to reduce the costs of these services will therefore be an improvement for women, considering that they rely more on such services and that they generally have lower incomes than men.
- In France, difficulties in access to long-term care still exist for individuals belonging to a poor or modest household. In particular, beneficiaries of the old-age minimum income are over the income ceiling and consequently cannot benefit from free access to the Complementary Universal Health Coverage (CMUC), however, they may experience difficulties in affording private complementary coverage. Women aged 60 and over are overrepresented in the beneficiaries of the old-age minimum income,

so they may experience more difficulties than men in the same age bracket.

- According to a recent study⁽⁴⁶¹⁾, elderly Greeks pay 7.5% of their annual income for health services. The consequence of this high expenditure for healthcare is that the elderly have to cut down their expenses. Additionally, Greece has a very high proportion of elderly people who spend between 15% and 25% of their income for private health services. This happens above all with people living on a lower income.
- In Norway women are the great majority among the elderly receiving minimum level pensions. Recent statistics show that while only 10% of men received minimum level pensions, 48% of women pensioners received the lowest pensions⁽⁴⁶²⁾. At the same time, statistics show that more men receive treatment at hospitals, while more women use municipal care services. To ensure similar medical treatment for elderly women and men, the government ensures that a gender perspective on treatment be integrated in the activity of hospitals.

3.3.2. Gender and geographical barriers

LTC (both social and health) services are typically the responsibility of local authorities or regions. This causes substantial differences in service provision among regions, within urban and rural areas or within cities⁽⁴⁶³⁾. It often results in different waiting times according to different areas of a given country.

In some countries, such as Denmark, Hungary, Slovenia and Bulgaria, geographical differences play a crucial role in accessibility, because social institutions are not evenly spread in the country and this affects the efficiency of LTC. Furthermore, in some countries, such as Slovenia, there are also significant regional financial differences in the payment for these services. Namely, some of the regions or municipalities co-finance the cost of these services and some municipalities even offer them for free, while others do not. Elderly women and men living in regions with low service coverage and/or with higher service costs therefore face significant barriers in accessing LTC.

⁽⁴⁶¹⁾ Mergoupis, T. (2003), Income and Health Services in Greece, in Venieris, D., Papatheodorou, C., Social Policy in Greece, Athens.

⁽⁴⁶²⁾ Helse og omsorgsdepartementet, Nasjonal Strategi for spesialisthelsetjenester for eldre 2008–12. <http://www.regjeringen.no/upload/HOD/Vedlegg/Specialisthelsetjenestestrategi%20for%20eldre.pdf>

⁽⁴⁶³⁾ Council of the European Union (2008), Joint Report on Social Protection and Social Inclusion, Directorate-General for Employment, Social Policy, Health and Consumer Affairs, Brussels.

In Romania, Greece and Portugal, geographical barriers have led to a concentration of LTC services in the urban centres to the detriment of rural areas. For example, in Greece there is a special LTC programme, called 'Help at home'. It is an example of geographical disparity because it is not provided in every municipality.

Geographical barriers remain an important issue in other European countries as well: for example in Spain, where geographical and physical barriers are not addressed evenly, especially in depopulated areas. In many cases, there are also unused day-care centres in rural areas, due to the lack of transport infrastructures. The main issue in these areas is not the lack of places, but difficulty in reaching the institutions. Geographical barriers have a gender dimension: as women are more frequent users, they have to travel more often, in addition to the fact that they tend to rely more on public transport or on someone to take them.

3.3.3. Gender and bureaucratic and administrative barriers

LTC services are provided through the coordination of different care levels and different administrative levels (national, regional and local levels of governments). This fragmented system may reduce accessibility to LTC services because dependant and elderly patients have tailored multiple needs, due to their social, health and economic conditions. In addition, their needs may only be satisfied by a combination of different institutions, depending on different levels of government or different departments of government. For example, in Spain's LTC system there is a lack of coordination between regional and local administrations, which may be particularly burdensome for users, who due to their advanced age or disability are not always capable of fully understanding the process and the rights they are entitled to.

A typical example of limited accessibility caused by bureaucratic/administrative barriers is hospital discharge, which ought to be followed up by specific home-care provisions. In order to ease this transition, Germany has created a 'case manager' who deals with 'transfer care' from hospital to a home care setting for people entitled to it.

3.3.4. Gender and cultural barriers

Cultural barriers in accessing LTC services are linked to social status, because poorly educated people have more difficulty in accessing services. Additionally, some ethnic groups don't accept care provision for socioeconomic reasons, linked to their cultural heritage. This is the case of the Roma in some countries such as the Netherlands and Portugal, who do not accept the LTC system for cultural reasons: as described in the EGGSI Synthesis Report of 2008 on ethnic minority and Roma women in Europe, 'Traditionally, Roma family ties are strong and institutionalisation can be considered an extreme alternative for older family members. Normally, Roma women are first expected to care for other dependant family members in addition to other work related to domestic responsibilities. Elderly people, men and women alike, enjoy a high social status in Roma communities. This is one of the reasons why elderly people are accustomed to remaining with the family in old age and do not apply for long-term care services, even in the cases where these services are accessible/affordable'⁽⁴⁶⁴⁾. In addition, in Austria there are bureaucratic barriers affecting elderly migrants in particular, because to be entitled to receive some benefits, it is necessary that recipients have worked for a few years in that country.

Women are overexposed to cultural barriers, both as carers and as persons in need of care: this especially affects immigrant and ethnic minority women. For them, in some countries such as the Netherlands, cultural barriers seem to make access to long-term care more difficult than for the general public. A study in Austria on age and migration in the Vienna area showed that female migrants feel very worried about their old age⁽⁴⁶⁵⁾. Moreover, in Malta, the language barrier is often a hindrance to accessing health information and services among migrant women with long-term illnesses. Women with refugee status, humanitarian protection, and rejected asylum seekers living in Malta have access to free medical care in state hospitals and state healthcare centres, however, data drawn from the 2005 Malta Census suggest there are more women than men suffering from long-term illnesses and/or health conditions⁽⁴⁶⁶⁾.

⁽⁴⁶⁴⁾ Corsi, M., Crepaldi, C., Samek Lodovici, M., Boccagni, P., Vasilescu, C. (2008), Ethnic minority and Roma women in Europe: A case for gender equality? — report prepared by the Network of experts in gender equality, social inclusion and health- and long-term care (EGGSI network) for the European Commission, Directorate-General for Employment, Social Affairs and Equal Opportunities.
<http://ec.europa.eu/social/BlobServlet?docId=2481&langId=en>.

⁽⁴⁶⁵⁾ Kienzl-Plochberger, Reinprecht, C. (2005), MigrantInnen im Gesundheits- und Sozialbereich, Vienna.

⁽⁴⁶⁶⁾ Elaborations on Malta Census 2005, National Statistics Office, Malta.

Box 3-3 — Main barriers accessing LTC in European countries

Austria

For elderly migrants there are some structural barriers in accessing available institutions and entitlements to specific allowances. First, to be entitled to old-age pensions, one has to have worked for 15 years within the last 30 years in Austria. Many migrants reach this minimum by adding their working experiences abroad, however those years are not always accepted. The same problems regard the entitlement to the federal care allowance which is dependent on pension payments and on continuous residence in Austria. If migrants or refugees cannot fulfil the requirements for the federal care allowance, they can apply for provincial care allowance.

Denmark

Generally speaking, no barriers to LTC exist in the Danish model as the main part is based upon a local evaluation of the needs in order to get support. Depending on the municipality, there can be waiting lists for a place in a hospice, whereas support in the private homes has no waiting time.

The main difference between men and women is that women often have to take care of men with more limited support and, when they themselves are in need of care, nobody might be available to help them.

Estonia

The main problems with LTC are the lack of provision and high costs of services. For instance, the cost of a care home (i.e. long-term care in institution) varies according to the institution. A study of disabled persons carried out in 2007 showed that 85 % of them saw a need for rehabilitation services, but only 47 % of them received it⁽⁴⁶⁷⁾. The main obstacle in receiving these services is the lack of information (54 %), economic reasons (45 %), and transport problems (41 %). The need for physiotherapy is especially great.

Italy

There are several regional disparities in service provision. According to Istat, three quarters of beneficiaries of residential LTC live in the northern regions. Geographical barriers exist with regard to public home care, because the financial resources allocated vary among regions and municipalities. Moreover, the amount of users' co-payments varies across regions and cities and the average income varies greatly according to region. Additionally, women's average old-age pension is lower than men's.

Portugal

There are three main barriers for access to long-term care: (i) the low supply of services; (ii) lack of technical expertise and management of existing difficulties, (iii) cultural issues. LTC institutions are located mainly in urban areas, which imply that non-autonomous elderly people living in rural areas might have barriers to accessing LTC. The other difficulty is the lack of human resources prepared to provide assistance.

Romania

Health and long-term care in Romania suffer from regional disparities, particularly from uneven coverage of medical services and healthcare workers. Differences are particularly marked between rural and urban areas. There are also issues of inadequate medical equipment and a shortage of medical staff in many rural areas. It may be assumed that as women tend to live longer and as the number of women surpasses the number of men, more women compared to men are affected by difficulties in accessing long-term care facilities.

There are still old people who are not registered with a family doctor or people that have no identity documents (i.e. many Roma, homeless), which denies them access to social health insurance or to any type of healthcare (except for emergency treatment). Reduced availability of services and lack of volunteer services deprive many elderly people that live on their own of the support they need for housework (cleaning, getting food supplies). Many people are excluded from health or LTC because of the very real perception of having to pay additional costs in order to receive proper attention, or in many cases, people will postpone their medical care until it becomes an emergency.

Slovenia

The main barriers are bureaucratic. The fact that the existing services and income are not linked to an even system, in addition to the fact that, in practice, there is a lack of coordination among the institutes which provide these services, hinders access to services and reduces their quality. It is also acknowledged that waiting periods are relatively long. Elderly women and men living in regions with low service coverage and/or with higher service costs therefore face significant barriers in accessing long-term care.

Spain

The main barriers can be summarised as follows: lack of procedural homogeneity among different administrations; excessive delay in the provision of services; complexity of the process; individualised programmes limited by inadequate resources; lack of agreement between regional and local administrations; insufficient economic support; geographical barriers.

Sweden

Most of Sweden's local authorities have a small number of elderly people belonging to the national minorities or of foreign background. However, the metropolitan regions, and regions bordering neighbouring countries, have a large proportion. The number of different ethnic groups in the elderly population also varies according to different areas. This, together with the fact that the health and social service system for the elderly in Sweden is operated and funded by local governing bodies, has led to different strategies to meet their needs and to differences among the municipalities in terms of service coverage and availability. Some local authorities offer

⁽⁴⁶⁷⁾ Masso, M. (2007), Puuetegainimesteuuring, Sotsiaalministeerium, Viide täpsustada.

special housing, home help and/or day activities specially intended for or adapted to elderly people of a different ethnicity. Other local authorities have staff from different ethnic backgrounds in their units, matched with users of the same background. Family-care providers are also common among these groups.

United Kingdom

There are criticisms that the current funding system for formal care is unsustainable, unfair and unclear⁽⁴⁶⁸⁾. According to Collins: it is unsustainable because without reforms, older people — even those on modest incomes — will have to pay more from their own funds; it is unfair because there are inconsistencies regarding who pays what; and it is unclear because there is often confusion regarding who is responsible for payment — entitlements vary between local authority areas⁽⁴⁶⁹⁾. Even in Scotland, where there is more universal provision, perceptions of

⁽⁴⁶⁸⁾ Collins, S. (2009), Options for Care Funding: What could be done now?, Joseph Rowntree Foundation.

<http://www.jrf.org.uk>

⁽⁴⁶⁹⁾ Collins, S. (2009), Options for Care Funding: What could be done now?, Joseph Rowntree Foundation. p. 2.

<http://www.jrf.org.uk>

inconsistencies across local authorities exist regarding what care is provided and who pays for what⁽⁴⁷⁰⁾.

Access to informal care among those over 65 varies greatly. According to Del Bono et al.⁽⁴⁷¹⁾, the differences are not so much dependent on gender but on age, car ownership and marital status. Older men are more likely to be married than older women. Although men over the age of 65 carry out more caring activities than younger men, as women live longer than men they are less likely to be able to rely on care from a spouse and will be more likely to have to resort to public care facilities. More men than women have access to a car and so women are more dependent on public services.

Source: EGGSI network national reports 2009.

⁽⁴⁷⁰⁾ Bell, D., Bowes, A. (2006), Informing Change: Lessons from the funding of long-term care in Scotland, Joseph Rowntree Foundation.

<http://www.jrf.org.uk>

⁽⁴⁷¹⁾ Del Bono, E., Sala, E., Hancock, R., Gunnell, C., Parisi, L., (2007), Gender, older people and social exclusion, A gendered review and secondary analysis of the data, ISER Working Paper 2007–13, Colchester.

3.4. Programmes aimed at overcoming barriers to LTC

Some examples of provisions to overcome barriers to accessing LTC can be found all over Europe.

The kind of programmes offered can be summarised as follows:

- a. supporting low income and most disadvantaged groups;
- b. improving the quality of care;
- c. supporting relatives.

The gender impact of these programmes may be both direct and indirect.

Programmes supporting low income and most disadvantaged groups

Almost all European countries, with the exception of Italy and Greece, have a basic income scheme covering also old people in need, helping them to sustain the economic burden of LTC. Some countries have introduced specific programmes to overcome barriers to access LTC for most disadvantaged groups (specifically low income groups and cultural minorities). Here are some interesting examples:

- In the Netherlands there is a local programme, called 'Prevention Information Team Eindhoven', promoted by the municipality of Eindhoven. The

aim of the programme is to identify people with specific financial problems and people who do not make use of all potential financial support mechanisms. The aim is to help them fulfil the necessary requirements for receiving extra financial support. The target population of this programme includes not only old people but also children, single parent families, young people, people with chronic diseases, ethnic minorities, and people with disabilities. This programme is not specifically oriented to healthcare access, but the overall financial problems of specific target groups might influence also financial access to healthcare.

- In the UK there is a programme, started in 2002, called 'Free Personal Care'. It is implemented only in Scotland. It is aimed at offering free personal care in care homes and at home. The programme is a good practice to overcome financial gender barriers thanks to a substantial reduction in care home fees for elderly people (especially women).
- In Austria there is a local programme (in Vienna), specifically aimed at overcoming cultural barriers, called 'Integration of elderly migrants into social centres for elderly people'. The programme is aimed at establishing a counselling, information and socialising centre for elderly people. Specifically, elderly migrants are the target of this programme. The counselling centre provides non-bureaucratic counselling for elderly people on social issues, financial and legal questions following illness and need for LTC.

- In Romania there is a programme called ‘Socio-medical assistance for disadvantaged groups’. The key point of the programme is the diversification of services at the local community level by developing social and medico-social assistance for women and men belonging to disadvantaged groups. The programme aims at the development of a network of medico-social services in two counties (Alba and Mures) for elderly people (both women and men) living on their own with no family or community support, who have difficulty in accessing existing social and medical services.

Programmes aimed at the improvement of the quality of care

Improving the quality of care is a crucial point for the LTC system within European states, so some countries have introduced programmes aimed at improving the professional skills of workers in LTC provision.

- In Germany, the Federal Ministry for Family Affairs has promoted the campaign ‘Modern care for the elderly’ to promote the occupation field of professional care. In particular, the initiative is aimed at improving public awareness and at promoting a high level of training for elderly caregivers.
- In Norway there is a national programme called ‘Care plan 2015’. The aim of the plan is to address the main future challenges within elderly care in a long-term perspective. In particular, the plan is focused on research and development, increased quality of care, increasing qualification among workers within elderly care, specialised healthcare for the elderly and increased emphasis on volunteers and relatives as carers. The care plan is important from a gender perspective, as women are in the majority among carers and those who are cared for. This gender perspective is clearly emphasised in the plan.
- Another programme promoted in Norway is the ‘National strategy for specialised healthcare for the elderly 2008–12’. The main aims of the strategy are to strengthen elderly people’s access to specialised healthcare, create cooperation with primary healthcare, preventive care and emphasise research and development within the area of the elderly and of their needs for specialised healthcare. The programme emphasises equal treatment within specialised healthcare, which is important as elderly women use it less than elderly men, despite the fact that women are in the majority among the elderly.
- The Dementia plan 2008–12, promoted in Norway, aims at increasing the knowledge, collaboration and quality of the care of dementia patients. In particular, the programme is meant to increase the quality of care,

development, research and planning, raising skills and knowledge, improving collaboration between health professionals, partnerships with families and local communities. The focus is on women as private and professional carers for the elderly. The plan clearly identifies women as the majority among caregivers, both professional and private.

- In Finland there is a local programme called ‘Act on assessment of service needs for people over 80 (2006) and over 75 (2009)’. The objective of the programme is to make a broad assessment of the need for social and health services. The programme does not have a specific gender orientation, but most people aged 75 or over are women, and most of them live alone. Moreover the Ministry of Social Affairs and Health (MSAH) and the Association of Finnish Local and Regional Authorities issued a recommendation on good practice in LTC (National framework for high-quality services for older people) in 2008⁽⁴⁷²⁾. The focus of the framework is to reform the content of home care and 24-hour care services with new ideas. The framework also presents examples of good practices from the field regarding the coordination of health and social care issues at the local level, such as ‘service selection houses for elderly people’ and ‘new concepts for home care’ developed by NGOs.
- In Italy there is a programme, called ‘Nonne-Care’. It is a regional programme promoted by the Municipality of Naples, the Campania Region, Campania Local Health Units and other semi-public bodies. The objective is to enhance the possibility to meet new assistance and healthcare needs in order to keep elderly women at home instead of in residential public care facilities, thanks to telephone and tele-assistance. The target group of the programme are elderly women (over 70 years old) who live alone and suffer from specific pathologies.

Support programmes to the relatives

LTC provision by informal carers plays a crucial role, so some countries have introduced programmes aimed at supporting those who provide care to people in need in their household.

- In Sweden a local programme (implemented by the Municipality of Jönköping) called ‘Support in partnership 2006’ helps relatives to care, making life easier for the carers and the cared for and to receive good quality help and support⁽⁴⁷³⁾. The programme aims at planning, following up and evaluating the individual support of relatives. The COAT (carers

⁽⁴⁷²⁾ Ministry of Social Affairs and Health — MSAH (2008), National framework for high-quality services for older people, Ministry of Social Affairs and Health’s publications, Helsinki.

⁽⁴⁷³⁾ Socialstyrelsen (2005), Planeringsinstrument för anhörigstöd.

outcome agreement tool) does interviews, keeps in contact and relieves the relatives. The programme is addressed to relatives who take care of the elderly, mostly women, and therefore has very relevant indirect gender effects. The programme is important as it recognises the carers' needs and the important work they do.

- In Cyprus the national programme 'Expansion of and improvement of care services for children, the elderly, disabled persons and other dependants', implemented period 2005–08 by the Social Welfare Services, is aimed at improving and expanding social care services at the local level, in order to enable women to cope with the care needs of children, the elderly, disabled persons and other dependants. The ultimate aim is to encourage their integration in the labour market as economically active members. The largest portion of these actions concerns the financing of social-care structures which operate under the responsibility of voluntary organisations and local authorities. Within this framework, financing was approved for 31 programmes for the pilot phase of the programme, implemented by Local Authorities and Non-Governmental Organisations all over Cyprus. It does not target women as receivers of care specifically, but as carers, and thus can have a positive impact on women as carers⁽⁴⁷⁴⁾.
- In Finland there is a programme called '*Voimapolku*' (Path to empowerment), aiming at promoting an operational model for informal carers who plan to return to or access the labour market for the first time, in particular finding methods and practices to support the empowerment process of carers.

3.5. Overall conclusions about gender barriers to access LTC

Different institutional and organisational LTC settings exist throughout European countries. Service provision can be described on the basis of two variables: the typology of care providers and the place where care is provided. In the first case the differentiation is between formal and informal care. Formal care is provided in most of the cases by municipalities for the social support and/or by local healthcare services for the health component. In those countries where public service coverage is less developed, informal care plays a crucial role in service provision. This is the case in particular in southern European countries such as Greece and Italy. With reference to the second variable — where the care

is provided — a distinction has been made between institutional care and care at home. Institutions include nursing homes, residential care homes and old-age homes where there is the permanent presence of care assistants. Care at home may be provided by care professionals or by informal care (as it often happens in countries characterised by family care model).

With reference to service beneficiaries, women are more often institutionalised than men.

One of the main elements to be considered while regarding LTC in a gender perspective is the role played by women in informal care: women are the majority among informal care providers (according to the WHO, women represent two thirds of informal caregivers) and so the programmes aimed at supporting those who provide homecare are very relevant from a gender perspective.

Women are also the majority among LTC recipients for biological and socio-demographic reasons, but the EGSI national reports have shown that they have to face additional barriers to access with respect to men. Even in those countries where the system is particularly evolved and where there are no institutional barriers in accessing services, cultural barriers play a relevant role, in particular in countries with a high level of immigration or a large presence of Roma communities. In these cases, specific difficulties have been reported in relation to cultural norms, habits and traditions connected with the role of women in the community. This is particularly the case of countries such as Austria, Germany, France and the Netherlands, where there are large communities of cultural minorities. In eastern countries, such as Bulgaria and Estonia, the most consistent barriers reported are, on the contrary, bureaucratic and administrative.

Access to LTC is also affected by financial barriers for low-income groups, which often includes elderly women, because their average income is lower than men's. In many countries, forms of co-payment may in particular lead to gender barriers due to the weaker economic position of women.

LTC systems in Southern countries are mainly affected by geographical barriers, as it happens in Italy, Spain, Portugal and Greece. These countries are characterised by disparities in service provisions between different regions and cities. For example, in Italy in terms of the extent of the provisions and expenditure for citizens, the differences between the northern and the southern regions play a crucial role. In Spain geographical barriers are mainly due to lack of public transport. With regard to Portugal and Greece, the main issue for geographical barriers is the backwardness of rural areas. In these countries the family care model is dominant.

⁽⁴⁷⁴⁾ Ministry of Labour and Social Insurance (2008), National Strategy reports on Social protection and social inclusion 2008–10, Social Welfare Services.
http://ec.europa.eu/employment_social/spsi/docs/social_inclusion/2008/nap/cyprus_en.pdf

4. Conclusions

While healthcare systems have contributed to significant improvements in health in Europe, access to healthcare remains uneven across countries and social groups, according to socioeconomic status, place of residence, ethnic group, and gender.

Gender plays a specific role both in the incidence and prevalence of specific pathologies and also in their treatment and impact in terms of well-being and recovery. This is due to the interrelation between sex-related biological differences and socioeconomic and cultural factors which affect the behaviour of women and men and access to services.

The report has highlighted the main differences in the health status and health-relevant behaviours of women and men in European countries, in the accessibility of existing healthcare and long-term care services and the main barriers to accessing these services for women and men.

Generally, women are more aware of their health status and make greater use of healthcare services than men due to several reasons, such as their reproductive role, their role as caregivers for dependants (children, the elderly, the disabled), their higher share among the older population and also gender stereotypes, according to which men usually do not consider it normal to complain about their health and visit physicians.

Gender differences in healthcare

In some European countries (for example: Austria, Bulgaria, Germany, Iceland, Ireland, Italy, Norway, Spain, the Netherlands, the United Kingdom, Slovenia), there is increasing awareness of the need to acknowledge gender differences in access to healthcare among governmental institutions, universities, and especially NGOs, which have traditionally been very active in providing specialist services to women, ethnic minorities and other disadvantaged groups. Gender-sensitive strategies have recently been introduced within healthcare and medical research, research centres and research institutes with special knowledge regarding women and health have been created, observatories on women's health have been set up to support the development of sex-disaggregated data and gendered medical research. In addition, some countries have implemented specific training programmes aimed at general practitioners and healthcare providers, to raise their awareness of the importance of gender-specific treatment. Specific programmes for the treatment of

disadvantaged women, such as homeless women, immigrant women, disabled women and single mothers, have also been carried out.

The comparative analysis presented in this report, however, has shown that in most countries, besides reproductive care, there are still few gendered healthcare strategies and services.

Programmes promoting healthy behaviour are in some cases gender oriented, targeted at either women or men. The promotion of breastfeeding is the most widespread promotion programme across Europe. Other programmes are aimed at reducing the consumption of alcohol and smoking, promoting diet and physical activity, as well as promoting mental health and occupational health. Health promotion programmes and campaigns specifically targeted at more vulnerable groups also exist.

On the other hand, health prevention programmes are usually mainly targeted at women. Screening programmes are important preventive measures, since many diseases can be avoided through early detection. The most important and widespread gendered prevention programmes implemented in Europe are breast and cervical cancer screenings. Across Europe, many prevention programmes address maternity: prenatal tests, support for mothers with newborn children and family development, support for groups of children and mothers with special needs. Other widespread prevention programmes across Europe concern sexual and reproductive health. On the other hand specific masculine pathologies, where prevention could be useful (such as prostate or testicular cancer) are less addressed by prevention programmes, even if in some countries there is an increasing attention to these issues.

The physical, psychological and social barriers that prevent many women from making healthy decisions are often not visible or addressed by healthcare treatment programmes and regulations. For example, there is usually little recognition of gender specificities in the treatment of some pathologies such as heart diseases, sexually transmitted diseases, mental disorders, or work-related illnesses, and of the long-term consequences on women's health of violence and abuse. In many cases, the knowledge utilised is based on studies conducted on men, which results in treatment that may, in some cases, not address the needs of women. For example, there is still too little

knowledge about the female heart and since women often present different symptoms than men, there is a higher incidence of unrecognised myocardial infarction; and in addition, women treated with 'male-based' treatment may not respond in the same ways as men. Regulations regarding health and safety in the workplace usually do not cover housework and serious domestic accidents are not regularly recorded and are thus left out of the statistics. Also, the treatment of some diseases related to gendered behaviours, such as alcohol addiction and alcohol-related diseases, which are predominantly — although not exclusively — a male problem, do not consider gender differences sufficiently.

While some programmes address these issues, this is still an underdeveloped area for implementing gender equality principles.

It has also been noticed that sometimes women and men are treated differently, not because their specific needs are recognised, but because of prejudiced and stereotyped attitudes by health practitioners. For example, therapeutic support aimed at returning to work after work accidents is more frequent among men than women, also due to the attitudes of occupational health physicians and employers, who feel that rehabilitation is more important for men than for women.

Even if universal or nearly universal rights to care are basic principles in most Member States and most of the European population is covered by public health insurance, these basic principles do not always translate into equal access to and use of healthcare. Residency, socioeconomic and geographical factors can affect the accessibility to healthcare for specific groups. These include the lack of insurance coverage (affecting those without residency or citizenship, the long-term unemployed and the homeless in countries based on social security contribution systems), the direct financial costs of care (affecting low income groups), the lack of mobility (affecting disabled and old persons), the lack of language competence (affecting migrants and ethnic minorities), the lack of access to information (affecting the low educated and migrants/ethnic minorities), time constraints (affecting single mothers) or lack of services for specific groups. In all of these factors there are specific gender issues to consider.

Financial barriers are particularly relevant for low income groups and women. Income inequalities are especially related to the lack of insurance coverage, the cost of certain (specialised) types of care (such as dental, ophthalmic and aural care) which are often not covered by public insurance systems, the incidence of private insurance systems and of out-of-pocket costs

and the persistence of informal payments in many eastern (such as Slovakia, Romania, Bulgaria, Hungary, Poland, Lithuania, Latvia) and southern European (such as Italy and Greece) countries.

The growing role of private health insurance and out-of-pocket payments may also increase gender inequalities, as men are more likely to be covered by private insurance than women, yet women are higher consumers of healthcare services and medicines. Women usually have a lower income and do not benefit from the same kind of firm-based private insurance coverage as men do. They present lower employment rates in the regular economy (many women are either inactive or work at home or in the informal sector) and, when employed, they are more likely to be employed in the public sector and in small firms (which are not likely to provide supplementary private insurance schemes) with part-time and/or temporary contracts in low paying jobs. In addition, private insurance schemes are less attractive to women since they often consider age and gender-specific risks in defining contributions. Women from ethnic minorities and poor households may be especially penalised by the privatisation of health services and the increase in out-of-pocket spending on healthcare.

Among European countries, financial barriers to access appear to be particularly relevant in the Baltic countries (especially in Latvia), Greece, Cyprus, Bulgaria and Romania, where the incidence of cost sharing is particularly relevant. In the Baltic countries, Poland, Sweden, Hungary and Germany, women's perceptions of unmet needs due to problems of access are higher than the EU-25 average.

Geographical variations in coverage and provision are another relevant barrier to healthcare access. The distance from hospitals and healthcare centres and the lack of accessible transportation particularly affect women living in rural or mountainous areas, disabled women and older women, as they are less autonomous concerning mobility than men (they drive cars less frequently than men), and live more years in old age and ill-health.

The distinct roles and behaviours of men and women in a given culture, resulting from gender norms and values, give rise to gender differences and inequalities in access to healthcare as well as in risk behaviours and in health status. Cultural barriers can be expressed in terms of prejudices and lack of knowledge among healthcare professionals concerning gender specificities in needs and types of care to be provided. Language barriers, as well as traditions and cultural practices also play a role, as certain groups of immigrant women and women of ethnic origin have more difficult access to health facilities and information on sexual health.

On the other hand, men also have to face stereotypes in accessing healthcare and prevention programmes. Osteoporosis, for instance, is perceived as a female disease, and it might be less obvious that men should be treated for osteoporosis as well. Education and health prevention programmes are also targeted mostly at women and only occasionally address men. The report shows that it is important to take into consideration a variety of elements while analysing cultural barriers in accessing healthcare. These are prejudices and gender stereotypes, social status and level of education, cultural differences inherent in ethnicity and migration issues (that involve not only language skills but also traditions and norms of hygiene), religious practices, prejudices concerning sexual orientation, and working culture.

Gender differences in long-term care

There are two key issues to be considered from a gender perspective when discussing access to long-term care. First of all the role of women as caregivers, that is usually in unpaid informal care. Being relatives, friends or volunteers they do not receive any form of compensation for their engagement, while as informal caregivers they receive cash benefits/allowance in many cases without any form of employment contract. Secondly the increasing use of LTC by women: because of their longer lifespan, women are the main LTC beneficiaries, both in kind and in cash. Women's reliance on formal care is linked to the fact that they often have no care alternatives in their household, as generally speaking, elderly women are more likely to live alone than men. Elderly women are also likely to be more negatively affected than men by the forms of co-payment for access to LTC which have been introduced in many countries, because their average income is lower than men's.

Examples of provisions to overcome barriers to accessing LTC can be found across Member States and they have important gender impacts. Interesting examples which may positively affect women both as LTC users and providers have been found for example in the Netherlands, where specific measures support the lowest income groups, where women are the majority; in Germany, Norway, and Romania, where there are measures improving the quality of care; in Sweden and Finland, where measures supporting informal care providers, especially relatives, have been implemented.

Addressing gender inequalities in access to healthcare and long-term care

The comparative analysis presented in this report has highlighted some important issues which have to be addressed in order to reduce gender inequalities in access to healthcare and long-term care and provide cost-effective and high quality care.

The most important is the need to adopt a gender perspective in healthcare policies, considering the biological, economic, social and cultural factors which affect the health condition of women and men and their access to healthcare. A gender mainstreaming approach to healthcare policies, addressing gender-specific risk factors in medical research, service delivery (considering promotion, prevention and treatment policies) and the design of financing systems enhances the effectiveness of the care provided for women and men and reduce inequalities in access, as shown in some of the good practices presented in the report.

Gender-based health research increases knowledge regarding the complex ways in which biological, social, cultural and environmental factors interact to affect the health of women and men. Gender-based medical research also improves the attention of health practitioners to gender differences and supports the provision of gender-differentiated treatment when necessary. For example, it is important that research in cardiovascular diseases considers gender differences in morbidity and mortality and in reaction to treatment; occupational health and safety research and practices should take gender-specific factors into account, such as the different health risks that women and men are exposed to, due to occupational gender segregation and the health risks resulting from precarious employment, domestic work and informal care work performed by women.

The implementation of gendered health information systems and analysis tools (such as gender impact assessment), upgrading quality in data collection and analysis, is essential to support medical research and the systematic gender-specific monitoring and evaluation of healthcare systems.

The promotion of capacity building for gender sensitivity in healthcare systems and gender-specific training for healthcare professionals is likely to improve the attention paid to gender differences in service delivery and the effectiveness of healthcare services.

Attention to the gender impact of recent trends in health sector reform, especially when addressing healthcare financing and delivery, is particularly relevant. The fact that healthcare reforms increase the incidence of cost-sharing through private insurance schemes and out-of-pocket payments may adversely affect women more than men, since women are the majority among healthcare users and the low income groups. Recent trends in cost containment are also likely to increase gender and income inequalities if not adequately addressed: the limitation in the basic care provisions included within primary care; the rationalisation of healthcare services which, in many countries, has reduced the number of local clinics and services in rural or low-populated areas

and increased patient/staff ratios, may have negative consequences on women more than on men, as women are the main healthcare users and providers. These issues are particularly relevant for long-term care, where gender plays an even more relevant role, with women being the main care providers (formal and informal) and care users.

To conclude, the evidence emerging from this comparative report underlines the need to adopt

a gender mainstreaming approach to healthcare policies in order to improve their effectiveness. This is even more relevant as the current financial and economic crisis may reduce the available resources for improving the quality and coverage of healthcare and LTC provisions, with pilot gender-based programmes risking more from budget cuts. Eastern European countries, in the process of improving the quality and extension of their healthcare systems, present such a risk.

5. Annex – Statistical tables

Table 1 — Consultation of a medical doctor during the past 12 months of women and men, by education 2004

	Total		Pre-primary, primary education or first stage of basic education — level 0 and 1		Lower secondary or second stage of basic education — level 2		Upper secondary education — level 3		Post-secondary non-tertiary and tertiary education — level 4,5 and 6	
	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men
Austria	86.7	87.8	82.1	83.1	:	:	90.4	83.2	92.0	92.2
Belgium	92.5	84.0	95.7	88.9	92.1	82.8	91.0	83.7	91.7	81.9
Bulgaria	73.8	60.9	77.8	65.8	74.9	62.1	72.1	58.2	71.7	62.4
Cyprus	74.9	56.7	84.8	70.2	64.9	45.8	72.1	53.2	71.0	54.3
Czech Republic	94.6	89.4	92.8	90.2	96.3	88.5	95.1	88.7	93.8	93.1
Estonia	78.6	66.1	71.2	62.6	74.8	67.2	79.6	65.0	84.1	70.9
Finland	88.4	75.9	:	:	85.5	78.6	89.6	77.6	89.4	71.2
Germany	94.5	84.6	92.8	90.9	94.4	85.8	95.9	82.3	94.2	79.3
Greece	72.4	54.3	83.9	71.2	64.5	41.3	58.2	38.9	64.8	49.9
Hungary	90.3	81.8	89.0	80.0	91.0	81.6	89.8	82.1	93.6	84.4
Iceland	78.1	71.2	72.2	64.7	79.1	67.0	79.4	74.1	82.1	76.6
Latvia	74.9	60.1	66.3	64.3	74.1	61.2	75.0	58.2	78.1	62.8
Lithuania	82.6	67.9	:	:	78.9	66.2	85.5	64.5	82.0	69.9
Malta	80.2	80.9	82.1	78.7	77.8	81.4	82.6	82.6	80.5	81.5
Netherlands	86.4	74.2	89.0	78.7	84.3	73.3	85.5	73.1	84.4	70.9
Norway	81.6	74.1	:	:	84.1	80.0	80.8	74.3	81.2	70.2
Romania	46.8	32.6	57.6	42.4	43.6	29.6	43.4	28.9	47.5	44.1
Slovakia	83.8	76.6	89.2	79.2	78.5	74.3	83.7	78.8	84.9	74.6
Slovenia	73.3	67.6	76.5	65.2	62.0	71.7	74.5	62.5	77.9	72.5
Spain	88.1	76.4	91.8	81.8	84.5	73.9	85.0	73.9	85.2	70.1

Source: Eurostat data based on national health interview surveys (HIS round 2004: period 1999–2003).

Explanatory note: Data refers to the number of persons who consulted a medical doctor (including general practitioners, specialists) during the past 12 months. It refers to persons from 15 years and older, living in private households and for some countries also in institutions like homes for the elderly. Data are expressed as relative percentages within population groups defined ⁽⁴⁷⁵⁾.

⁽⁴⁷⁵⁾ For further information see Eurostat metadata.
http://epp.eurostat.ec.europa.eu/portal/page/portal/product_details/dataset?p_product_code=HLTH_CO_INPA

Table 2 — Inpatient hospitalisation of women and men during the past 12 months by educational level (%) in some European countries, 2004

	Total		Pre-primary, primary education or first stage of basic education — level 0 and 1		Lower secondary or second stage of basic education — level 2		Upper secondary education — level 3		Post-secondary non-tertiary and tertiary education — level 4,5 and 6	
	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men
Austria	13.4	13.1	15.6	15.0	:	:	12.0	12.7	11.5	11.6
Belgium	15.4	13.3	20.6	16.5	14.5	16.8	14.1	12.0	13.1	10.7
Bulgaria	9.3	8.4	14.3	15.9	10.2	9.9	7.4	6.0	7.0	6.3
Cyprus	9.7	8.1	12.6	11.2	9.7	7.0	8.9	7.7	7.0	5.8
Czech Republic	15.7	10.4	20.0	10.7	15.6	12.1	12.1	9.9	13.5	4.8
Estonia	10.6	11.3	12.8	18.9	11.6	13.8	10.5	9.3	8.0	10.6
Germany	14.5	10.5	11.9	13.2	15.3	11.1	12.2	7.7	12.0	9.3
Greece	7.2	7.4	10.5	11.8	4.3	4.2	3.5	3.8	3.8	4.2
Hungary	18.0	12.5	22.9	17.6	19.7	13.2	13.6	10.1	14.5	8.4
Iceland	15.0	7.9	23.4	10.7	17.4	8.0	10.7	7.4	14.4	7.6
Latvia	11.8	10.9	18.2	13.2	14.2	12.9	10.2	10.3	11.9	8.5
Malta	10.7	10.0	11.5	9.5	11.3	10.8	7.1	9.1	10.3	9.9
Netherlands	7.3	5.0	9.4	7.1	5.2	3.8	6.6	4.2	5.9	4.0
Norway	14.1	10.5	:	:	16.4	14.8	12.8	10.0	14.9	8.2
Poland	12.4	8.8	12.4	10.0	:	:	12.8	8.3	10.4	7.0
Romania	8.1	5.5	8.3	6.9	7.9	5.5	7.7	4.9	9.6	7.0
Slovenia	16.0	18.4	20.3	17.9	12.3	15.9	15.1	21.8	10.3	18.8
Spain	10.4	9.2	12.1	12.2	9.0	8.1	8.1	5.4	9.4	7.5
United Kingdom	8.4	6.2	9.3	9.1	8.4	6.5	7.6	6.2	8.1	4.5

Source: Eurostat data based on national health interview surveys (HIS round 2004; period 1999–2003).

Explanatory note: Number of persons (15 years and older) who were hospitalised for more than one day. Refers to persons living in private households and for some countries also in institutions like homes for the elderly. Data are expressed as relative percentages within population groups defined. Data are expressed as relative percentages within population groups defined by the background variables: sex, age groups (10 years intervals) and educational level (according ISCED 97) ⁽⁴⁷⁶⁾.

⁽⁴⁷⁶⁾ For further information see Eurostat metadata.
http://epp.eurostat.ec.europa.eu/portal/page/portal/product_details/dataset?p_product_code=HLTH_CO_INPA

Table 3 — Inpatient hospitalisation during the past 12 months of women and men by age in some European countries, 2004

	Total		15 to 24 years		25 to 34 years		35 to 44 years		45 to 54 years		55 to 64 years		65 to 74 years		75 to 84 years		> 85 years	
	w	m	w	m	w	m	w	m	w	m	w	m	w	m	w	m	w	m
Austria	13.4	13.1	10.2	9.2	10.0	10.2	10.6	10.7	13.6	12.3	14.5	16.3	18.2	20.7	22.6	25.7	19.8	25.2
Belgium	15.4	13.3	12.2	11.0	15.0	8.6	9.9	11.8	14.1	14.5	16.0	15.7	20.5	18.6	23.7	20.4	29.3	16.2
Bulgaria	9.3	8.4	9.8	4.4	9.4	3.4	6.1	5.8	8.6	10.5	9.1	10.2	11.4	16.8	13.6	18.2	5.6	3.1
Cyprus	9.7	8.1	5.6	7.6	11.1	3.8	8.7	6.1	7.4	7.0	10.1	11.2	16.2	15.1	14.5	16.6	25.5	18.0
Czech Republic	15.7	10.4	11.2	4.9	18.3	3.5	11.9	5.1	12.8	10.0	13.0	17.0	18.3	25.2	29.5	36.2	44.0	:
Estonia	10.6	11.3	10.2	9.7	7.9	8.7	10.3	9.5	11.1	10.0	10.9	13.6	11.9	18.1	15.2	21.5	:	:
Germany	14.5	10.5	11.5	9.5	16.7	4.7	13.4	7.4	11.6	10.0	13.6	14.7	18.4	19.2	17.8	23.2	:	:
Greece	7.2	7.4	2.3	1.5	2.6	2.7	4.2	3.6	4.1	4.2	9.6	9.6	12.7	15.5	15.6	21.6	18.9	25.8
Hungary	18.0	12.5	15.2	7.2	15.6	5.3	13.0	8.4	19.3	16.4	15.4	18.0	23.8	22.8	30.4	21.2	15.3	:
Iceland	15.0	7.9	13.4	6.6	15.7	6.9	15.1	4.7	6.8	8.8	11.3	9.4	30.5	15.8	:	:	:	:
Latvia	11.8	10.9	9.9	7.5	8.4	8.4	7.4	8.7	11.5	11.3	14.6	16.0	20.5	19.8	:	:	:	:
Malta	10.7	10.0	10.8	10.2	10.5	10.4	11.5	10.2	10.2	9.8	9.7	10.4	13.8	9.5	10.0	4.9	20.8	:
Netherlands	7.3	5.0	4.5	1.7	7.3	3.0	5.3	2.9	6.4	4.3	8.0	7.3	11.0	12.0	14.2	16.6	9.3	7.2
Norway	14.1	10.5	10.6	7.2	22.2	8.7	11.1	6.7	10.5	9.3	10.6	16.0	11.9	14.3	22.9	19.8	22.4	15.9
Poland	12.4	8.8	9.8	4.8	13.9	4.6	9.4	7.4	12.3	11.2	13.7	13.5	16.4	16.2	18.8	20.1	12.0	11.6
Romania	8.1	5.5	6.3	1.5	7.4	3.1	7.0	4.9	9.3	8.0	8.9	9.0	11.1	10.3	8.7	8.8	2.3	9.8
Slovenia	16.0	18.4	20.3	15.9	19.4	15.2	6.5	12.3	14.9	16.9	10.3	22.4	19.7	26.1	27.3	:	:	:
Spain	10.4	9.2	3.7	5.0	12.6	5.3	9.5	6.8	6.7	9.7	10.7	12.8	13.1	15.6	18.7	19.2	21.0	24.6
UK	8.4	6.2	6.8	5.5	12.3	3.1	6.7	5.4	7.6	5.7	8.6	9.6	6.5	14.8	:	:	:	:

Source: Eurostat data based on national health interview surveys (HIS round 2004; period 1999–2003).

Explanatory note: Number of persons (15 years and older) who were hospitalised for than one day. Refers to persons living in private households and for some countries also in institutions like homes for the elderly. Data are expressed as relative percentages within population groups defined ⁽⁴⁷⁷⁾.

⁽⁴⁷⁷⁾ For further information see Eurostat metadata.
http://epp.eurostat.ec.europa.eu/portal/page/portal/product_details/dataset?p_product_code=HLTH_CO_INPA

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European Commission

**ACCESS TO HEALTHCARE AND LONG-TERM CARE: Equal for women and men?
Final Synthesis Report**

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Though significant progress has been made in increasing the quality of health care across the European Union, many inequalities persist. In particular, this report looks at the inequality in access to healthcare and long-term care between men and women in the EU. The synthesis presented in this comparative report by the Expert Group on Gender Equality, Social Inclusion, Health and Long-term Care Issues describes the main differences in the health status of women and men in European countries and examines how healthcare and long-term care systems respond to gender specific needs in ensuring equal access. The report considers the main financial, cultural and physical barriers to access and provides good practice examples of healthcare promotion, prevention and treatment programs, as well as of long-term care. It calls attention to the need for promoting gender mainstreaming in healthcare and long-term care.

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