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REPORT

on gender discrimination in health systems
(2004/2218(INI))

Committee on Women's Rights and Gender Equality

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PR_INI

CONTENTS

Page

MOTION FOR A EUROPEAN PARLIAMENT RESOLUTION...3

EXPLANATORY STATEMENT 6

PROCEDURE...

MOTION FOR A EUROPEAN PARLIAMENT RESOLUTION

on gender discrimination in health systems
(2004/2218(INI))

The European Parliament,

– having regard to the EC Treaty, in particular to Articles 2, 3(2), 13 and 152 thereof,

– having regard to the Community acquis in the field of women's rights and gender equality,

– having regard to its resolution of 9 March 1999 on the health situation of women in the Community[1],

– having regard to its resolution of 5 June 2003 on breast cancer[2],

– having regard to its resolution of 18 December 2003 on Petition 842/2001 concerning the effects of discriminatory treatment afforded to persons with multiple sclerosis within the European Union[3],

– having regard to the Platform for Action adopted at the Fourth World Conference on Women held in Beijing on 15 September 1995 and its resolution of 18 May 2000 on the follow-up to the Beijing Action Platform[4],

– having regard to the UNAIDS annual reports,

– having regard to the report of the European Monitoring Centre for Drugs and Drug Addiction published in November 2004,

– having regard to its resolution of 10 March 2005 on the trade in human egg cells[5],

– having regard to its resolution of 20 September 2001 on female genital mutilation[6],

– having regard to Rule 45 of its Rules of Procedure,

– having regard to the report of the Committee on Women's Rights and Gender Equality (A6-0250/2005),

A. whereas good health is essential for physical and mental wellbeing; whereas good health for all, equal care and quality social security services on equal terms, irrespective of income, is a fundamental objective of all public health work,

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[1] OJ C 175, 21.6.1999, p. 68.
[2] OJ C 68 E, 18.3.2004, p. 611.
[3] OJ C 91 E, 15.4.2004, p. 683.
[4] OJ C 59, 23.2.2001, p. 258.
[5] *Adopted Texts* P6_TA(2005)0074.
[6] OJ C 77 E, 28.3.2002, p. 126.

B. whereas health is a state of complete physical, mental and social well-being which comprises emotional, social and bodily well-being and which is determined by the social, political and economic environment as well as biological factors,

C. whereas the Charter of Fundamental Rights of the European Union[1] states that any discrimination based on any ground such as sex, race, colour, ethnic or social origin shall be prohibited (Article 21) and that everyone has the right of access to preventive health care and the right to benefit from medical treatment and that a high level of human health protection shall be ensured (Article 35),

D. whereas public health is affected, in addition to biological differences, primarily by ethical and moral principles, environment, access to education, knowledge and information, socio-economic disparities and bureaucratic difficulties affecting access to health care,

E. whereas chlamydia infection is a common bacterial sexually transmitted disease which is estimated to lead to infertility in one third of cases, making it the commonest cause of sterility arising from infection; whereas early diagnosis and treatment of the infection is very important and routine screening for chlamydia can reduce its prevalence among the population,

F. whereas 46% of all deaths among women in the enlarged European Union are due to cardiovascular diseases and the mortality of women therefore significantly exceeds that of men (39%); whereas for example more men suffer heart attacks but more women die of the consequences of a heart attack (European Cardiovascular Disease Statistics 2005),

G. whereas in 2004, 275 100 women in the enlarged European Union contracted breast cancer and 88 400 women died of it[2]; whereas breast cancer is the commonest cause of death among women aged between 35 and 55 in the European Union,

H. whereas, according to WHO data, mammography screening of guaranteed quality, that is, regular calling-up of women aged between 50 and 69 for voluntary screening and subsequent diagnosis, free of charge, as part of an organised population-related regional or national programme, can reduce breast cancer mortality by up to 35% among women in this age group and according to scientific studies could also reduce it by up to 20% among women aged between 40 and 49,

I. whereas in 2004 cervical cancer affected 30 400 women and caused 13 500 deaths among women in the enlarged European Union[3]; whereas the significant decrease in mortality in cervical cancer over the last decades can be ascribed to the introduction of screening programmes (pap test) in the Member States,

J. whereas in 1985 the World Health Organisation recommended that the frequency of caesarean operations should not exceed 10-15%, in order to maintain low levels of infant and maternal mortality[4]; whereas however since the early 1990s caesareans have rapidly

[1] OJ C 364, 18.12.2000, p. 1.
[2] 'Cancer incidence and mortality in Europe, 2004', Boyle, P and Ferlay, J, 2005 Annals of Oncology 16 481-488.
[3] *Ibid.*
[4] 'Appropriate technology for birth', World Health Organisation, 24(8) The Lancet (1985) 436-437.

been becoming more frequent in Europe, and in Germany, for instance, attained a rate of 26.7% in 2003,

K. whereas psychological disturbances cause great human suffering and considerable damage to health, depression being the commonest form of disease, and women are affected more than men; whereas self-harm due to psychological disturbances is common among younger women; and whereas there is a higher risk that women aged between 35 and 55 commit suicide,

L. whereas, overall, alcohol consumption in the European Union in the form of 'alcopops' has significantly increased among the 14-29 age group in recent years, and whereas within this age group the proportion of girls consuming them has particularly increased, to the point where in Finland, Ireland and the United Kingdom, for example, there are more girls than boys who consume 'alcopops'[1],

M. whereas attaining good health does not merely require the absence of disease or infirmity, but implies a state of complete physical, mental and social well-being, underpinned by individuals having the opportunity to make decisions concerning their own lives and to take part in working and social life during the various stages of their lives on their own terms,

N. whereas maintaining a public health service, ensuring equal access to that service and achieving good health for all citizens is a responsibility of the Member States; whereas achieving this objective requires cooperation between the Member States, the EU institutions, international organisations, medical personnel and citizens; whereas the Open Method of Coordination is a good instrument to reinforce the commitments of the Member States and to encourage the exchange of information and best practices,

O. whereas violence against women in all its forms and female genital mutilation, as well as diseases such as osteoporosis and breast cancer and eating and other disorders, the sex slave trade and prostitution and a lack of safety at the workplace are among the most serious health problems affecting women,

P. whereas genital mutilation causes irreparable physical and psychological damage to the health of women and girls and can even lead to death, which cannot be justified on the grounds that it complies with a religious imperative or that the parents or the person concerned have given their consent,

Q. whereas gender must be mainstreamed into all areas of occupational safety and health strategy,

R. whereas in order to formulate a gender policy, it is necessary to carry out analyses of the differences in the relationships between women and men and their respective roles, and of how these differences impact on protective and risk factors, access to resources, including information, education, technology and services, the occurrence, severity and frequency of disease, the social and cultural conditions of ill health and disease, the response of health systems and services and the roles of women and men as formal and informal health care

[1] European School Survey Project on Alcohol and other Drugs, 2003.

providers,

S. whereas the main challenges in respect of gender equality are the need to develop gender statistics and indicators, the allocation of the necessary resources, and the implementation of the instrument of 'gender budgeting',

T. whereas barriers to accessing health care for Roma women result from the inter-related effects of discrimination and poverty,

U. whereas the harvesting of egg cells poses a high medical risk to the life and health of women, resulting *inter alia* from hyperstimulation of the ovaries,

V. whereas, despite the difficulty of making precise estimates owing to the lack of official data, female genital mutilation appears to be carried out in immigrant communities in the Member States, and is neglected by healthcare services,

1. Stresses that good physical and mental health for all must be a priority objective in all economic and political decision-making and that, to achieve that objective, the focus must be on disease prevention strategies which include proper provision of information to the public and guaranteed access to adequate health care for everyone;

2. Stresses the importance of taking account of the gender perspective in all health policies and in decision-making processes;

3. Stresses the importance of developing the gender perspective in both the Member States' public health strategies and the Commission's health strategy; calls on the Commission to include research into the health situation of the sexes in the new health and consumer protection programme (2007-2013) and take it into account when planning the Seventh Framework Programme of Research;

4. Stresses the fact that the reflection paper 'Enabling Good Health for all' proposes mainstreaming health into all European Union policies, but that it is also important to remember EU commitments to mainstreaming gender;

5. Calls on all Member States and the Commission to ensure the availability of reliable data, broken down by gender, both on the take-up of medical treatment and on the taking of prescribed medicines;

6. Calls on the EU institutions to use standardised data and common indicators to measure gender disparities within health and medical services in the EU, while showing strict respect for the subsidiarity principle and the specific characteristics of the Member States' public health systems;

7. Welcomes the establishment of a European Institute for Gender Equality;

8. Stresses the importance of research into the link between biological, economic and social factors in health and medical services; notes in this connection that socioeconomic factors such as low income, a low level of education or physically demanding or monotonous work entail health risks; observes that single parents in particular, 80% of whom are

women, are subject to severe mental and physical strain, lack of material resources and limited social participation, which directly affect their health; calls on the Member States, therefore, to transpose and apply as quickly as possible existing EU law on the equality of women and men, thereby helping to attain a high level of protection of the health of both sexes; calls, in addition, for targeted measures to promote the health of women;

9. Calls on the Commission and the Member States to include gender perspectives on health and safety aspects, with special attention to pregnant women and breast feeding mothers and women-dominated jobs and, consequently, for more research into the effects of long-term visual display unit screen use, the incidence of repetitive strain injury amongst women and the aetiology of back injuries among carers; requests that the Commission make an evaluation of the consequences of three-shift work for women's health;

10. Calls on the Commission, in the light of the United Nations General Assembly resolution of 8 March 2005 (A/59/516/Add. I), which refers explicitly to the need to avert health risks and prevent the exploitation of women, to rule out support and funding for human cloning under any European Union programme;

11. Calls on the EU institutions and the Member States to take account of the effects of gender disparities in budget work, projects and programme planning relating to health and medical services; points out that the exchange of information and best practices helps to develop an effective national health policy;

12. Calls on the Member States to adopt or support initiatives required, in particular, to facilitate access by elderly women to health and medical services;

13. Considers that combating poverty among women should be given priority in budget work, projects and programme planning; emphasises the need to make the poorest sections of society, including women, leading partners in policies concerning the fight against poverty, including the programming, implementation and evaluation of such policies, with a view to gearing public health systems as closely as possible to the needs of the most disadvantaged groups;

14. Points, in particular, to the need for medical support and health care for pregnant women, chronically ill, disabled and elderly women and other vulnerable groups, which find themselves in a particularly difficult situation in many respects; calls on Member States, within their national health systems, to eliminate discrimination and improve access to health care for Roma women by:

    - creating conditions for equal access to health care,

    - enhancing Roma women's participation in improving their own access to healthcare,

    - coordinating law enforcement efforts to put an end to non-consensual sterilisation;

15. Asks the Commission to supply further information on the potential risks resulting inter alia from hyperstimulation of the ovaries; asks the Commission accordingly to supply accurate figures on the number of women suffering from side-effects of ovarian stimulation and calls on it to disseminate such information in the Member States; places

particular emphasis on the obligation to inform women of all potential risks caused by ovarian stimulation;

16. Stresses that both men and women should be able to take advantage of measures enabling them to combine work and parenthood;

17. Notes that, in addition to paid employment and parenthood, many women also undertake a significant proportion of domestic care for parents or parents-in-law, which is neither socially recognised nor remunerated; calls on the Member States therefore to take account of demographic trends by means of appropriate training and payment of care staff;

18. Observes that many caesarean operations currently performed are not necessarily required on medical grounds and that as a result more caesareans are being performed upon demand at a time scheduled in advance, although considerable risk to mother and child is associated with such operations; observes likewise that the rising number of caesareans is costly to national health services; calls on the Member States therefore explicitly to draw attention to the disadvantages and risks associated with caesareans during preparations for birth and to have caesareans performed only when they are medically necessary; instructs the Commission furthermore to study this subject in order to ascertain the causes of the growing prevalence of caesareans;

19. Notes that the right of women to good living conditions and their ability to support themselves are fundamental factors in determining good health;

20. Notes that in absolute terms significantly more women than men work in the health sector, but that they are severely under-represented in decision-making bodies, as the European NEXT study (Nurses' Early Exit Study) of June 2005 again showed for the nursing sector; calls on the Member States, therefore, strongly to promote gender equality in the health sector and to take measures to increase the number of women appointed to leading positions in the medical profession;

21. Notes that good health in general, and unrestricted access to sexual and reproductive health care and family planning in particular, are important tools to empower women fully to partake in society and fight poverty;

22. Stresses that gender and age prejudices must be eliminated in the interaction with patients in clinical settings, health care systems, research and public policy;

23. Stresses the need for compulsory education on gender disparities and ethical and moral principles to be included in training and further training of health service personnel;

24. Stresses the need for knowledge about and the development of methods of supporting and treating women who have been subjected to violence;

25. Stresses that preventing and banning female genital mutilation and prosecuting perpetrators must become a priority in all relevant European Union policies and programmes; points out that immigrants residing in the Community should be aware that female genital mutilation is a serious assault on their health; calls on the Member States to adopt administrative provisions concerning health centres and the medical profession, as

well as codes of conduct, decrees and ethical codes, to ensure that health professionals report cases of which they are aware or instances of people at risk who need protection; calls on the Commission to devise a comprehensive strategic approach at European level with the aim of putting an end to the practice of female genital mutilation in the European Union; calls on the European Union to support the wish of African NGOs to declare 6 February International Day Against Female Genital Mutilation and calls for this position also to be adopted in the appropriate United Nations bodies;

26. Calls for doctors who conduct genital mutilation of young women and girls not only to be prosecuted but also to have their practising licence withdrawn;

27. Calls on the European Union and the Member States, in view of the feminisation of HIV/AIDS, to continue investing in the development of microbicides to enable women to protect themselves against HIV/AIDS; draws Member States' attention to the need to step up information campaigns and allocate more resources to combating the HIV/Aids virus among 15 to 25 year-olds in the European Union, given that the statistics published by UNAIDS in 2004 point to an alarming increase in the incidence of the disease in this age group;

28. Stresses the medical and economic impact of the high incidence of and mortality from cardiovascular diseases among women; calls on the Member States therefore, in the training of medical staff, expressly to draw attention to the different clinical pictures and symptoms of cardiovascular diseases in women and men and to include women in current and future studies of cardiovascular diseases; welcomes in this connection also the new European Union antismoking campaign 'HELP - For a Life Without Tobacco', which is intended to induce more women and men to stop smoking, thereby reducing the risk they run of contracting a cardiovascular disease, and particularly of suffering a heart attack; calls on the Commission and Member States to reduce heart disease and strokes in women by developing preventive strategies, diagnostic tests, treatment and rehabilitation policies which address women’s needs;

29. Criticises the fact that comprehensive screening programmes in accordance with European Union guidelines exist in only nine Member States (Belgium, Finland, France, Hungary Luxembourg, the Netherlands, Spain, Sweden and the United Kingdom) and therefore calls on the other Member States to make available as soon as possible to all women aged between 50 and 69 mammography screening at two-yearly intervals which accords with European guidelines, as recommended in Council Recommendation 2003/878/EC of 2 December 2003 on cancer screening[1]; calls on the Member States also to make available mammography screening to women aged between 40 and 49 as soon as evidence-based studies have provided data for the fact that this can further reduce breast cancer mortality;

30. Calls for every woman who contracts breast cancer to have the right to be treated by an interdisciplinary team, and calls on the Member States, therefore, to build up a complete network of certified, interdisciplinary breast centres in accordance with the criteria called for in its abovementioned resolution of 5 June 2003 on breast cancer;

31. Welcomes the abovementioned Council recommendation of 2 December 2003 on cancer

[1] ***OJ L 327, 16.12.2003, p. 34.***

screening ; calls on the Commission to submit the interim report called for in the recommendation concerning the implementation of these early cancer diagnosis programmes on schedule before the end of 2007;

32. Calls on the Commission and the Member States to include prevention of endometriosis and ovarian cancer in future Community Action Programmes for Public Health to allow more research into the causes, prevention and treatment of endometriosis and ovarian cancer for major information campaigns targeting the public and health professionals; calls on the Member States to support awareness-raising initiatives by national organisations;

33. Calls on the Commission to continue supporting the publication of European guidelines on cervical cancer;

34. Calls on the Member States, within the national health systems, to devote particular attention, and assign priority, to:

    (a) preventive measures to discourage women from smoking in order to reduce the number of cases of lung cancer and other smoking-related diseases, as well as the various forms of cancer, inter alia through appropriate information and awareness-raising campaigns;

    (b) care and rehabilitation in cases of damage caused by strain to the necks, backs and shoulders of working women, as this is the commonest cause of sick leave, and

    (c) the significance of early diagnosis of osteoporosis among older women in order to prevent fractures, inter alia through improved access to measurement of bone mineral density; emphasises the fact that women are four times more likely than men to develop osteoporosis; deplores the fact that access to bone mineral density tests is still suboptimal in many European countries and calls on the Member States to provide for information on, and prevention of, this disease within their national health systems;

35. Calls on the Commission and Member States to improve their efforts to fight the spread of chlamydia, particularly by means of public information work and preventive examinations; calls, in this connection, on the Commission to assess the need for a uniform notification requirement for chlamydia in all Member States;

36. Stresses the need for research into the causes of overweight and eating disorders, particularly anorexia nervosa, bulimia nervosa and adipositas, and for sufferers to be offered psychological support and appropriate treatment; stresses that eating disorders are not addictive diseases in the true sense but psychosomatic conditions which arise as a consequence of numerous problems and contradictory demands made on girls and young women during puberty; calls for people with eating disorders not to be treated as addicts but for a separate form of therapy to be made available which focuses not on eating behaviour but on the social problems of girls and young women; calls on the Member States to pool their experience and follow best practice in treating such disorders; calls for the Union and the Member States to take appropriate steps to publicise healthy eating habits;

37. Calls on the Commission, in the forthcoming communication on mental health in the European Union, to consider the specific situations of women and men and to identify gender-specific options for action; hopes, therefore, that the communication from the Commission will take account of fields specific to women such as pre-menstrual tension, postnatal depression and complaints during the menopause;

38. Calls on the Commission and the Member States to allocate more resources to combating poverty-related diseases (such as tuberculosis and malaria), both in Member States and in third countries;

39. Stresses that, while hormone replacement therapy can alleviate the symptoms of the menopause, maintain constant bone hardness in women and reduce the risk of intestinal cancer, hormone replacement therapy significantly increases the risk of cardiovascular disease and breast cancer; calls on the Commission and Member States, therefore, to ensure that greater attention is drawn to the advantages and disadvantages of hormone replacement therapy as a treatment for problems associated with menstruation and the menopause and that alternatives to it are studied;

40. Considers it self-evident to perform more gender-specific clinical trials of medicines and to increase awareness of the different conditions and life styles of women and men within all medical research in the development of new drugs and in the prescription of drugs;

41. Points to the lack of information concerning differences in the effects of medication, and stresses the need for greater awareness in this connection, as well as to the lack of information concerning the effects of the advertising of medicines in terms of the onset of dependency; recommends that medicines be used in accordance with doctors' prescriptions and, as the next step, that information be provided about relevant scientific findings and that such findings are highlighted; regrets the fact that new medicines, even those intended specifically for women, are normally tested on men only;

42. Calls for the introduction of gender-specific information in instructions accompanying medicines which goes beyond warnings to pregnant women and nursing mothers; calls for instructions accompanying medicines to draw attention to any differences in dosage for women and men and differences in the impact of the medicine on the sexes;

43. Stresses the need for independent fundamental research concerning gender-specific terms of reference for research into medicines;

44. Notes that women are prescribed psychotropic drugs with disproportionate frequency and that, in particular, more older women are prescribed tranquillisers;

45. Notes that alcohol, nicotine and drug consumption among women is still lower than among men, but is concerned that in certain Member States alcohol, nicotine and drug consumption is increasing alarmingly among women; recommends that appropriate preventive action be taken;

46. Stresses the need for research into gender-specific addictive diseases; notes in this connection that although women consume alcohol and illegal drugs, such as heroin, cocaine and ecstasy, more rarely than men, dependence on medicines (especially

amphetamine derivatives and tranquillisers) is more common among women than men; deplores the fact that hitherto very few data have been gathered concerning gender-specific features of addiction and welcomes therefore the intention of the European Monitoring Centre for Drugs and Drug Addiction to submit a gender-specific report on drug consumption and drug dependence among women and men during the next year;

47. Welcomes the adoption by the Brussels European Council of December 2004 of a drugs strategy for the period 2005-2012 and calls for the new European Union Action Plan in this area for the period 2005-2008, which was submitted by the Commission for adoption by the Member States, to focus in particular on combating drug taking, including cannabis and ecstasy, among young people, and particularly girls, in the 15 to 18 age group, since over the past ten years or so there has been a major increase in drug taking in this group, with disastrous consequences for the integration of such people in society;

48. Calls on the Commission to start information and education campaigns concerning the damaging effects of alcohol consumption and to submit proposals for measures to reduce the consumption of alcohol, nicotine and drugs which cause major mental and public health problems both among men and women and among the younger population;

49. Calls on the Commission and the Member States to carry out a detailed analysis of the causes of and best solutions for the alienation felt by many teenagers in the European Union, particularly teenage girls, which is reflected in an increase in suicides and suicide attempts, runaways, school drop-outs, self-inflicted violence and violence directed at others and high-risk behaviour;

50. Deplores the fact that very few gender-specific addiction centres and advice centres exist in the Member States, although addictive substances affect the sexes differently and although these differences also require differing detoxification and withdrawal processes; stresses in particular, moreover, that such establishments should provide help with child care to enable women to attend the programmes; calls on the Member States, therefore, to extend gender mainstreaming to the treatment of addictive diseases and to facilitate the gender-specific treatment of addiction;

51. Observes expressly that Structural Fund resources may be used for preventive medical purposes; notes that this comprises building measures, the procurement of medical devices and training or further training of staff; calls on the Member States therefore to make greater use of Structural Fund resources than hitherto for investment in the health sector, subject to the specific conditions which apply to grants;

52. Reaffirms the importance of civil society in the public health debate at European Union and national level and calls on the Commission and the Member States to strengthen its role through open and transparent consultation processes;

53. Calls on the Commission to produce a report on the state of women's health that includes data from the new Member States;

54. Stresses that, owing to the difficult working conditions within the health service, shorter working hours, as well as rest breaks, should be introduced, particularly for nurses and

doctors on on-call duty, and that pay levels should be raised;

55. Draws attention to the need to provide special care and support to women following childbirth, particularly to young single mothers;

56. Instructs its President to forward this resolution to the Council, the Commission, and the governments and parliaments of the Member States and to health care professional bodies and consumer organisations.

EXPLANATORY STATEMENT

It has long been the generally held view that there has not been gender discrimination in treatment and care within the health and medical services. This view has been shared by health and medical service actors, decision-makers and the public. During the last 20 years, however, there has been a change and an increasing number of people have become aware that women and men are treated differently in those services. There is now acceptance and understanding that gender is an equally important health determinant as social, economic and ethnic background. Since the UN Conferences in Cairo in 1994 and Beijing in 1995, the links between gender and health have been placed on the agenda. Despite these international successes in promoting women's health, they have not entailed any systematic reforms/implications, either at national or EU level. The Commission has followed up the Beijing Platform to some extent but has not focused on the development of a gender perspective within the health sector. Women's health is often seen as synonymous with sexual and reproductive health.

Greater knowledge has not resulted, to any appreciable extent, in changed/improved circumstances in regard to women's special needs within the health and medical services. The total resources of the health and medical services have not been redistributed to benefit women to the same extent as men. Most of the Member States still have no statistics and data based on gender. Gender disaggregated statistics and data are necessary to identify and substantiate the disparities between men and women in terms of diagnosis, treatment and distribution of resources.

Women live longer than men but have worse perceived health and seek more treatment. One of the explanations may be the complex link between biological and social factors but there is a need for research in that area to find explanations for women's greater degree of ill health/perceived ill health and need for medical care.

The fact that women have a longer average lifespan will mean that the majority of the elderly population are women, especially among the oldest section of the population. In addition to the fact that women are the largest group among the ageing population, elderly women are also affected more often than men by certain age-related diseases such as rheumatic pain and Alzheimer's disease. Owing to inequalities in income and ownership earlier in life, elderly women have fewer financial resources available for care and treatment. In the majority of the Member States, women have had far less paid work on the labour market and, therefore, have worse pension benefits. These are some of the reasons why the Member States must have a well-developed and publicly financed health system and geriatric care. Otherwise, large numbers of elderly women in the Member States will be totally without the necessary care and treatment. The Member States must also give priority to women's right and ability to support themselves.

Poverty is a heavily influential factor in relation to health. Women are over-represented in the poor groups throughout the EU. Some 120 million women in the EU live in poverty. Poverty obviously makes it difficult for women to achieve physical and mental health. Combating poverty among women will have a positive effect on women's health.

This report uses a holistic definition of gender. The term 'holistic' is an accepted and also

medical term which includes social, psychological, cultural and biological aspects. The gender perspective means that a holistic approach is taken to analysing how gender affiliation affects living conditions and how gender relates to power and privileges, for example.[1]

Key concepts within gender research are construction, hierarchy, relation and social situation.[2] Women are the subordinate group in the gender hierarchy. The term 'gender bias' is another problem that both men and women encounter within the health and medical services. Gender bias is the result of a lack of gender awareness in researchers and decision-makers. It means that when gender disparities have been indicated in a particular complaint, behaviour or living condition, there is a risk that gender bias arises in the meeting with the individual patient. For example, doctors think less often of asking about alcohol habits in a woman with stomach complaints than in a man with the same symptoms. The reason is probably that alcohol-related complaints are more common in men, though the phenomenon should be seen as a gender bias (the individual patient must, however, be seen as unique and not as a representative of a group.)[3]

It is now known that patients' gender is the crucial factor in how doctors/healthcare personnel understand symptoms, make diagnoses and provide treatment - even when women's and men's symptoms are exactly the same and no biomedical facts justify any discrepancy. A gender perspective on medicine also means revealing ill health which is caused by unequal power relations between the genders, such as men's violence against women. Medical gender research has been of crucial importance in highlighting the significance and the health repercussions of the violence and abuse to which women have been subjected by husbands, partners, and men close to them, and through trafficking and prostitution.[4]

Despite the fact that violence against women is such an extensive public health problem, it has remained an invisible phenomenon in medical training and practice. For example, patients are asked about their smoking habits, but most female patients are still not asked whether they are subjected to violence, despite the fact that violence against women, according to a prevalence study, occurs more often than smoking, for example. [5] Studies have been made by interview/survey with women who have been asked about violence and these studies show that a large majority of the women appreciate the fact that the question is asked.[6]

Violence against women causes higher mortality among women aged between 15 and 44 than cancer, malaria, road accidents or war. The World Health Organisation estimates that at least one in five women in the world has been subject to physical or mental abuse during her life .[7]

[1] Hamberg: 'Medicinsk genusforskning', (medical gender research), Swedish Research Council, ORD & FORM AB (2004), p. 26.
[2] ibid. p. 12.
[3] ibid. pp. 108-109.
[4] Risberg: 'Sexualiserat våld som folkhälsoproblem', (sexualised violence as a public health problem) Läkartidningen (Journal of the Swedish Medical Association) 1994:91 (50): 4770-71.
[5] Lundgren, Heimer, Westerstrand, Kallioski: 'Captured Queen - men's violence against women in 'equal' Sweden - a prevalence study', Fritzes 2001.
[6] Stensson, Kristina: Men´s violence against Women – a Challenge in Antenatal Care, Uppsala Universitet 2004, p. 12, Bacchus L, Mezay G, Bewley S: Women´s perception and experiences of routine enquiry for domestic violence in a maternity service, BJOG 2002:109:9-16 och McNutt LA, Carlsson BE, Gagen D; Reproductive violence screening in primary care: Perspectives and experiences of patents and battered women.
[7] World Health Organisation: Violence against Women Fact Sheets WHO/FRHWHD/97.8, 1997.

This report focuses on two different areas relating to women's health and gender discrimination in the health and medical services. The first focus area (Area A) deals with discrepancies in care between men and women affected by the same or similar diseases. The other focus area (Area B) is women's health from the perspective of so-called 'women's diseases', i.e. diseases which almost only affect women. Examples of these are certain muscle diseases, of the fibromyalgia type, breast cancer, osteoporosis, and health risks when women are forced to seek illegal abortions. Women's rights of self-determination over their own sexuality and their own body is an important factor in women's health.

Area A

An analysis carried out at Danderyd Hospital in Stockholm, Sweden, showed wide discrepancies between men and women in terms of prescription, treatment and costs. For example, men received twice as many light treatments of the body than women for diagnosis of eczema and psoriasis despite the fact that these diseases are equally common in both genders. The inference from the survey in terms of cost is that, if women were treated with the same intensity as men, the resources spent on women's treatment would increase by 61%. If, on the other hand, the intensity of women's treatment is taken as the norm and, in relation to that, men are under-treated to the same extent as women currently are, there would be a saving of 33% on treatment costs.[1]

Women's coronary diseases manifest themselves differently to some extent and when they seek hospital treatment, they are not dealt with as quickly as men. Women with acute heart complaints are forced to wait longer for ambulance transport, once they have been taken into hospital they do not get the same reception. It takes longer before their heart is X-rayed and they do not receive swift treatment as frequently in the form of angioplasty or a by-pass operation. Women suffer side-effects of heart drugs more often and one explanation could be that they are given the wrong dosage. However, there is no research to identify the cause.[2] An examination of ophthalmic care shows that women have worse access to cataract operations. Statistics also show that men receive quicker access to new drugs and modern treatment.[3]

Medicines affect men and women differently. Despite the fact that women consume more medicine than men, men are still most often the norm in medical research and the development of new drugs.

Area B

Osteoporosis is an ancient disease which has been regarded right up to the present day as an inevitable consequence of ageing, principally women's ageing. Not until recent times, and as a consequence of an upsurge in the frequency of fractures and the burden on medical care, has the disease attracted the attention of medical research and of decision-makers throughout the world. As late as the early 1990s, osteoporosis only exceptionally formed part of basic

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[1] Osika, Ingrid: 'Ett konkret exempel på ojämställd vård' (A specific example of unequal care), Linköping University.
[2] Asplund. Wigzell: 'Jämställd vård?' (Equal care?), National Board of Health and Welfare (2004), pp. 55-57.
[3] ibid. p. 74.

medical training. Current research shows that young people and men are also affected more than was previously assumed and that osteoporosis is a common secondary consequence of a number of other diseases and/or treatments with drugs. The reasons are complex and multifaceted and still insufficiently researched but there is much evidence indicating that the trend is affected, inter alia, by hereditary factors, a change in lifestyle and the rising number of elderly people in the population.

Osteoporosis is now regarded as a global public health problem of what is sometimes referred to as epidemic proportions, which has been highlighted in recent years with concern by international bodies such as the WHO and the EU.

Medical and technical developments show that there are good opportunities for preventing, diagnosing and treating osteoporosis at an early stage and thereby preventing fractures. However, far too few within the affected sections of society have sufficient knowledge about osteoporosis to take advantage of these opportunities and other possibilities. Access to bone densitometers is also totally inadequate. The best access within Member States is in Austria, Belgium, Greece and Portugal.

Breast cancer is one of the most common types of cancer among women in the EU and in other industrialised countries, such as the USA and Canada. The number of cases of breast cancer is still rising in the Member States but that may be due to the fact that early detection through mammography X-ray has become more common. Very little research has been carried out hitherto into the causes of and risk factors for breast cancer. Existing research shows that the risks increase with age, that heredity is significant, but many women develop cancer without any of those factors.

Chronic fatigue syndrome and fibromyalgia affect women more often than men. There is great uncertainty about the causes and symptoms of these diseases, which means that patients often have to take it upon themselves to find help. Moreover, there is a risk that they are turned away by medical staff if they are perceived as problematic or demanding. Women's perception of the disease is questioned, the complaints are wrongly psychologised and negative typifications of the diagnoses are made, according to interviews conducted with women who have these diseases. So that patients with chronic fatigue syndrome and fibromyalgia can receive treatment on equal terms, there is a need to change the attention they receive in the care system.[1]

Eating disorders, e.g. bulimia nervosa and anorexia, have increased particularly among young women. This is often explained by the fashion industry's and the media's fixation with slimming and appearance. Extremely few scientific studies have been carried out into the problems of eating disorders. Some of these show that there may also be links with abuse and violence in families.[2] Since there is huge ignorance in this area, there is a need for research to explain and thereby prevent these disorders and, by taking appropriate measures, help young women who are already affected.

[1] The journal 'Smärta', No 2/2004, Åsbring, Pia.
[2] WHO World Report on Violence and Health 2002, Heise Lori et al Population Report: Ending Violence against women, John Hopkins School of Public Health 1999.

Both men and women are dependent on care and attention at various stage of their lives - as children, adults, as they age and in the final phase of life. Both genders must therefore not only receive care but also be able to give care and attention. It is high time that men were involved in this unpaid work. This is of great significance for both men's and women's health. Let us hope that in the near future we will share both unpaid and paid work in an equal way and that unpaid work will then no longer be seen as a woman's responsibility but as a human responsibility.

PROCEDURE

Title	Gender discrimination and health systems
Procedure number	2004/2218(INI)
Basis in Rules of Procedure	Rule 45
Committee responsible Date authorisation announced in plenary	FEMM 18.11.2004
Committee(s) asked for opinion(s) Date announced in plenary	ENVI 18.11.2004
Not delivering opinion(s) Date of decision	ENVI 30.11.2004
Enhanced cooperation Date announced in plenary	 0.0.0000
Motion(s) for resolution(s) included in report	
Rapporteur(s) Date appointed	Eva-Britt Svensson 25.11.2004
Previous rapporteur(s)	Eva-Britt Svensson
Discussed in committee	26.5.2005 14.7.2005
Date adopted	14.7.2005
Result of final vote	for: 21 against: 2 abstentions: 5
Members present for the final vote	Edit Bauer, Nicole Fontaine, María Esther Herranz García, Lívia Járóka, Emine Bozkurt, Hiltrud Breyer, Edite Estrela, Věra Flasarová, Lissy Gröner, Zita Gurmai, Anneli Jäätteenmäki, Piia-Noora Kauppi, Rodi Kratsa-Tsagaropoulou, Urszula Krupa, Pia Elda Locatelli, Astrid Lulling, Angelika Niebler, Doris Pack, Marie Panayotopoulos-Cassiotou, Christa Prets, Eva-Britt Svensson, Konrad Szymański, Corien Wortmann-Kool, Anna Záborská
Substitutes present for the final vote	Jillian Evans, Sophia in 't Veld, Karin Jöns, Christa Klaß, Marta Vincenzi
Substitutes under Rule 178(2) present for the final vote	
Date tabled – A6	25.7.2005 A6-0250/2005