

Health



Relevance of gender in the policy area

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

Regarding the health policy field, it is of utmost importance to bear in mind the distinction between the concepts of 'sex' and 'gender'. Health research and health policy need to adequately explore and address the combination of social and biological sources of differences in women's and men's health. An understanding of the interaction between sex and gender in the development and management of health and disease can benefit both sexes in terms of prevention, intervention and outcome. For example, gender medicine has made strong advances in explaining how the incorporation of gender issues into research can affect the medical understanding. This affects the treatment of heart disease, osteoporosis, arthritis and pain, among other conditions.

In the European population, there are more women than men. Women generally live longer than men in all parts of Europe and there are more male deaths than female deaths in the working-age population (15 – 64 years). However, while living longer, women experience more years of disability than men. Across Europe, women are expected to live a smaller proportion of their years in good health than men, as measured in healthy life years (HLYs). This is an indicator of disability-free life expectancy, or the remaining years a person of a specific age is expected to live without any moderate or severe health problems, or acquired disabilities). With an ageing population, the risk of chronic disease such as diabetes and mental health problems – dementia, Alzheimer’s disease, and depression – is increased, notably among women. Moreover, some diseases such as breast cancer, osteoporosis and eating disorders are more common in women, while others, such as endometriosis and cervical cancer, affect women exclusively. Men are more likely to contract, and die from, lung and colorectal cancers, ischaemic heart diseases and traffic accidents. Some diseases, such as prostate cancer, affect men exclusively.

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.

Sexual abuse and domestic violence particularly affect women and girls in all countries and in all social classes. Domestic violence against women remains one of the most pervasive human rights violations of our time. In the EU, 9 out of 10 victims of intimate partner violence are women. The number of women victims of physical intimate partner violence in the EU Member States ranges between 12% and 35%. The World Health Organisation (WHO) provides global data on violence against women. Recent global prevalence figures indicate that 35% of women worldwide have experienced either intimate partner violence or non-partner sexual violence in their lifetime. Moreover, on average, 30% of women who have been in a relationship report that they have experienced some form of physical or sexual violence by their partner. Globally, 38% of murders of women are committed by an intimate partner.

An EU-28 survey on violence against women was launched in 2010 by the Fundamental Rights Agency (FRA), and carried out between April and September 2012. According to the FRA survey, an estimated 13 million women in the EU had experienced physical violence over the course of the 12 months preceding the survey interviews. This corresponds to 7% of women aged 18 – 74 years in the EU. Around 22% of women are, or have been, involved in a relationship with a partner where they experienced physical and/or sexual intimate partner violence. Equally, around 1 in 5 women (22%) has experienced this type of violence by somebody other than an intimate partner. Overall, 1 in 3 women in the EU has been a victim of physical and sexual violence by a partner, a non-partner, or both.

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:

- their reproductive role
- their role as care-givers for dependants (children and the elderly or disabled)
- their position in representing a larger proportion of the older population
- gender stereotypes

There is a strong gender dimension to lifestyle choices and risky behaviours that place men at higher risk of ill health. Men face greater levels of occupational exposure to physical and chemical hazards, behaviours associated with 'masculine norms' of risk-taking and adventure. There are health-behaviour paradigms related to masculinity and the fact that men are less likely to visit a doctor when they are ill. When they do see a doctor, men are less likely to report on the symptoms of disease or illness. At the same time, men usually tend to pay less attention than women to health-related issues.

Men generally have poorer knowledge and awareness of health. Across the EU, women and men make different use of health systems and services, and this affects their health status. There is evidence that some men use primary health services less frequently and are more likely to need hospitalisation for the principal causes of disease compared to women. This may be due to the services only being available during the working day, and thus less accessible to many working men. In addition, women and men may receive a different diagnosis and treatment when they seek medical assistance for similar health problems. For example, women are more frequently diagnosed with 'depression' and men with 'stress', based on the same complaints.

Health is also important while considering the sexual and reproductive behaviours of people. Reproductive health is defined as a state of physical, mental and social well-being in all matters relating to the reproductive system, at all stages of life. Good reproductive health implies that people are able to have a satisfying and safe sex life, the ability to reproduce and the freedom to decide if, when and how often to do so. This implies that women and men should be informed about and have access to safe, effective, affordable and acceptable methods of family planning of their choice. They should also have the right to appropriate healthcare services that ensure women a safe pregnancy and childbirth.

The healthcare workforce is predominantly composed of women. However, women healthcare workers tend to occupy lower-status positions (e.g. nurses and midwives) and, at the same time, to be a minority among more highly trained health professionals (e.g. doctors and dentists). Women are also under-represented in managerial and decision-making positions in the sector. Moreover, due to the high presence of women in the healthcare sector, specific attention should be paid to gender-sensitive training and education in the sector.

The major gender differences and inequalities within the health policy sectors are the following:

- gender differences in health status and behaviours
- gender inequalities and barriers in terms of access to health services
- sexual and reproductive health
- gender segregation in the healthcare workforce
- gender-sensitive training and education for health professionals.

Issues of Gender Inequality in the policy area

Gender differences in health status

Women's life expectancy has been increasing in the EU-28 and exceeds that of men. In 2013, the average life expectancy at birth in the EU-28 was 83.1 years of age for women and 77.5 years for men. However, despite longer life expectancy, women spend more of their lives in disability and ill health. In 2013, the number of healthy life years (HLYs) at birth was estimated at 61.4 years for men and 61.5 years for women in the EU-28. This represented approximately 79% and 74% of total life expectancy for women and men. The gender gap was considerably smaller in terms of healthy life years than it was for overall life expectancy. This means that women suffer from health problems at a later age but for a longer time than men.

While life expectancy rates are higher for women than for men in the EU, these differences decrease as educational attainment rises. Life expectancy rises with higher educational attainment (i.e. more educated people live longer than less educated people). In general, this trend is observed both in women and in men. However, the life expectancy of men with higher education is still lower than the life expectancy of women with the lowest educational attainment.

Though more women are diagnosed with mental health problems, this masks the extent of the problem among men. Men's depression and other mental health problems are under-detected and undertreated in all European countries. This is due to men's difficulty in seeking help and the limited capacity of health services to reach out to men. Men present symptoms differently compared to women, with higher levels of substance abuse and challenging behaviours.

Differences in health-risk behaviour exist between women and men from childhood onwards. The literature shows that in childhood and adolescence, boys present a higher mortality rate due to behaviour-generated causes (suicide, drug abuse, traffic accidents) and more physical and mental health problems than girls. Overall, the main health problems among young men are injuries caused by traffic accidents. Young women suffer especially from invisible health risks such as excessive use of medication and dieting, and sexual violence. Their economic situation is generally less favourable than that of men leading to socio-economic deprivation, with serious effects on their health status.

Cardiovascular disease (CVD) is still the main natural cause of death for both women and men in the EU. The most frequent types of cancer and causes of cancer-related mortality are breast cancer, colon and lung cancer for women, and prostate cancer for men. The increase in the incidence of lung cancer and lung cancer mortality in women, compared to the decrease in men, is due to the growing number of women smokers.

Gender-based violence has serious health consequences for women, from injuries to unwanted pregnancies, sexually transmitted infections (STIs), depression and chronic diseases. Between 15% and 71% of women around the world have suffered physical or sexual violence committed by an intimate male partner at some point in their lives. The abuse cuts across all social and economic backgrounds.

Gender inequalities and barriers in access to healthcare

There are no significant reported differences between women and men in terms of unmet medical needs. EU-SILC data 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-28 in 2013, 7.4% of women declared that they had unmet needs terms of medical examinations, compared to 6.4% of men. 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 accessing medical services. This can be the cost of medical care which can be prohibitively expensive, time and geographical barriers caused by waiting lists and the distance to travel for care. Men are more likely than women to declare other reasons, such as lack of time.

Gender plays a specific role in the incidence and prevalence of certain types of pathologies (as described above), but also in their treatment and their impact in terms of well-being and recovery. This is due to the interrelation of biological aspects, psychological and cultural behaviour (related to ethnic, social and religious backgrounds), socio-economic conditions and the features of healthcare systems. Some factors can exacerbate gender inequalities in health and well-being, such as differences in economic resources and the burden of family and care responsibilities, as well as poverty and isolation. As such, women are particularly vulnerable, especially in financial terms, when it comes to accessing health services. Their longer lifespan compared to men increases their chance of living a longer proportion of their life in illness and disability, as stated above. 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. For example, the presence of a tax-based, comprehensive national public system providing universal coverage has a strong effect on access to healthcare systems. A public healthcare system mainly financed through compulsory social insurance contributions, or even a mix of the two (such as out-of-pocket payments and private insurance schemes), can also be effective.

Sexual and reproductive health

Sexual and reproductive health is very personal, so people may have trouble finding or asking for accurate information about it. This may also help explain why these issues are still not addressed openly, and services are inadequate, fragmented and unfriendly in some countries in the EU. There has been good progress but there are still major differences between and within the Member States. Many people lack information on, for example, sexuality, family planning, pregnancy and childbirth, STIs, infertility, cervical cancer prevention and the menopause. Young people are particularly vulnerable, often facing barriers to sexual and reproductive health information and care. Young people are disproportionately affected by HIV, for example. Every year millions of girls face unintended pregnancies, exposing them to risks during childbirth or unsafe abortions, and interfering with their ability to go to school.

EU-28 figures show that some aspects of the sexual and reproductive health situation is improving. Maternal mortality and infant mortality have decreased in many countries as a result of prevention strategies, and as a consequence of many programmes and plans on maternal health. A decrease in legal abortions has been reported in many countries, which may be explained by an increase in consultations on family planning and improved access to contraceptive methods, especially among young women. Finally, regarding STIs, a decrease in new HIV/AIDS infections and sexually transmitted disease, both among women and men, has been reported in several Member States.

Gender segregation in the healthcare workforce

The workforce in the healthcare sector is dominated by women, with 78% of workers being female in the EU-28. Both vertical and horizontal occupational segregation can be observed when comparing women's and men's healthcare positions. On the one hand, women are under-represented in managerial and decision-making positions. On the other hand, the female healthcare workforce is usually concentrated in occupations such as nursing, midwifery and other 'care' professions such as community health workers. These occupations tend to be perceived as low-status jobs, while medicine, dentistry and pharmacy (positions mostly occupied by men) are understood as high-status occupations.

Gender-sensitive training and education of health professionals

Due to the high presence of women in the healthcare sector, specific attention should be paid to gender-sensitive training and education. Gender equality training activities remain scarce and tend not to be tailored specifically to the needs of the participants. There is a recognised need for tailored or issue-specific gender training and some good practices have been identified in some of the EU Member States.

Gender equality policy objectives at EU and international level

Both at the EU and the international level, the eradication of gender-based inequalities in health is a policy priority. Existing gender-based inequalities in health regard health status as well as the provision of healthcare services.

EU level

European Council

In June 2006, the Council of the European Union adopted a statement on common values and principles in EU healthcare systems, listing the overarching values of universality, access to good-quality care, equity and solidarity. 'Equity' in healthcare is defined as follows: "Equity relates to equal access according to need, regardless of ethnicity, gender, age, social status or ability to pay."

In 2006, in its Council Conclusions on women's health, the Council invited the European Commission to:

- integrate gender aspects in health research
- support the exchange of information and experience on good practice in gender-sensitive health promotion and prevention
- assist Member States in developing effective strategies to reduce health inequalities with a gender dimension
- promote and strengthen the comparability and compatibility of gender-specific information on health across Member States and at EU level through the development of appropriate data
- present a second report on the state of women's health in the European Union

(which was published in 2009).

The Council Conclusions on Equity and health in all policies: solidarity in health was published in 2010. In it, the Council expressed concerns about differences in health status between the EU Member States and the vulnerability of certain groups of people to poor health. The Council recognised that health services alone are not enough to maximise health potential and address inequalities. It invited Member States to develop policies and actions to reduce inequalities, optimise the collection of data and knowledge, and enhance public health capacities.

European Commission

The European Commission, in its health strategy "Together for health" dating from 2007, defines health inequities as "inequalities in health that are avoidable and unfair". It is committed to working towards reducing such inequities.

The Second Programme of Community Action in the Field of Health 2008 – 2013 came into force on 1 January 2008, aiming to complement, support and add value to the policies of the Member States. This should contribute to increasing solidarity and prosperity in the EU by protecting and promoting human health and safety, and improving public health. In this programme, the European Commission is committed to promoting health and reducing health inequalities, increasing healthy life years and promoting healthy ageing. Moreover, the third multi-annual health programme covering the period between 2014 and 2020 strengthened the European Commission's commitment "to contribute to addressing health inequalities through action under the different objectives and by encouraging and facilitating the exchange of good practices to tackle them".

The action plan for the EU health workforce recognises some gender inequalities in this area:

- the gender pay gap
- overall wage levels being lower in the healthcare sector (when compared to other sectors of the economy)
- work–life balance
- the provision of supportive and safe working environments.

The Commission staff working document on the action plan explains:

The issue of work–life balance is all the more relevant in the healthcare sector as the

participation of women in the workforce has historically been significant and is increasing. Overall, there were more than 13.1 million women working in the healthcare sector in 2010, making up more than three quarters of the health workforce in the EU. In many Member States the intake of women to medical schools is now over 50%. However, so far, this growing feminisation of the healthcare workforce has not always been properly reflected in measures to improve the reconciliation of professional and private life. It is a factor which might increase the difficulties to retain the healthcare workforce in the future.

Moreover, although skill levels are relatively high and working conditions are often demanding (e.g., night and shift work), overall wage levels in health and social services tend to be lower than in other sectors. This tendency, which is related to the high rate of women's employment and the gender pay gap, is becoming more pronounced and may be another disincentive to work in this sector.

The Commission's plans to address health inequalities are set out in the Commission communication *Solidarity in health: reducing health inequalities in the EU*, published on 20 October 2009. This includes, but is not limited to, those inequalities based on sex and gender. In this communication, the European Commission commits to helping address health inequalities including through the following actions:

- collaboration with national authorities, regions and other bodies
- assessment of the impact of EU policies on health inequalities to ensure they help reduce them where possible
- regular statistics and reporting on the size of inequalities in the EU and on successful strategies to reduce them
- better information on EU funding to help national authorities and other bodies address the inequalities.

European Parliament

In March 2011, the European Parliament adopted a resolution on reducing health inequalities in the EU, highlighting common values and principles such as access to high-quality care, equality and solidarity. The resolution reiterates that health is influenced by gender. Women are more affected by malnutrition and unhealthy behaviours such as smoking. They are under-represented in clinical trials, and suffer health consequences related to experiencing violence. It recognises that violence against women is a public health issue and also that the number of women involved in the development of health policies and programmes should increase. Inequality in accessing healthcare for economic reasons is also underlined. Various groups, such as people with disabilities, also face exclusion from the healthcare system. In conclusion, the European Parliament called on the Commission and the Member States to improve access to disease prevention, health promotion and healthcare services and to reduce inequalities between social and age groups. It also called for a focus on access to healthcare for disadvantaged groups as well as a focus on women's access to methods of contraception. Disadvantaged groups include children and adolescents, migrant groups, undocumented migrants especially women, ethnic minorities, people with disabilities and the elderly.

International level

Council of Europe

The Council of Europe adopted a Recommendation in 2008 on the inclusion of gender differences in health policy. The Council issued a series of recommendations and specific measures to governments of member states as to ensure the mainstreaming of gender in the health sector.

United Nations

At the Fourth World Conference on Women held in Beijing in 1995, the following strategic objectives on women and health were outlined (critical area of concern 'C'). The Beijing Declaration and Platform for Action (BDPfA), adopted in 1995 by 189 UN Member States, defined health as complete well-being, not just the absence of illness or infirmity. It stipulated that women must enjoy the highest standards of health throughout their lives and that there should be increased resources for research and follow-up on women's health concerns. It reaffirmed women's right to sexual and reproductive health and choices about their sexuality. Among other actions, governments committed to:

- delivering affordable quality care and boosting investments in services essential to women

- increasing women's access throughout the life-cycle to timely, appropriate, affordable and quality healthcare, information and related services
- strengthening preventive programmes that promote women's health
- undertaking gender-sensitive approaches that ensure sexual and reproductive health and rights, including in the area of HIV/AIDs
- promoting research and disseminating information on women's health
- increasing resources and monitoring mechanisms with engendered indicators to ensure gender mainstreaming of health policies and programmes.

Under each of these objectives, there are details of actions to be taken by governments and other stakeholders, both individually and collectively. The declaration also emphasises the rights-based approach to women's health in all its dimensions – on the demand side in particular – and the gender-sensitive provision of health services on the supply side, respecting women's rights. It emphasises women's participation and leadership in the health sector as critical to gender equality and women's empowerment. It also portrays the overall objective of the attainment of the highest standards of health for women as a right, and stresses it is the responsibility of the state and the community to ensure the enjoyment of this right.

The Convention on the elimination of all forms of discrimination against women, adopted in 1979 by the UN General Assembly, can be described as an international bill of rights for women. It defines what constitutes discrimination against women and sets up an agenda for national action to end such discrimination. Article 21 of the convention empowers the Committee on the Elimination of Discrimination against Women (CEDAW) to make suggestions and general recommendations based on the examination of reports and information received from state parties. CEDAW's General Recommendation 24 (1999) sets out a series of recommended actions for state parties. The recommendations are summarised below.

- Place a gender perspective at the centre of all policies and programmes affecting women's health and involve women in the planning, implementation and monitoring of such policies and programmes and in the provision of health services to women
- Ensure the removal of all barriers to women's access to health services, education and information, including in the area of sexual and reproductive health, and in particular, allocate resources to programmes directed at adolescents for the prevention and treatment of STDs, including HIV/AIDS
- Prioritise the prevention of unwanted pregnancy through family planning and sex

education and reduce maternal mortality rates through safe motherhood services and prenatal assistance. Where possible, legislation criminalising abortion could be amended to remove punitive provisions imposed on women who undergo abortion

- Monitor the provision of health services to women by public, non-governmental and private organisations, to ensure equal access and quality of care
- Require all health services to be consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice
- Ensure that training curricula for health workers include comprehensive, mandatory, gender-sensitive courses on women's health and human rights, in particular gender-based violence.

In the framework of the sustainable development goals (SDGs), Transforming our world: the 2030 agenda for sustainable development, a set of aspiration goals with 169 targets were established. Goals and targets specifically devoted to health and gender equality were defined.

Goal 3. Ensure healthy lives and promote well-being for all at all ages

- 1 | By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births.
- 2 | By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births.
- 3 | By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases.
- 4 | By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being.
- 5 | Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol.
- 6 | By 2020, halve the number of global deaths and injuries from road traffic accidents.
- 7 | By 2030, ensure universal access to sexual and reproductive healthcare services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.

- 8 | Achieve universal health coverage, including financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all.
- 9 | By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination.
- 10 | Strengthen the implementation of the World Health Organisation Framework Convention on Tobacco Control in all countries, as appropriate.
- 11 | Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all.
- 12 | Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States.
- 13 | Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks.

Goal 5. Achieve gender equality and empower all women and girls

- 1 | End all forms of discrimination against all women and girls everywhere.
- 2 | Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation.
- 3 | Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation.
- 4 | Recognise and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies and the promotion of shared responsibility within the household and the family as nationally appropriate.
- 5 | Ensure women's full and effective participation and equal opportunities for leadership at all levels of decision-making in political, economic and public life.
- 6 | Ensure universal access to sexual and reproductive health and reproductive rights

as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences.

- 7 Undertake reforms to give women equal rights to economic resources, as well as access to ownership and control over land and other forms of property, financial services, inheritance and natural resources, in accordance with national laws.
- 8 Enhance the use of enabling technology, in particular information and communications technology, to promote the empowerment of women.
- 9 Adopt and strengthen sound policies and enforceable legislation for the promotion of gender equality and the empowerment of all women and girls at all levels.

Policy cycle in health

How and when? Health and the integration of the gender dimension into the policy cycle

The gender dimension can be integrated in all phases of the policy cycle. For a detailed description of how gender can be mainstreamed in each phase of the policy cycle visit EIGE's Gender mainstreaming platform.

Below, you can find useful resources and practical examples for mainstreaming gender into health policy. They are organised according to the most relevant phase of the policy cycle they may serve.

Practical examples of gender mainstreaming in health

Ireland

Women's Health Council, 2007 – a guide to creating gender-sensitive health services.

Drawing on the models already in place internationally, this document aims to act as a guide to creating and implementing gender-sensitive health services in Ireland. Looking to the excellent examples set by Australia, Canada and Sweden, extensive reference to the models of best practice in these countries has been included in this guide. Case studies on mental health and cardiovascular disease have also been included to demonstrate the gendered nature of health in an Irish context.

Health Service Executive (HSE) and the National Women's Council of Ireland, 2012

Equal but different: a framework for integrating gender equality in health service executive policy, planning and service delivery.

The purpose of this framework is to support the Health Service Executive in developing a gender mainstreaming policy.

It is foreseen that the implementation of gender mainstreaming should be built into the HSE's performance monitoring system in order to monitor progress against the gender mainstreaming goals. Monitoring should be tied into the systems developed under the Health Inequalities Framework 2010 – 2012 and reporting on key performance indicators. These indicators would be very important to measuring the impact of gender mainstreaming and whether a gender perspective has been taken into account. Moreover, an annual report on gender mainstreaming should be presented to the HSE management team and the HSE board.

Key milestones of the EU health policy

Article 129 of the Treaty of Maastricht

Treaty of Maastricht with its Article 129 endows the European Commission, for the first time, with a degree of legal competence in the area of public health protection. Essentially, it specifies the Community's role in the coordination of national health policies, limited to topics of general interest: disease prevention, health information and education.

1992 - 1992

Health framework for action in the field of public health

Health framework – the Commission publishes a framework for action in the field of public health identifying 8 priority areas for Community action: cancer, AIDS, health promotion education and training, drug dependence, health monitoring, rare diseases, pollution related diseases, accidents and injuries.

1993 - 1993

Treaty of Amsterdam is strengthened

Treaty of Amsterdam: the legal authority on public health is strengthened; with this legal basis established, the EU could start shaping its EU health policies.

1997 - 1997

Establishment of the Directorate of Health and Consumer Protection and a dedicated European agency

Health protection is made a priority for the European Commission with the establishment of the Directorate of Health and Consumer Protection and a dedicated European agency.

1999 - 1999

First European health strategy proposal

First European [health strategy proposal](#) communication from the Commission to the Council, the European Parliament, the Economic and Social Committee and the Committee of the Regions on the health strategy of the European Community.

2000 - 2000

First Community Action Programme for "Public Health 2003 – 2008"

First Community Action Programme for Public Health 2003 – 2008; [decision No. 1786/2002/EC](#) of the European Parliament and of the Council of 23 September 2002 adopting a programme of Community action in the field of public health (2003 – 2008).

2002 - 2002

The EU Health Strategy "Together for health" supports the overall Europe 2020 strategy.

Europe 2020 aims to turn the EU into a smart, sustainable and inclusive economy promoting growth for all – one prerequisite of which is a population in good health.

White Paper – [Together for health: a strategic approach for the EU 2008 – 2013](#) (COM(2007) 630 final). The EU Health Strategy "Together for health" supports the overall Europe 2020 strategy.

2007 - 2007

Decision No. 1350/2007/EC of the European Parliament and the Council

[Decision No. 1350/2007/EC](#) of the European Parliament and the Council of 23 October 2007 establishing a second programme of Community action in the field of health (2008 – 2013).

2007 - 2007

Recommendation CM/Rec of the Committee of Ministers to Member States

Council of Europe: [Recommendation CM/Rec](#) of the Committee of Ministers to Member States on the inclusion of gender differences in health policy.

2008 - 2008

Commission Communication – Solidarity in health: reducing health inequalities in the EU

Commission Communication – [Solidarity in health: reducing health inequalities in the EU](#).

2009 - 2009

Proposal for a Regulation of the European Parliament and the Council on establishing a Health for Growth Programme

[Proposal for a Regulation](#) of the European Parliament and the Council on establishing a Health for Growth Programme, the third multi-annual programme of EU action in the field of health for the period 2014 – 2020.

2011 - 2011

Investing in health – Commission staff working document

[Investing in health](#) – Commission staff working document that is part of the social investment package for growth and cohesion.

2013 - 2013

Adoption of the third EU health programme, March 2014.

Adoption of the [third EU health programme](#), March 2014.

2014 - 2014

Current policy priorities at EU level

EU health policy complements national policies to ensure that everyone living in the EU has access to quality healthcare. EU actions are directed towards improving public health, preventing physical and mental illness and diseases, and avoiding sources of danger to physical and mental health. Such actions cover the fight against the major health scourges by promoting research into their causes, their transmission and their prevention. They also include health information and education, and monitoring, early warning and combating serious cross-border threats to health. The EU complements the Member States' action [in reducing drugs-related health damage, including information and prevention](#).

The European health policy thus aims to give all people living in the European Union access to high-quality healthcare, specifically by:

- preventing illnesses and diseases
- promoting healthier lifestyles
- protecting people from health threats such as pandemics.

The EU health policy, [implemented through the Health Strategy](#), focuses on:

- prevention – especially by promoting healthier lifestyles
- equal chances of good health and quality healthcare for all (regardless of income, gender, ethnicity, etc.)
- tackling serious health threats involving more than one EU country
- keeping people healthy into old age

- supporting dynamic health systems and new technologies.

In this context, the current priorities of EU policy for health are clearly identified in [the third EU health programme](#), which is the main instrument the European Commission uses to implement the EU health strategy. It is implemented by means of **annual work plans** which set out priority areas and the criteria for **funding actions** under the programme.

In particular, the current third health programme (2014 – 2020) has 4 overarching objectives. It seeks to:

- promote health, prevent diseases and foster supportive environments for **healthy lifestyles** taking into account the ‘health in all policies’ principle
- protect Union citizens from serious **cross-border health threats**
- contribute to innovative, efficient and sustainable **health systems**
- facilitate access to **better and safer healthcare** for Union citizens.

Through the funding of health projects, the health programme aims to:

- improve the health of EU citizens and reduce health inequalities
- encourage innovation in health and increase sustainability of health systems
- focus on themes that address current health issues across Member States
- support and encourage cooperation between Member States.

Want to know more?