

Policy Context

Health covers physical, mental and social well-being as well as the absence of sickness and infirmity, and is determined by the social, political and economic context of people's lives, as well as by biology (World Health Organisation). Health is an important area of inequality between women and men due to their different and unequal access to and use of basic health resources. At the same time, women are exposed to certain health risks associated with sexuality and reproduction. Women are also at risk of negative health consequences associated with poverty and economic dependence, the experience of violence and discrimination.

Council conclusions on equality and health in all policies (June 2010), the Council

- Expressed concerns about differences in health status between the EU Member States and the vulnerability to poor health of certain groups of persons.
- Recognised that health services alone are not enough to maximise health potential and address inequalities.
- Invited Member States to develop policies and actions to reduce inequalities, optimise the collection of data and knowledge and enhance public health capacities.

European Parliament resolution on reducing health inequalities in the EU adopted in March 2011

- Highlighted common values and principles such as access to high-quality care, equality and solidarity and reiterated that health is influenced by gender.
- Women are under-represented in clinical trials, and suffer health consequences related to experiencing violence.
- Called on the Commission and the Member States to improve access to disease prevention, health promotion and healthcare services and reduce inequalities between social and age groups.

In February 2013, the European Commission issued the Communication Social Investment Package recognising the role of the healthcare system in enabling the inclusive growth objectives in the Europe 2020 Strategy.

The strategic objectives of the BPfA and the EU indicators

- C.1.** Increase women's access throughout the lifecycle to appropriate, affordable and quality healthcare, information and related services.
- C.2.** Strengthen preventative programmes that promote women's health.
- C.3.** Undertake gender-sensitive initiatives that address sexually transmitted diseases, HIV/AIDS, and sexual and reproductive health issues.
- C.4.** Promote research and disseminate information on women's health.
- C.5.** Increase resources and monitor follow-up for women's health.

The three indicators for monitoring the implementation of this critical area of concern were adopted during the 2006 Austrian Presidency of the Council of the EU. They focus on the first strategic objective, i.e. the accessibility and quality of healthcare for women, and look at healthy life years (indicator 1), access to healthcare (indicator 2) and cardio-vascular diseases (indicator 3). Key topics that relate to several of its objectives, such as the effects of preventative schemes on women's health, therefore require more research.

The database, Women and men in the EU - facts and figures, developed by the European Institute for Gender Equality provides the latest data and information on these indicators.

<http://eige.europa.eu/content/women-and-men-in-the-eu-facts-and-figures>



Findings from EU-wide data

Cardio-vascular diseases have been in decline as the cause of mortality among women

Cardio-vascular diseases are still the main cause of mortality as well as of disability and morbidity among women in Europe. Approximately half of the deaths in the EU are caused by cardio-vascular diseases.

Coronary heart disease (CHD) is the most common cause of death among cardio-vascular diseases in the EU, accounting for 13 % of deaths in women and 15 % in men. Stroke, a cerebral-vascular disease, is the second most common cause of death among the cardio-vascular diseases in Europe; 11 % women and 8 % of men died from stroke in the EU in 2010. In all EU Member States, the percentage of women's deaths as a result of stroke is higher than that of men's. Generally, the percentage of women's deaths related to stroke, as a percentage of all causes of deaths, has declined in the majority of Member States since 2007.

Between 2007 and 2010, the percentage of women's deaths resulting from cardio-vascular diseases, as a percentage of all causes of deaths, has slightly decreased in the majority of Member States.

Increases in women's unhealthy behaviours is a threat to longer life expectancy

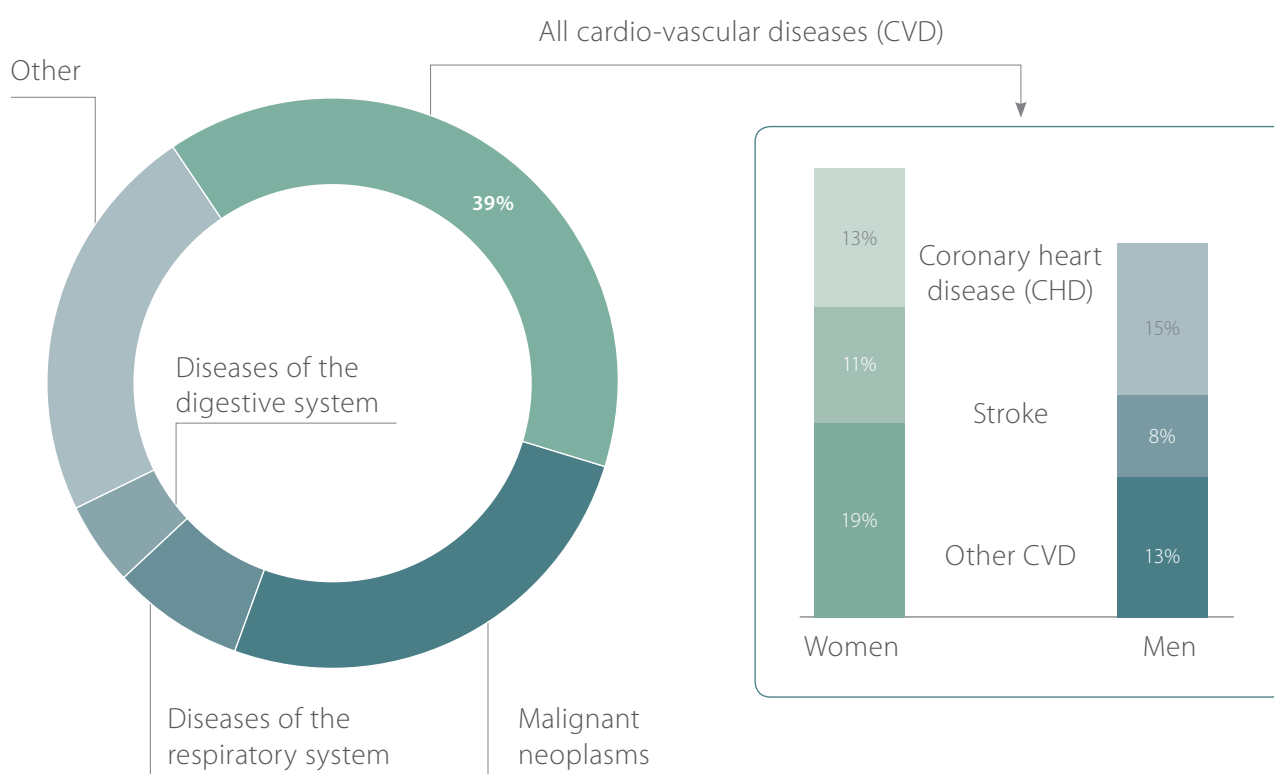
Women's life expectancy has been increasing in the EU and exceeds that of men. At the same time, in recent years, a noticeable closing of the gender gap has taken place; mostly in favour of men. Increases in the women's smoking rate and lung cancers among women, coupled with low participation in sports, may have contributed to the closing of the gender gap in life expectancy. Mortality from cancer of the respiratory system, for instance, has increased by almost 70 % for women since 1970.

Despite longer life expectancy, women spend more of their lives in disability and ill-health

Between 2007 and 2010, average healthy life years remained steady at 63 and 62 years at birth for both women and men in the EU-27. From 2010 to 2012, there was a slight decrease in average healthy life years for women (from 63 to 62), as well as for men (from 62 to 61).

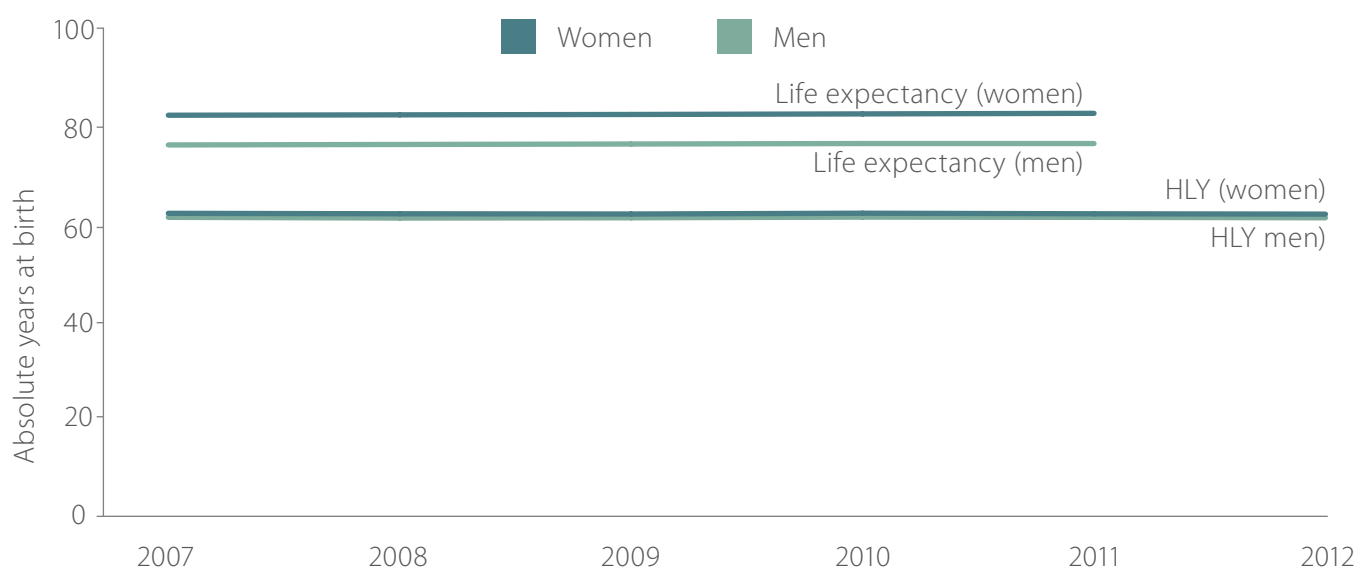
For the same period (2007-10), healthy life years at birth as a percentage of total life expectancy decreased for both women and men by 1 p.p. at EU level. On average, women spend 76 % of their life disability free, while for men this period extends to 80 %. As life expectancy in the EU has been steadily on the rise for both women and men since 1980 - with women having a life expectancy of 80 years or above in most (19) Member States - it points to a worrisome trend, as women face an increasing amount of time in disability and ill-health.

CARDIO-VASCULAR DISEASES, 2010





LIFE EXPECTANCY AND HEALTHY LIFE YEARS (HLY) FOR WOMEN AND MEN IN THE EU, 2007 – 12



Source: Eurostat Health statistics

Women are slightly more likely than men to perceive cost as a barrier to accessing healthcare

In 2012, there were no significant differences between women and men in terms of unmet medical examination needs (7 % of women; 6 % of men) and dental needs (7 % of women; 7 % of men) at EU level. These differences become more noticeable at Member State level, where the rates of women declaring unmet medical needs were at least 2 p.p. higher than men's rates,

ranging from 2 to 4 in five Member States. In comparison to 2007, the unmet medical examination needs slightly increased for both women and men at EU level in 2012.

In terms of reasons for unmet medical examination needs, the cost ('too expensive') differentiate women from men, as 3 % of women and 2 % of men gave this answer in 2012; although this represents a small difference. These figures are largely comparable to the situation of 2007.

Useful initiatives:

Prevention and early diagnosis reduced women's mortality caused by specific types of cancer: free-of-charge screening for breast and cervical cancer were established in several Member States (BE, DK, DE, EE, IE, FR, HR, CY, LV, LT, HU, SI), in addition, several Member States introduced a free-of-charge Human Papillomavirus vaccination for young girls (between 12 and 14) to prevent cervical cancer (BE, DK, IE, FR, CY, HU, MT, PT, RO). The Member States' reports to UNECE show a decrease in new HIV/AIDS infections and sexually transmitted diseases for both women and men in several EU Member States by pointing to the success of prevention programmes. Some countries have developed campaigns, websites or informative materials (such as brochures, pamphlets, leaflets and booklets) to sensitise the public on HIV/AIDS (BG, DK, DE, EE, FR, HR, CY, LT, PT, RO). In parallel, free-of-charge testing and counselling have been organised and sexual education programmes have been developed and delivered (BE, DK, EL, HR, CY, PT, SK).

In the past few years, many Member States have developed new programmes and plans on **maternal health**. An example is pre-natal counselling and care offered to all pregnant women, in most cases free of charge (BE, DE, EE, HR, CY, PL, RO, SI). Other measures taken were the promotion of breast-feeding, supporting women in breast-feeding and creating baby-friendly hospitals (CY, HU, RO). In Poland, the development of early detection reduced the perinatal mortality rate from 7.2 % in 2009 to 6.5 % in 2012. Another good example is an increase in consultations on family planning and improved accessibility to contraceptive methods especially for young women to decrease the legal abortions (BG, DK, DE, IT, CY, LT, NL, AT, PL, PT, RO, SI, SK). In other Member States, such as France, the number of abortions has been stable since 2006 and there is a high prevalence of use of contraceptives.

Several Member States have developed **measures to improve access to healthcare services** and information to certain marginalised groups of women such as women with disabilities, rural women or women from different ethnic communities (BE, CZ, DK, DE, EL, LT, PT, RO). Commitment to ensure an equal access to the healthcare system to the entire population was highlighted in BG, DK, DE, EE, IE, CY, LT, MT, PL, PT, SI, FI through the healthcare benefits administered by a public health insurance scheme.



ADVANCEMENTS AND OBSTACLES IN AREA C: WOMEN AND HEALTH

ADVANCEMENTS

- Life expectancy in the EU is on the rise among women and men.
- Healthy life years have increased in 15 Member States.
- In general women and men say they have good access to healthcare and no unmet needs.
- Overall the share of deaths from cardiovascular diseases has decreased.

OBSTACLES

- The gender gap in life expectancy is slowly closing.
- Women's life expectancy is increasing at a lower rate, due to unhealthy lifestyle changes.
- Healthy life years decreased slightly at EU level and are lower for women.
- Healthcare costs hinder women's access more than men's.
- Women are more likely to die as a result of cardio-vascular diseases than men.
- Addressing health from a gender perspective remains a key challenge.

The way forward for the EU

- Health needs to be addressed from both sex and gender perspectives, to ensure that the underlying causes of differences in health situations and the prevalence of diseases are better understood.
- Address women's access and right to reproductive health as central to women's lives and tackle the challenge of a lack of consensus in the Member States, concerning contraceptives and abortion.
- Ensure that the treatment of elderly and disabled women is equally addressed in relation to decreasing healthy life years and increasing life expectancy, as they face higher risks of abuse and/or neglect.
- Assess the determinants of health from a gender perspective to address changing patterns in health status and growing ill-health among women.
- Prioritise data collection in this area to allow for an assessment.
- Tackle general and specific barriers women face concerning healthcare access (e.g. costs).
- Ensure equality of access to healthcare for all (e.g. migrant women).

European Institute for Gender Equality (EIGE)

The European Institute for Gender Equality (EIGE) is the EU knowledge centre on gender equality. EIGE supports policy-makers and all relevant institutions in their efforts to make equality between women and men a reality for all Europeans and beyond by providing them with specific expertise and comparable and reliable data on gender equality in Europe.

More information: <http://eige.europa.eu>

The Resource and Documentation Centre (RDC) of the European Institute for Gender Equality is an innovative and practical tool developed to assist in locating key resources on gender equality, to facilitate the exchange of knowledge among those with an interest in gender equality policies and practices and to offer an online space for discussion and debate.

More information: <http://eige.europa.eu/content/rdc>



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