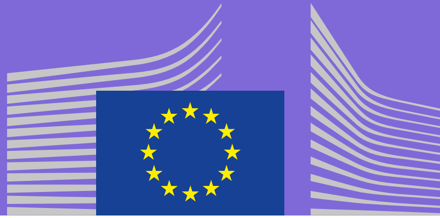

European network of legal experts in gender equality and non-discrimination

Tackling Gender Discrimination and Inequality in Access to Healthcare: scoping possibilities and opportunities for EU law

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Tackling Gender Discrimination and Inequality in Access to Healthcare: scoping possibilities and opportunities for EU law

Authors

Professor Tamara Hervey and Dr Rachel Horton[*]

* We are grateful to Adam Shank for research assistance.

This report has been coordinated by Franka van Hoof and Alexandra Timmer from Utrecht University, for the European network of legal experts in gender equality and non-discrimination.

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Members of the European network of legal experts in gender equality and non-discrimination

Management team

General coordinator	Yvonne van Leeuwen-Lohde	Human European Consultancy
Specialist coordinator gender equality law	Linda Senden	Utrecht University
Lead Coordinator gender equality law	Franka van Hoof	Utrecht University
Specialist coordinator non-discrimination law	Isabelle Chopin	Migration Policy Group
Project managers	Jamie Kaan Anne Meynaar Tobin den Blijker	Human European Consultancy
Content coordinator gender equality law	Birte Böök	Utrecht University
Content coordinator non-discrimination law	Catharina Germaine	Migration Policy Group
Senior coordinator gender equality law	Alexandra Timmer	Utrecht University
Assistant coordinator gender equality law	Luana Almeida	Utrecht University

Senior experts

Senior expert on gender equality law	Susanne Burri
Senior expert on age	Elaine Dewhurst
Senior expert on sexual orientation/trans/intersex people	Peter Dunne
Senior expert on racial and ethnic origin	Lilla Farkas
Senior expert on EU and human rights law	Christopher McCrudden
Senior expert on social security	Frans Pennings
Senior expert on religion or belief	Isabelle Rorive
Senior expert on EU law, CJEU case law, sex, gender identity and gender expression in relation to trans and intersex people	Christa Tobler
Senior expert on disability	Lisa Waddington
Senior expert on equality bodies and enforcement	Niall Crowley
Senior expert on violence against women	Sara de Vido
Senior expert on gender, trans and intersex equality rights	Marjolein van den Brink
Senior expert on pregnancy, maternity, work-life balance rights and social security	Miguel de la Corte Rodríguez
Senior expert on artificial intelligence and human rights, algorithmic discrimination, bias and data-driven inequality	Raphaële Xenidis

National experts

	Anti-discrimination	Gender Equality
Albania	Irma Baraku	Entela Baci
Austria	Dieter Schindlauer	Marion Guerrero
Bosnia and Herzegovina		Adnan Kadribasic
Belgium	Sébastien van Drooghenbroeck* Pieter Cannoot	Nathalie Wuiame
Bulgaria	Dilyana Giteva	Genoveva Tisheva
Croatia	Ines Bojić	Adrijana Martinović
Cyprus	Corina Demetriou	Vera Pavlou
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Denmark	Pia Justesen	Tine Birkelund Thomsen
Estonia	Mari-Liis Sepper	Anu Laas
Finland	Rainer Hiltunen	Kevät Nousiainen
France	Sophie Latraverse	Marie Mercat-Bruns
Germany	Matthias Mahlmann	Jule Mulder
Greece	Athanasios Theodoridis	Panagiota Petroglou
Georgia		Tamar Dekanosidze
Hungary	András Kádár	Lídia Hermina Balogh
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Malta	Tonio Ellul	Romina Bartolo
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Romania	Romanița Iordache	Iustina Ionescu
Serbia	Ivana Krstić Davinic	Ivana Krstić Davinic
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Türkiye	Ulaş Karan	Kadriye Bakirci
Ukraine		Oleksandra Golub
United Kingdom	Lucy Vickers	Rachel Horton

* The network would like to express its sincere gratitude for the valuable contributions of Sébastien Van Drooghenbroeck, dedicated member of the network, who recently passed away. His commitment and insights have left a meaningful mark on our work, and he will be remembered with appreciation and respect.

Executive Summary

Those who are familiar with either European Union equality law, or health law and policy, may be surprised to learn of any relations between the two. Union equality law is best known for its long-standing contribution to promoting equality in the workplace and in social security, and its more recent contributions to combating violence against women. (Gender) equality in health law and policy may seem like a wholly national competence. This first scoping report on the subject shows that, in fact, there are many points of connection between Union (gender) equality law and access to healthcare. Union law affects gender equality in access to healthcare directly and indirectly through a range of legal instruments. Key provisions include the Goods and Services Directive, the 'Recast' Directive, and the Violence Against Women Directive. Many more measures of Union law are also engaged. This legislation is based on a wide range of formal Union competences, including but also going well beyond the 'traditional' Union equality law legislation.

A scoping report of this nature shows the breadth of possibilities for Union law to tackle gender discrimination and inequality in access to healthcare. It can offer depth only in a few selected areas. The report does so, drawing on comparative national expertise from the European Equality Law Network, on personal and material coverage by national healthcare systems, gender-sensitive healthcare, obstetric violence, and sexual harassment/assault in healthcare settings. We consider regulatory matters and the role of national equality bodies in promoting gender equality in access to healthcare.

The opportunities for Union law to contribute to tackling gender discrimination and inequality in access to healthcare are under-appreciated and full of untapped potential. This report – focused only on Union 'internal' law, and excluding Union external relations law – shows the extent of these possibilities.

1 Introduction

Access to healthcare is a fundamental human right.[1] There is, however, evidence of significant gender inequality across the European Union and rest of Europe in both access to healthcare and good health more generally.[2] Patterns of inequality are complex, structural, and very often intersectional.[3] They include: differences in life expectancy between men and women; differences in healthy life expectancy between men and women; unequal outcomes in respect of certain forms of ill health, including mental health;[4] discrimination and inequality in the provision of reproductive and sexual health care services,[5] including contraception, abortion and maternity care; lack of research into conditions and treatment pathways that affect, or predominantly affect one sex;[6] lack of adequate understanding by clinicians about the ways in which conditions common to both sexes may present differently in, or require a different approach to treatment for, men and women; and harassment,[7] stereotyping, prejudice and discrimination in the provision of and at the point of access to healthcare.

It is well established globally that the most effective mechanisms for improving gender equality in access to healthcare involve tackling the underlying determinants of health. Principal among these health determinants is poverty, the biggest indicator of poor health and the need to access healthcare.[8] Access to good quality housing and to education are also critical.[9] To the extent that the Union has improved the standard of living across its Member States, the Union has made a significant contribution in the health domain. Improved economic performance, consequent upon the Union's economic project, plays a role here. But overall improved economic performance is not enough. Further action is necessary to ensure that the benefits of Union membership are enjoyed equally by all, irrespective of protected characteristics. Union (gender) equality law is a very important vector for such action.

The European Commission's 2025 *Roadmap for Women's Rights* includes, in its declaration of women's rights principles for a gender equal society, the principle that 'every woman has a right to the highest attainable

[1] International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 993 UNTS 3, Art. 12(1); Revised European Social Charter (adopted 3 May 1996, entered into force 1 July 1999) ETS No 163, Art. 11, https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-economic-social-and-cultural-rights.

[2] European Commission (2021), *Gender Equality and Health in the EU*, https://data.europa.eu/doi/10.2838/991480; Council of Europe (2017), *Women's Sexual and Reproductive Health and Rights in Europe*, p. 18, https://rm.coe.int/women-s-sexual-and-reproductive-health-and-rights-in-europe-issue-pape/168076dead.

[3] See further below, section 1.3.

[4] European Commission (2023) 'Widening Health-Related Inequalities' (Knowledge4Policy), https://knowledge4policy.ec.europa.eu/foresight/widening-health-related-inequalities_en; European Commission (2025), 'Mental Health', https://health.ec.europa.eu/non-communicable-diseases/mental-health_en.

[5] Council of Europe Commissioner for Human Rights (2024), *Sexual and Reproductive Health and Rights in Europe: Progress and Challenges*, https://rm.coe.int/follow-up-report-on-the-2017-ip-on-srhr-sexual-and-reproductice-health/1680aea9b4.

[6] Criado Perez, C. (2025) 'Male bias is medical trials risks women's lives. But at least the data gap is finally being addressed' *The Guardian*, 9 May 2025, https://www.theguardian.com/commentisfree/2025/may/09/male-bias-medical-trials-women-lives-data-gap; Criado Perez, C. (2019) *Invisible Women: Exposing Data Bias in a World Designed for* Men, Chatto & Windus.

[7] Violence against women and harassment affects up to one-third of all women in the EU; see: European Parliament (2025), *Violence Against Women in the EU: State of Play in 2025* (European Parliamentary Research Service Briefing); European Commission, 'What is gender-based violence?' https://commission.europa.eu/strategy-and-policy/policies/justice-and-fundamental-rights/gender-equality/gender-based-violence/what-gender-based-violence_en; Pedjasaar, V. (2023) 'Violence Against Women: A Public Health Crisis', European Policy Centre, https://epc-web-s3.s3.amazonaws.com/content/PDF/2023/ViolenceAgainstWomen_DP_v4.pdf.

[8] European Commission (2018), *Inequalities in Access to Healthcare – A Study in National Policies 2018*, https://data.europa.eu/doi/10.2767/371408; European Commission (2023), *Report on Access to Essential Services in the EU: Commission staff working document*, p.12, https://employment-social-affairs.ec.europa.eu/report-access-essential-services-eu-commission-staff-working-document_en.

[9] See also: Domurath, I. and Mak, C. (2020) 'Private Law and Housing Justice in Europe', *Modern Law Review* 83(6) 1188; European Institute of Women's Health (2023), *EU Manifesto for Women's Health* (Standing Committee of European Doctors (CPME), https://www.cpme.eu/api/documents/adopted/2023/06/EIWH-Manifesto-for-Women's-Health.pdf.

standards of physical and mental health'.[10] It further notes that, while 'respecting the Member States' responsibilities for the definition of their health policy including bioethical questions and for the organisation of health services and medical care,' steps to be taken to advance this principle should include:

> 'promoting women's and girls' physical and mental health, including through improving access to evidence-based information on women's health and sexuality; protecting women's health by supporting and complementing, in full respect of the Treaties, health action by the Member States regarding women's access to sexual and reproductive health and rights; ensuring respectful and high quality obstetric, gynaecological, antenatal, childbirth and postnatal care, free from discrimination and combating harmful practices; access to affordable menstrual hygiene products and contraception; and gender-sensitive medical research, clinical trials, diagnostics and treatments.'[11]

This report aims to contribute to furthering these objectives, and other objectives of increasing gender equality in access to healthcare in the European Union. It does so by reviewing the scope of relevant Union competences, in the light of values and principles of Union law. The scoping analysis is on three levels: Union law that directly and indirectly provides for gender equality in access to healthcare (both Union equality law and Union internal market and human migration law); other potentially relevant areas of Union law; and Union law that enables gender-supporting investment in national healthcare systems. A fourth level – Union external relations law – is not covered in this scoping report: it would need to be the subject of a separate report. This overview is followed by a comparative analysis of selected aspects of gender equality in access to healthcare, drawing on data from the national experts in the European Equality Law Network (EELN).

1.1 Subject matter and scope

The European Union's actual and potential legal contributions to gender equality in healthcare and public health are dispersed across the *acquis communautaire*.

The scoping report provided in Chapters 2-8 considers 'Union gender equality law' and 'Union health law',[12] both of which are broadly defined. The structure of the scoping report combines the structure used in the European Commission's 2021 report on gender inequality and health;[13] the contours of Union equality law; and Hervey and colleagues' schematic visualisation of Union health law, embodied in the Oxford University Press online encyclopaedia of EU law.[14]

To our knowledge, this is the first such scoping report. It provides an analytical tool for a scoping of Union and national action for compliance with specific Union gender equality obligations, read in the context of the broader gender mainstreaming obligation and equality and non-discrimination as human rights in Union law. This scoping necessarily extends across a wide range of fields of Union competence.[15] The scoping report also

[10] European Commission (2025), *A Roadmap for Women's Rights,* COM (2025) 97, Annex, Principle 2, 7d965089-e332-473a-88a9-e246f214e3bf_en.

[11] European Commission (2025), *A Roadmap for Women's Rights,* COM (2025) 97, pp. 2-3, 7d965089-e332-473a-88a9-e246f214e3bf_en.

[12] For a comprehensive overview, see Hervey, T. and McHale, J. (2015) *European Union Health Law* (Cambridge University Press); Hervey, T. 'EU Health Law (Visualisation)' (MCI Innsbruck), https://research.mci.edu/en/jean-monnet-chair/eu-health-law-en.

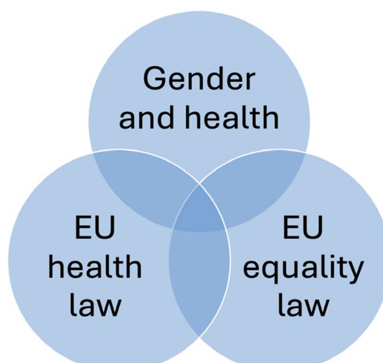
[13] European Commission (2021), *Gender Equality and Health in the EU*, Publications Office of the European Union, https://data.europa.eu/doi/10.2838/991480; Council of Europe (2017), *Women's Sexual and Reproductive Health and Rights in Europe*, p. 18, https://rm.coe.int/women-s-sexual-and-reproductive-health-and-rights-in-europe-issue-pape/168076dead.

[14] Garben, S. and Gormley, L. (eds) (2022), *Oxford Encyclopaedia of EU Law*; see pictogram at https://research.mci.edu/en/jean-monnet-chair/eu-health-law-en.

[15] See further below, Chapter 2, section 2.2.

provides a basis for the potential commissioning of future detailed comparative reports on specific aspects of national practice on gender equality and health, if desired.

Figure 1: The focus of Chapters 2-8 (scoping the field) is at a three-way intersection



The scoping parts of the report sit at a three-way intersection (Figure 1). Note that the Venn diagram implies that the edges of all three categories are agreed and fixed. In fact, although each has a core that is more or less agreed upon, the categories are both disputed and to some extent open-ended.

The report does not include consideration of the gendered dimensions and potentials of global-facing, or external, Union health law, for example work on the new Pandemic Agreement; bilateral cooperation agreements on medicines and substances of human origin (for example with the USA and Canada); work with the Council of Europe such as the European Directorate for the Quality of Medicines & HealthCare (EDQM); and access to essential medicines and vaccines work with the World Health Organisation (WHO). These elements of Union external health law are relevant to a range of gendered issues from health security (for example, because, in general, pandemics affect women worse than men[16]); to medicines supply (ensuring supply of critical medicines with a gendered dimension, for example HRT); to blood, organ and tissue donation (relevant in particular to donation of gametes for reproductive treatments); to safety and post-market vigilance and data gathering on medicines sourced from outside the Union, which needs to be gendered; and so on. These could be the subject of a future report.

1.2 National healthcare systems in the Union[17]

There is no 'Union healthcare system'. Each Member State determines its own national healthcare system, with its own unique history and trajectory. These trajectories have resulted in more than 31[18] unique healthcare systems across the European Union, European Economic Area and the United Kingdom.

[16] Connor, J. and others, (2020) 'Health Risks and Outcomes that Disproportionately Affect Women during the Covid-19 Pandemic: A Review' 266 *Social Science and Medicine* 113364, https://pubmed.ncbi.nlm.nih.gov/32950924/; European Parliament (2021), *COVID-19 and its Economic Impact on Women and Women's Poverty: Insights from 5 European Countries* pp. 41-45, https://www.europarl.europa.eu/RegData/etudes/STUD/2021/693183/IPOL_STU(2021)693183_EN.pdf; European Commission (2021), *Gender Equality and Health in the EU*, pp. 52-55, https://op.europa.eu/en/publication-detail/-/publication/5b59409f-56e4-11eb-b59f-01aa75ed71a1.

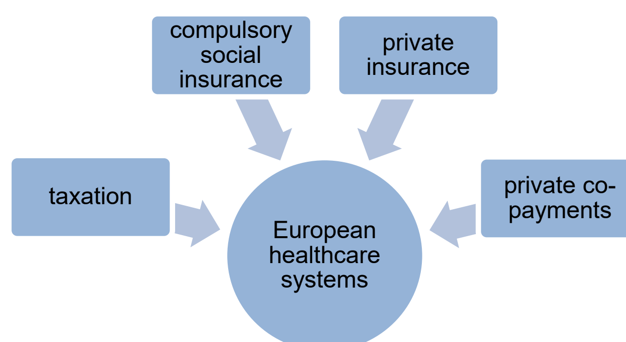
[17] This section draws heavily on Hervey, T. and McHale, J. (2015) *European Union Health Law* (CUP) pp. 213-225.

[18] For example, the UK has more than one healthcare system, with separate systems in Northern Ireland, Scotland and Wales from that in England: Greer, S.L. (2016) 'Devolution and health in the UK: Policy and its lessons since 1998' 118 *British Medical Bulletin* 16, https://doi.org/10.1093/bmb/ldw013.

That said, healthcare systems in Europe share important common features. All European healthcare systems operate, in principle, on the basis of a universal 'right to (minimal necessary) healthcare', recognised in several national constitutions of the Member States[19] and in international law, as well as in the law of the European Union.[20] In principle, such a right to healthcare applies irrespective of ability to pay. It also must be provided on the basis of non-discrimination in terms of 'protected characteristics', such as sex, race,[21] religion, sexuality and age.

To achieve this dignity-based right to healthcare, European healthcare systems operate on the basis of 'solidarity': a redistributive principle of social justice. Affiliation in some way (through payment of taxes or social/occupational insurance) is mandatory: no one may opt out. In the context of a healthcare system, solidarity requires cross-subsidisation of less healthy people from healthier people, which takes place through taxation or compulsory social or occupational insurance. In practice, every contemporary European Union/EEA/UK healthcare system also relies to some extent on private payments, including elements of private health insurance.

Figure 2: Funding sources for European healthcare systems



In European national healthcare systems, healthcare services are delivered to patients either through benefits in kind or through refund/reimbursement. In a benefits-in-kind system, services are received by patients free at the point of receipt. In a reimbursement system, patients choose their healthcare provider (sometimes from a closed list), and a sickness fund repays the expense.

Notwithstanding the shared human rights-based principles of universal access, equality and the redistributive principle of solidarity, the details of healthcare systems within the Union/EEA/UK differ significantly. Differences concern which treatments are covered for whom (the 'basket of care'); how such decisions are made for a particular patient (almost always involving a healthcare professional); where and by whom treatments are provided (for example, hospital, polyclinic, outpatient, specialist healthcare professional, general practitioner, nurse, health visitor). There is no universally accepted taxonomy for reporting such differences.

Commonly found taxonomies for discussing different types of national healthcare system include those based on the balance and patterns of influence of key actors and institutions (for example, the state, the medical

[19] See, for example, the Belgian Constitution, Article 23; the Finnish Constitution, Chapter 2, Section 19(3); the Italian Constitution, Article 32; the Spanish Constitution, Articles 43, 50 and 51.

[20] For discussion, see Hervey, T. and McHale, J. (2014) 'Article 35 – the right to health care' in Peers, S. and others (eds), *The EU Charter of Fundamental Rights: a Commentary*, Hart.

[21] A factor in intersectional analysis that strongly interplays with gender and sex; see González-Rábago, Y., Lanborena, N. and Rodríguez-Álvarez, E. (2025) 'Barriers to healthcare for racialised populations in Europe: a scoping review of reviews' 24 *Int J Equity Health* 212, 5.

profession and private finance); levels of centralisation or decentralisation (for example, Spain, Sweden and Finland have highly decentralised healthcare systems); and legal relationships between healthcare providers (both natural and legal persons) and the state. The extent to which a national healthcare system moves towards a 'planned economy' model or a 'neoliberal market model' is another possible typology.

The most widespread (but ultimately not particularly useful) typology relates to the funding of national healthcare systems: 'Beveridge' versus 'Bismarck'.[22] Under the 'Bismarck' type, healthcare is paid for by compulsory social/occupational insurance. Sickness insurance funds hold employer and employee contributions, from which they pay hospitals, clinics and other healthcare providers, with whom they have contractual relationships. Those who are neither employed/self-employed, nor family members of those who are employed/self-employed, are covered by schemes to 'fill the gaps'. The 'Beveridge' model involves state-owned healthcare institutions, paid for by public taxation. Everyone present in the territory is covered, irrespective of their economic status.

No Member State conforms directly to either the 'Beveridge' or the 'Bismarck' model.

All Member States blend taxation, social/occupational and private insurance in their national healthcare systems and thus all have adopted a hybrid model in terms of the Bismarck/Beveridge taxonomy. Because of this, distinctions in Union (equality) law between 'social insurance', 'occupational insurance', and 'taxation' make little sense in the context of securing equality in national healthcare systems. We elaborate this below.

1.3 Definitions

Access to/supply of healthcare: Discussion of supply of/access to healthcare within the report covers three interconnected concepts. The report considers the formal legal entitlement to medical treatment within a national healthcare system (known as the 'basket of care'), a matter of national competence, but affected by Union equality, criminal justice, asylum, internal market and citizenship law. It also considers decision making on what falls within that 'basket of care' (health technology assessment). Specific European Union law on vulnerable women and girls, especially asylum seekers and refugees, concerns entitlements to access certain types of healthcare, particularly mental healthcare. The report also considers the *practical* access to medical treatment to which a patient is legally entitled under a national healthcare system (whether funded predominantly through social insurance or through taxation). Thirdly, where relevant, the report considers permitted privately-paid access to medical treatments within a particular state. The latter is also affected by European Union internal market law, particularly on freedom to provide and receive cross-border services. These are all specific instances of the 'right to healthcare' in European Union law.

Basket of care: the formal legal entitlement to medical treatments within a national healthcare system. Also known as the 'health benefit basket', 'benefit package' or 'benefit catalogue', this term refers to the taxonomy of benefit catalogues for curative services within a national healthcare system.[23] These can be more or less explicit, depending on national approaches. The details of the 'basket of care' vary quite significantly across European Union Member States. Each basket of care has three coverage dimensions: population, service, and

[22] For discussion, and explanation of why the distinction is not particularly helpful, see: Dixon, A. and Poteliakhoff, E. (2012) 'Back to the Future: 10 Years of European Health Reforms' 7 *Health Economics, Policy and Law*.

[23] Schreyögg, J. and others, (2005) 'Defining the "Health Benefit Basket" in Nine European Countries: Evidence from the European Union Health BASKET Project' Suppl 1 *European Journal of Health Economics* 2, https://pmc.ncbi.nlm.nih.gov/articles/PMC1388078/.

cost. Population coverage determines who has access to a particular healthcare service or benefit from the national healthcare system. Service coverage determines which healthcare services are covered (the actual treatments and so on that patients may access). Cost coverage concerns what aspects of healthcare access are covered by prepaid financial resources (from taxation or social insurance) rather than cost-sharing requirements where patients must pay for aspects of their healthcare (for example, where patients must pay a contribution towards prescription medicines).

Gender: In common with contemporary global understandings, the authors consider 'gender' to be socially constructed. Contemporary[24] science[25] explains how, for humans,[26] 'biological sex' (referring to females and males by reference to different biological and physiological characteristics, such as chromosomes, hormones and reproductive organs),[27] when viewed as a binary category, and thus excluding intersex people,[28] is *also* socially constructed. We take the view that, in scientific epistemic communities such as biomedicine, as well as in how the law applies in health domains such as healthcare systems, social insurance for ill health, and public health, convenience has resulted in reliance upon binary categories that exclude some people both in terms of their biological sex and in terms of their gender.

Therefore, the scope of this report, which looks at European Union law on gender equality/non-discrimination and health, covers the position of both cis-gender men (for example, who have on average a shorter lifespan than women); and cis-gender women (for example, who have higher morbidity; and experience the 'gender pain gap'). In keeping with Union law's ameliorative approach to equality law, greater attention is paid to the legal position of women and girls. Future reports could build on the European Commission's 2018 work on trans and intersex equality rights in Europe,[29] noting that queer/trans-gender/intersex people are least well served in healthcare systems and public health systems precisely because biomedicine tends to be constructed based on binaries and the binary gender assigned at birth.

Intersectionality: Where appropriate, the report considers intersectional disadvantage with other characteristics protected in European Union equality law: chiefly nationality and migration status, and age. Intersectionality, as conceived by Kimberlé Crenshaw,[30] concerns '[regarding individual characteristics] where power comes and collides, where it interlocks and intersects',[31] and the resulting system of disadvantage. Intersectionality, which differs fundamentally from a 'multiple discrimination' approach,[32] seeks to capture the

24 See Boggs, C., Bolnick, D. and Ware, J. (2025) 'Letter to the US President and Congress', https://www.evolutionsociety.org/news/display/2025/2/7/letter-to-the-us-president-and-congress-on-the-scientific-understanding-of-sex-and-gender/.

25 Ainsworth, C. (2015) 'Sex redefined', *Nature* 518, pp. 288–291, https://doi.org/10.1038/518288a.

26 Goymann, W., Brumm, H., Kappeler, P. (2023) 'Biological sex is binary, even though there is a rainbow of sex roles' 45 *BioEssays*, https://doi.org/10.1002/bies.202200173.

27 WHO (2025), 'Health Topics Overview', https://www.who.int/europe/health-topics/gender#tab=tab_1; Montañez, A. (2021) 'Beyond XX and XY', *Scientific American*, infographic available here: https://www.genderinclusivebiology.com/newsletter/poster-beyond-xx-and-xy.

28 See table: 'the sex spectrum', in Ainsworth, C. (2015) 'Sex redefined', *Nature* 518 https://www.nature.com/articles/518288a/tables/1.

29 Van den Brink, M. and Dunne, P. (2018), *Trans and Intersex Equality Rights in Europe – A Comparative Analysis*, European network of legal experts in gender equality and non-discrimination, https://www.equalitylaw.eu/downloads/4739-trans-and-intersex-equality-rights-in-europe-a-comparative-analysis-pdf-732-kb.

30 Crenshaw, K. (1991) 'Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color' 43 *Stanford Law Review* 1241; see also: Salem, S. and Jibrin, R. (2015) 'Revisiting Intersectionality: Reflections on Theory and Praxis', University of California, Santa Barbara, https://cpb-us-e2.wpmucdn.com/sites.uci.edu/dist/f/1861/files/2014/10/2015 5 salem.pdi; Roig, E. (2018) 'Intersectionality in Europe: a Depoliticized Concept?', *Volkerrechtsblog*, 6 March 2018, https://voelkerrechtsblog.org/intersectionality-in-europe-a-depoliticized-concept/.

31 Columbia Law School (2017) 'Kimberlé Crenshaw on Intersectionality, More Than Two Decades Later', news article, 8 June 2017, https://www.law.columbia.edu/news/archive/kimberle-crenshaw-intersectionality-more-two-decades-later.

32 For a conceptual overview, see Schiek, D. and Lawson, A. (eds) (2011), *European Union Non-Discrimination Law and Intersectionality*, 2nd edition, Routledge. See also: Fredman, S. (2016), *Intersectional Discrimination in EU Gender Equality and Non-*

compounded disadvantages experienced by women situated at the intersection of gender and other legally protected characteristics. Intersectional discrimination has been recognised in Union law,[33] but only relatively recently, in the context of equal pay transparency.[34] This report aims to analyse the substantive inequality outcomes that intersectional dynamics produce, especially for those whose lived experiences are shaped by both gender and migration-related and/or nationality-based inequalities in access to healthcare and medicine. The report does not cover the intersection with social care or disability rights.

Healthcare regulatory and supervisory bodies: These may include statutory or independent professional regulatory bodies (bodies responsible for registration, standard setting, training and disciplinary action for medical professionals) and bodies responsible for inspecting, reporting and enforcing safety and quality standards in the provision of healthcare.

National healthcare system: The report uses the term 'national healthcare system' to describe the system through which a Member State provides healthcare services to its population. Union Member States' national healthcare systems share four features: a dignity-based 'right to healthcare'; reliance on the concept of 'solidarity'; respect for equality; and reform pressures, to increase systemic efficiencies. National healthcare systems may be classified according to institutional structures; administrative or legal structures; or funding approaches (sometimes called 'Beveridge' and 'Bismarck'). No Union Member State's national healthcare system represents any 'ideal type'.

Obstetric violence: The report draws on the World Health Organisation's definition of obstetric violence, as adopted in its 2014 statement on the prevention and elimination of disrespect and abuse during facility-based childbirth.[35] Obstetric violence refers to women experiencing 'disrespectful, abusive or neglectful treatment during childbirth in [healthcare] facilities'. Examples include 'outright physical abuse, profound humiliation and verbal abuse, coercive or unconsented medical procedures (including sterilisation), lack of confidentiality, failure to get fully informed consent, refusal to give pain medication, gross violations of privacy, refusal of admission to health facilities, neglecting women during childbirth to suffer life-threatening, avoidable complications, and detention of women and their newborns in facilities after childbirth due to an inability to pay.'[36]

Sexual and reproductive health*:* The report adopts the World Health Organisation's definition of reproductive health:

> 'Sexual and reproductive health refers to a broad range of services that cover access to contraception, fertility and infertility care, maternal and perinatal health, prevention and treatment of sexually

Discrimination Law, European network of legal experts in gender equality and non-discrimination, https://data.europa.eu/doi/10.2838/241520; Center for Intersectional Justice (CIJ) commissioned by the European Network Against Racism (ENAR) (2019), *Intersectional Discrimination in Europe: Relevance, Challenges and Ways Forward*, pp. 13-19; European Commission (2024), *2024 Report on Gender Equality in the EU*, Publications Office of the European Union, Luxembourg, pp. 66-67; Schiek, D. (2016) 'Revisiting Intersectionality for EU Anti-Discrimination Law in an Economic Crisis - a critical legal studies perspective' 2 *Sociologia del Diritto* 22, https://doi.org/10.3280/SD2016-002003.

[33] Directive (EU) 2023/970 of the European Parliament and of the Council of 10 May 2023 to strengthen the application of the principle of equal pay for equal work or work of equal value between men and women through pay transparency and enforcement mechanisms, OJ L132/21, Article 3(2)(e).

[34] For commentary see: Howard, E. (2024) 'Intersectional Discrimination and EU Law: Time to Revisit Parris' 24 *International Journal of Discrimination and the Law* 292; Dube, N. (2024) 'Taking Stock of the EU Pay Transparency Directive's Intersectional Approach', *European Equality Law Review* pp. 43-57.

[35] World Health Organisation (2014), *The prevention and elimination of disrespect and abuse during facility-based childbirth* https://iris.who.int/server/api/core/bitstreams/a287bfd1-97c0-4af6-ba57-a4469f1d3ed8/content.

[36] World Health Organisation (2014), The prevention and elimination of disrespect and abuse during facility-based childbirth, p 1.

transmitted infections (STIs), protection from sexual and gender-based violence, and education on safe and healthy relationships.

Experiencing sexual and reproductive health means that a person has complete physical, mental and social well-being in all matters relating to their reproductive system and its functions. In everyday life, this means that people are able to have satisfying and safe sex lives, to have healthy pregnancies and births, and decide if, when and how often to have children.

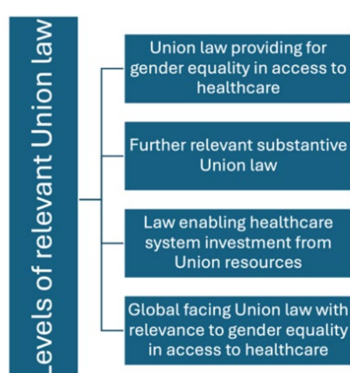
Access to sexual and reproductive health services is a human right and should be available to all people throughout their lives, as part of ensuring universal health coverage. This not only contributes to improved health outcomes, but also to gender equality and wider development.'

Solidarity: Following the influential definition developed by Prainsack and Buyx,[37] solidarity 'signifies shared practices reflecting a collective commitment to carry "costs" (financial, social, emotional, or otherwise) to assist others'. European healthcare systems are examples of solidaristic institutions.[38] 'In European healthcare systems, solidarity refers to the collective commitment to organise healthcare in such a way that people contribute to it according to their means and receive support according to their need. In its institutionalised form, health solidarity works through risk sharing and through redistribution: in European healthcare systems health risks are collectivised through mandatory (public) insurance or tax funded healthcare, or both measures combined. Redistribution is organised through residents of a country contributing to a central entity according to their (economic or other) ability, and in turn receiving support from that entity on the basis of need.'[39]

1.4 Overview of the Report

The report has 10 chapters. After this introduction, the first part (Chapters 2-8) scopes the legal dimensions of the Union's contribution and potential contributions (including currently untapped legal potential) to gender equality in access to healthcare. It does so on three levels (Figure 3).

Figure 3: The levels of scoping analysis



[37] Prainsack, B. and Buyx, A. (2012) 'Solidarity in Contemporary Bioethics– towards a new approach' 26 Bioethics, https://pubmed.ncbi.nlm.nih.gov/22827315/.

[38] De Ruijter, A., Hervey, T. and Prainsack, B. (2024) 'Solidarity and Trust in European Union Health Governance – Three Ways Forward' 46 Lancet Regional Health Europe, p. 1, https://pubmed.ncbi.nlm.nih.gov/39529813/.

[39] De Ruijter, A., Hervey, T. and Prainsack, B. (2024) 'Solidarity and Trust in European Union Health Governance – Three Ways Forward' 46 Lancet Regional Health Europe, p. 2.

At the first level, the report considers Union law directly (Chapter 3) and indirectly (Chapter 4) providing for gender equality in access to healthcare. It begins with Union law applicable to recipients and/or providers of healthcare within all Member States of the Union, without the need for a cross-border element or movement across Union borders. First, it considers Union legislation directly providing rights to gender equality in access to healthcare (or, to put it another way, healthcare services provision) to all people. It focuses particularly on the entitlements of women to equal access to healthcare within that legislation. Then the report turns to Union legislation which provides rights to gender equality in access to healthcare (healthcare services provision) to specific categories of women and girls, particularly vulnerable women and girls.

Still at the first level, the report (Chapter 4) considers the indirect impact of Union gender equality law on access to healthcare, especially through the impacts of Union equality law on healthcare services provision. Here, the report covers Union employment equality law and health and safety law as it applies to healthcare professionals. Union law plays a crucial role in this regard, by supporting and enabling women to access all parts of the healthcare professional workforce. The presence of women within all levels of that workforce indirectly determines greater gender equality in access to healthcare services.

The report's focus moves to Union law applicable in internal European Union cross-border situations (Chapter 5). This includes patients' rights to access cross-border healthcare, relevant for access to healthcare services like abortion and gender-affirming treatment.

Chapter 6 considers Union law applicable at the Union's external border. These provisions of Union law relate to the Union's obligation – and that of its Member States – to protect the human right to healthcare, as found in international conventions such as the Convention on the Elimination of all forms of Discrimination against Women (CEDAW) 1979, Article 12.[40] The Union has not ratified CEDAW, but all its Member States have, and CEDAW thus 'complements the [Union's] legal protection regime applicable to women and girls, including in the context of refugees'.[41]

At a second level of analysis, the report also scopes substantive areas of Union health law which have a gendered dimension (Chapter 7): on quality and safety of human organs and substances of human origin like blood,[42] the 'European Health Data Space'; and the regulation of medicines and medical devices (such as breast implants)[43] and equipment, including clinical trials. Focusing on non-communicable diseases, the report covers Union law on products that are especially harmful to health, in particular tobacco, alcohol and food. For example, at least for tobacco, Union law has eradicated the kinds of gendered advertisements of the 1950s and 60s that encouraged many girls and women to become addicted to smoking. Union law on communicable diseases, in particular responding to cross-border health threats such as pandemics and health threats

40 See also: UN Division for the Advancement of Women, *General Recommendation No 24: Article 12 of the Convention* (1999), https://www.refworld.org/legal/general/cedaw/1999/en/11953.

41 CJEU, C-621/2, WS v Intervyuirasht organ na Darzhavna agentsia za bezhantsite pri Ministerskia savet, 16 January 2024, ECLI:EU:C:2024:47, para 45.

42 C-528/13 *Geoffrey Léger v Ministre des Affaires socialies, de la Santé et des Droits des femmes and Établissement français du sang*, 29 April 2015ECLI:EU:C:2015:288; see also: Dunne, P. (2015) 'A Right to Donate Blood? Permanent Deferrals for "Men who have Sex with Men" (MSM): Léger' 52 *CML Rev* 1661, https://kluwerlawonline.com/journalarticle/Common+Market+Law+Review/52.6/COLA2015135.

43 C-219/15, *Elisabeth Schmitt v TÜV Rheinland LGA Products GmbH*, 16 February 2017, ECLI:EU:C:2017:128; Verbruggen, P. and van Leeuwen, B. (2018) 'The Liability of Notified Bodies under the EU's new Approach: The Implications of the PIP Breast Implants Case (C219/15)' 43 *EL Rev* 394, https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3038830; see also: Martindale, V. and Menache, A. (2013) 'The PIP Scandal: an analysis of the process of quality control that failed to safeguard women from health risks' 106 *Journal of the Royal Society of Medicine* 173, https://pmc.ncbi.nlm.nih.gov/articles/PMC3676226/.

preparedness law[44] is considered, in terms of the extent to which it is gendered or could be a vector for improving women's access to healthcare.

Finally, a third level of analysis (Chapter 8) covers those dimensions of Union health law that incentivise improvements of and investments in national healthcare systems. To what extent are the contours of Union incentive measures and Union-backed investment supportive of healthcare system development that improves women's access to healthcare and closes the gender gap?

A fourth level, not covered in this report, would concern global-facing Union law. The basis of Union competence in the areas at the second, third and fourth levels rests more heavily on the obligations in Article 8 Treaty on the Functioning of the European Union (TFEU), and Articles 20 and 21 Charter of Fundamental Rights of the European Union (EU CFR)[45] than the areas of Union law at the first level. However, the *potential* of Union law to drive a gender equality agenda in access to healthcare, and indeed to the underlying determinants of health (which themselves determine practical equality in access to healthcare), through these other substantive and institutional vectors of Union law, is significant. Seizing these opportunities and potential would build a 'European Health Union' that respects the value of (gender) equality.

This preliminary scoping report provides more detail on the first level, and much less on the second and third levels. However, a scoping report cannot be exhaustive, and elements of the report even at the first level could be the subject of future, more detailed, reports. The potential of Union law for tackling gender discrimination and inequality in access to healthcare (and the broader determinants of health) in the second, third and fourth levels could also be the subject of future reports.

The coverage of this part of the report is necessarily broad. It reveals potential opportunities, demonstrating both the interconnected nature of gender discrimination in access to healthcare with a wide range of other societal, legal, economic and cultural factors, and the range of potential points of intersection with Union law, and Union competence. Throughout, this part of the report makes recommendations of steps the European Commission could potentially take to improve gender equality in access to healthcare.

The final part of the report (Chapter 9), drawing on information from the EELN national experts, develops a clearer picture of the nature and extent of gender discrimination and inequality in access to healthcare in the Member States and legislative and policy steps taken to address it.

Chapter 9 of the report is not intended to be comprehensive. Rather, the aim is to identify key examples and categories of barriers to equal access to healthcare in the Member States, and map these against existing legal protections, in order to identify important gaps. As a whole, the report assesses the role and potential of the gender equality directives – and broader Union law in relevant domains – in addressing these challenges and in underpinning action to advance gender equality in access to healthcare, including gender sensitive approaches to the provision of healthcare; and identifies possible practical steps for the Commission to take in response. These are drawn together in the report's conclusion (Chapter 10).

[44] European Commission (2025), Proposal for a Regulation of the European Parliament and Council laying a framework for strengthening the availability and security of supply of critical medicinal products as well as the availability of, and accessibility of, medicinal products of common interest, and amending Regulation (EU) 2024/795 COM (2025) 102 final, https://health.ec.europa.eu/document/download/2abe4fc8-059e-47d9-a20a-d9e3bfc5dc2c_en?filename=mp_com2025_102_act_en.pdf.

[45] See further below, Chapter 2.

2 Values, Principles, Competences

This chapter sets the scene by briefly outlining key relevant values and principles of Union law; and discussing relevant Union competences and legal basis provisions in the Treaty on the Functioning of the European Union.

2.1 Values and principles of Union law

The Union is founded on the **values** of respect for **human dignity**, freedom, democracy, equality, the rule of law and respect for **human rights**, including the rights of persons belonging to minorities. These values are common to the Member States in a society in which pluralism, non-discrimination, tolerance, justice, **solidarity** and **equality between women and men** prevail.

Article 2 Treaty on European Union (TEU), emphasis added

The Union's aim is to promote peace, its values and the **well-being** of its peoples.

Article 3 TEU, emphasis added

Values of the Union particularly relevant to the scope of this report are equality between women and men, human dignity, human rights, and solidarity.[46] One of the overall three aims of the Union is to promote the well-being of the Union's 'peoples'.[47] The use of the word 'peoples' here extends the aim beyond Union citizens, and is best interpreted as those resident within the Union. Union external action, which also affects people elsewhere in the world, must also 'be guided by … the universality and indivisibility of human rights and fundamental freedoms, respect for human dignity, the principles of equality and solidarity'.[48] Union international relations must seek, among other things, to safeguard Union values and human rights.[49] This scoping report does not cover the Union's international relations, except concerning Union asylum law.

The 'rights, freedoms and principles' set out in the Union's Charter of Fundamental Rights 2000 (EU CFR) are provisions of primary Union law.[50] Rights guaranteed by the European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR) are 'general principles' of Union law,[51] and the Union 'affirms' rights found in the Council of Europe's European Social Charters.[52]

The right or principle of gender equality is found in both general[53] and specific[54] forms in Union primary law.

[46] Article 2 TEU; Preamble, recital 2 EU CFR.
[47] Article 3 TEU.
[48] Article 21 TEU.
[49] Article 21(2) TEU.
[50] Article 6(1) TEU.
[51] Article 6(3) TEU; Preamble, recital 5 EU CFR.
[52] Preamble, recital 5 EU CFR.
[53] Article 9 TEU; Articles 20, 21 EU CFR.
[54] Article 23 EU CFR; Article 8 TFEU; Article 157 TFEU.

General forms of right to (gender) equality or principle of (gender) equality in Union primary law

'In all its activities, the Union shall observe the principle of the equality of its citizens, who shall receive equal attention from its institutions, bodies, offices and agencies. …'

Article 9 TEU

'Equality before the law
Everyone is equal before the law.'

Article 20 EU CFR

'Non-discrimination
Any discrimination based on any ground such as sex, race, colour, ethnic or social origin, genetic features, language, religion or belief, political or any other opinion, membership of a national minority, property, birth, disability, age or sexual orientation shall be prohibited.'

Article 21 EU CFR

Specific forms of right to gender equality in Union primary law

'Equality between women and men
Equality between women and men must be ensured in all areas, including employment, work and pay.
The principle of equality shall not prevent the maintenance or adoption of measures providing for specific advantages in favour of the under-represented sex.'

Article 23 EU CFR

'In all its activities, the Union shall aim to eliminate inequalities, and to promote equality, between men and women.'

Article 8 TFEU

'Each Member State shall ensure that the principle of equal pay for male and female workers for equal work or work of equal value is applied. …
3. The European Parliament and the Council, acting in accordance with the ordinary legislative procedure, and after consulting the Economic and Social Committee, shall adopt measures to ensure the application of the principle of equal opportunities and equal treatment of men and women in matters of employment and occupation, including the principle of equal pay for equal work or work of equal value.
4. With a view to ensuring full equality in practice between men and women in working life, the principle of equal treatment shall not prevent any Member State from maintaining or adopting measures providing for specific advantages in order to make it easier for the underrepresented sex to pursue a vocational activity or to prevent or compensate for disadvantages in professional careers.'

Article 157 TFEU

Human rights to health and healthcare are found in Article 35 EU CFR and in Articles 11 and 13 of the European Social Charter 1961 and the Revised European Social Charter 1996. Other important human rights in healthcare contexts include the rights to human dignity,[55] life and integrity of the person; respect for private and family life; protection of personal data;[56] freedom of thought, conscience and religion; the right to asylum; rights of

[55] Article 1 EU CFR.
[56] Article 16 TFEU; Article 8 EU CFR; Article 8 ECHR; see also: *Leander v Sweden* (1987) 9 EHRR 433.

the elderly; the right to social security and social assistance; and access to services of general economic interest (which include healthcare services within a national/social insurance healthcare system). More indirectly, especially concerning access of women to healthcare professions, freedom to choose an occupation and the right to work; the right to fair and just working conditions; and the right to reconciliation of family and professional life are all pertinent.

The value or principle of solidarity is the foundational basis of all national healthcare systems within the Member States of the Union, whether funded by taxation, social insurance, or a blend of both. Solidarity is a 'value' of the Union,[57] and is embedded in primary provisions of Union law on 'services of general economic interest',[58] of which healthcare is one.

Services of general economic interest

'… given the place occupied by services of general economic interest in the shared values of the Union as well as their role in promoting social and territorial cohesion, the Union and the Member States, each within their respective powers and within the scope of application of the Treaties, shall take care that such services operate on the basis of principles and conditions, particularly economic and financial conditions, which enable them to fulfil their missions. The European Parliament and the Council, acting by means of regulations in accordance with the ordinary legislative procedure, shall establish these principles and set these conditions without prejudice to the competence of Member States, in compliance with the Treaties, to provide, to commission and to fund such services.'

Article 14 TFEU

In addition to its commitment to values and principles relevant to gender equality in access to healthcare, the Union is under legal obligations to 'mainstream' both equality and 'a high level of … protection of human health'.[59] Mainstreaming obligations apply both to the legislative process, and to the interpretation of Union law.

Equality 'mainstreaming' provisions

'In all its activities, the Union shall observe the principle of the equality of its citizens, who shall receive equal attention from its institutions, bodies, offices and agencies.'

Article 9 TEU

'In all its activities, the Union shall aim to eliminate inequalities, and to promote equality, between men and women.'

Article 8 TFEU

[57] Article 2 TEU.
[58] Article 14 TFEU.
[59] Article 9 TFEU; Article 168(1) TFEU.

‘In defining and implementing its policies and activities, the Union shall aim to combat discrimination based on sex, racial or ethnic origin, religion or belief, disability, age or sexual orientation.’

Article 10 TFEU

Health ‘mainstreaming’ provisions

‘In defining and implementing its policies and activities, the Union shall take into account requirements linked to the promotion of a high level of employment, the guarantee of adequate social protection, the fight against social exclusion, and a high level of education, training and protection of human health.’

Article 9 TFEU

‘A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities.’

Article 168 (1) TFEU

The obligation in Article 8 TFEU, that ‘In all its activities, the Union shall aim to eliminate inequalities, and to promote equality, between men and women’, applies across every area where Union law concerns health. The gender mainstreaming obligation applies not only when the European Commission proposes and Parliament and Council adopt new primary legislation. It also applies when the Commission implements Union primary law, especially through delegated and implementing instruments, and through soft law interpretative recommendations and guidelines; and when the Union deploys funding, or other ‘steering’ instruments designed to incentivise particular behaviours among the Member States and/or other entities or actors. Article 8 TFEU also imposes an obligation of interpretation, so that a more gender equality supporting interpretation of Union law is to be preferred over one that is less equality supporting. Although Article 8 TFEU applies only to the Union institutions, a similar obligation, as a general principle of Union law, embodied in Articles 20 and 21 EU CFR, applies to the Member States when they implement Union law.

2.2 Union competences and relevant legal bases of Union law

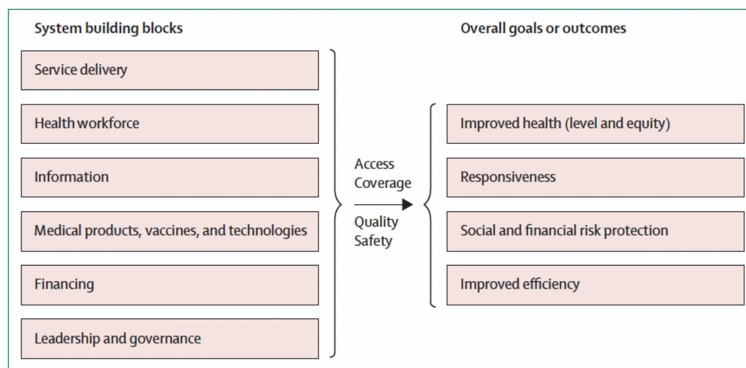
What then are the areas where Union law concerns health, to which such an obligation applies? Union gender equality law and Union health law may both be described as ‘transversal’ in that Union competence to act within those domains is dispersed across the Treaty on the Functioning of the European Union, rather than being contained within one specific legal basis provision alone.

Although many matters pertaining to healthcare are national competences,[60] the Union’s ‘transversal’[61] health law now spans a wide field, covering in some way almost every aspect of healthcare systems (see Figure 4

[60] Article 4(1) TEU; Article 5 TEU; Article 168(7) TFEU.
[61] Hervey, T. (2022) ‘Health Law’ in Garben, S. and Gormley, L. (eds), *Oxford Encyclopaedia of EU Law,* OUP, https://opil.ouplaw.com/display/10.1093/law-oeeul/law-oeeul-e148?print=pdf.

below),[62] and preventive public health.[63] This field includes both access to healthcare and the broader determinants of health. Here we focus on the transversal competences relevant to gender equality in access to healthcare, while acknowledging that healthcare needs are affected significantly by the broader determinants of health.[64]

Figure 4: The World Health Organisation health system framework:[65]



The Union's competence in health and healthcare begins with Article 168 TFEU, but it does not end there.

Article 168 TFEU

1. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities.

Union action, which shall complement national policies, shall be directed towards improving public health, preventing physical and mental illness and diseases, and obviating sources of danger to physical and mental health. Such action shall cover the fight against the major health scourges, by promoting research into their causes, their transmission and their prevention, as well as health information and education, and monitoring, early warning of and combating serious cross-border threats to health.

The Union shall complement the Member States' action in reducing drugs-related health damage, including information and prevention.

2. The Union shall encourage cooperation between the Member States in the areas referred to in this Article and, if necessary, lend support to their action. It shall in particular encourage cooperation between the Member States to improve the complementarity of their health services in cross-border areas.

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62 For a schematic classification of a healthcare system, see WHO (2007), *Everybody's business: strengthening health systems to improve health outcomes: WHO's framework for action*. For an explanation of how EU law covers every aspect of a healthcare system, see Fahy, N., Hervey, T., Greer, S., Jarman, H., Stuckler, D., Galsworthy, M. and McKee, M. (2017) 'How will Brexit affect health and health services in the UK? Evaluating three possible scenarios against the WHO health system building blocks' *The Lancet* 390(10107): 2110, http://dx.doi.org/10.1016/S0140-6736(17)31926-8.

63 Article 4(2)(a), (j), (f), (k) and (3) TFEU; Article 6(a) TFEU; Article 48 TFEU; Article 168(4) TFEU. For a comprehensive overview, see also: Hervey, T. and McHale, J. (2015) *European Union Health Law*; for a schematic visualisation, see also: Hervey, T. 'EU Health Law (Visualisation)' (MCI Innsbruck), https://research.mci.edu/en/jean-monnet-chair/eu-health-law-en.

64 World Health Organisation (2025), World Report on Social Determinants of Health Equity.

65 See: https://www.who.int/publications/i/item/everybody-s-business----strengthening-health-systems-to-improve-health-outcomes, p 3.

Member States shall, in liaison with the Commission, coordinate among themselves their policies and programmes in the areas referred to in paragraph 1. The Commission may, in close contact with the Member States, take any useful initiative to promote such coordination, in particular initiatives aiming at the establishment of guidelines and indicators, the organisation of exchange of best practice, and the preparation of the necessary elements for periodic monitoring and evaluation. The European Parliament shall be kept fully informed.

3. The Union and the Member States shall foster cooperation with third countries and the competent international organisations in the sphere of public health.

4. By way of derogation from Article 2(5) and Article 6(a) and in accordance with Article 4(2)(k) the European Parliament and the Council, acting in accordance with the ordinary legislative procedure and after consulting the Economic and Social Committee and the Committee of the Regions, shall contribute to the achievement of the objectives referred to in this Article through adopting in order to meet common safety concerns:

(a) measures setting high standards of quality and safety of organs and substances of human origin, blood and blood derivatives; these measures shall not prevent any Member State from maintaining or introducing more stringent protective measures;

(b) measures in the veterinary and phytosanitary fields which have as their direct objective the protection of public health;

(c) measures setting high standards of quality and safety for medicinal products and devices for medical use.

5. The European Parliament and the Council, acting in accordance with the ordinary legislative procedure and after consulting the Economic and Social Committee and the Committee of the Regions, may also adopt incentive measures designed to protect and improve human health and in particular to combat the major cross-border health scourges, measures concerning monitoring, early warning of and combating serious cross-border threats to health, and measures which have as their direct objective the protection of public health regarding tobacco and the abuse of alcohol, excluding any harmonisation of the laws and regulations of the Member States.

6. The Council, on a proposal from the Commission, may also adopt recommendations for the purposes set out in this Article.

7. Union action shall respect the responsibilities of the Member States for the definition of their health policy and for the organisation and delivery of health services and medical care. The responsibilities of the Member States shall include the management of health services and medical care and the allocation of the resources assigned to them. The measures referred to in paragraph 4(a) shall not affect national provisions on the donation or medical use of organs and blood.

Article 168 TFEU thus grants legislative competence to harmonise national law on 'organs and substances of human origin, blood and blood derivatives'[66] (SOHO) and on 'standards of quality and safety for medicinal

[66] Article 168(4)(a) TFEU.

products and devices for medical use'[67] (medicines and medical devices). For non-harmonising measures 'improving public health, preventing physical and mental illness and diseases, and obviating sources of danger to physical and mental health', Article 168 TFEU grants supporting and complementary competence, including coordinating competence,[68] such as data gathering and comparison, and exchange of best practice. Member States are legally obliged to collaborate with such coordination.[69] In addition, Article 168 TFEU grants non-harmonising competence to adopt 'incentives' (usually funding) 'designed to protect and improve human health and in particular to combat the major cross-border health scourges, measures concerning monitoring, early warning of and combating serious cross-border threats to health, and measures which have as their direct objective the protection of public health regarding tobacco and the abuse of alcohol'.[70] Some of those powers may be relevant to gender equality in access to healthcare.

Beyond Article 168 TFEU, many legal basis provisions have been used to promote equality and prevent gender discrimination in access to healthcare, or have the potential to do so. The obligation in Article 9 TFEU informs the exercise of a range of competence provisions in the TFEU, which provide the basis for measures of Union health law across most of the components of a healthcare system, and provision for legal measures securing protection of public health and promotion of preventative health policies, for both communicable and non-communicable diseases. Principal among these competence provisions is Article 114 TFEU on competence to regulate the internal market (both goods and services). Union law that regulates the internal market – both legislation and case law of the CJEU – has important effects on healthcare, healthcare systems, and public/preventative health. Union law on human migration, both within the Union and into the Union, also touches on access to healthcare. Union criminal justice law covers healthcare needs of victims of violence.

Table of legal basis provisions, directly and indirectly relevant to this scoping report, numerical order in TFEU

Provision	Area (summary)	Power	Procedure
Article 16 TFEU	Personal data protection	'rules' on processing personal data applicable to Union institutions and MS in scope of Union law	Ordinary
Article 18 TFEU	Nationality discrimination	'rules' to prohibit nationality discrimination	Ordinary
Article 19 (1) TFEU	General non-discrimination including sex	'appropriate action'	Council unanimity Parliament consent
Article 19 (2) TFEU	Ditto	'incentive measures' excluding harmonisation	Ordinary
Article 21 (1)	EU citizens' rights to	'provisions' facilitating exercise of free	Ordinary, but residual

[67] Article 168(4)(c) TFEU.
[68] Article 168(2) TFEU.
[69] Article 168(2) TFEU, para 2.
[70] Article 168(5) TFEU.

Provision	Area (summary)	Power	Procedure
and (2) TFEU	move freely	movement rights	
Article 21 (3) TFEU	Ditto	'measures concerning social security or social protection' to facilitate exercise of free movement of EUCs	Council unanimity, Parliament consent, residual
Article 26 (1) TFEU	Internal market (not free-standing)	'measures' for establishing or functioning of internal market	'In accordance with relevant' other treaty provisions
Article 46 TFEU	Free movement of workers	'directives or regulations'	Ordinary
Article 48 TFEU	Social security for free movement of workers	'measures'	Ordinary, unless suspended
Article 50 TFEU	Freedom of establishment	'directives'	Ordinary
Article 53 (1) and (2) TFEU	Mutual recognition of diplomas	'directives'; coordination required for conditions of exercise for 'medical and allied and pharmaceutical professions'	Ordinary
Article 82 (2) TFEU	Police and judicial cooperation in criminal matters, including the rights of victims of crime	'directives'; 'minimum rules'; taking 'into account the differences between the legal traditions and systems of the Member States'	Ordinary
Article 114 TFEU	Internal market	'measures' with their 'object the establishment and functioning of the internal market': 'an area without internal frontiers in which the free movement of goods, persons, services and capital is ensured' (Article 26 TFEU)	Ordinary, residual
Article 122(1) and (2) TFEU	Emergencies	'measures appropriate to the economic situation' 'financial assistance'	Council on Commission proposal Parliament informed
Article 153(1) and (2) TFEU	Social policy including 'workers health and safety'; 'working conditions'; 'equality between men and women with regard to	'directives' with 'minimal requirements for gradual implementation'	Ordinary

Provision	Area (summary)	Power	Procedure
	labour market' opportunities and treatment at work'		
Article 157(3) TFEU	Equality in employment and occupation	'measures' to ensure equal opportunities and equal treatment, including equal pay	Ordinary
Article 168(2) TFEU	Coordination to improve public health	'any useful initiative to promote such coordination'	European Commission
Article 168(4) TFEU	Quality and safety of SOHO, medicines and medical devices	'measures'	Ordinary
Article 168(5) TFEU	To protect and improve human health	'incentive measures'	Ordinary
Article 175 and 177 TFEU	Cohesion	'define tasks, priority objectives and organisation of the Structural Funds'	Ordinary
Article 216 TFEU	International Agreements	'where necessary to achieve ... one of the objectives referred to in the Treaties	Procedure in Article 218, involves European Parliament in most instances
Article 311 TFEU	Own resources	'provisions relating to the system of own resources for the Union'	Council unanimity, consulting European Parliament
Article 322 TFEU	Union budget	rules, methods and procedures for Union budget, including own resources	Ordinary
Article 352 TFEU	Flexibility clause	'necessary action' to obtain a Treaty objective; 'measures'	Council unanimity, consulting European Parliament, residual

3 Union law directly providing for gender equality in access to healthcare

The Union's gender equality directives directly grant rights to non-discrimination on grounds of sex/gender to patients and to healthcare professionals within the Union. Unlike Union internal market law,[71] these instruments apply without the need for any cross-border dimension. Equal access to healthcare for patients is covered by Union law on equal treatment in sickness insurance schemes[72] and in access to goods and services.[73]

3.1 Union law directly providing rights to gender equality in access to healthcare (healthcare services provision) to all (women)

Key legal instruments
Directive 2004/113/EC on equal treatment between men and women in the access to and supply of goods and services
Directive 79/7 on the progressive implementation of the principle of equal treatment for men and women in matters of social security
Directive 2006/54/EC on the equality treatment of men and women in matters of employment and occupation (recast)

3.1.1 The Scope of Directive 2004/113

Directive 2004/113 (the Goods and Services Directive), provides that

> 'Within the limits of the powers conferred upon the [Union], this Directive shall apply to all persons who provide goods and services, which are available to the public irrespective of the person concerned as regards both the public and private sectors, including public bodies, and which are offered outside the area of private and family life and the transactions carried out in this context.'[74]

The provision goes on to delineate five explicit exceptions: freedom to choose a contractual partner (but such choice must not be based on the partner's sex);[75] the content of media and advertising;[76] education;[77]

[71] See further below, chapter 5.
[72] Directive of the Council 79/7/EEC of 19 December 1978 on the progressive implementation of the principle of equal treatment for men and women in matters of social security OJ L 6, 10.1.1979, pp. 24–25, Article 3(1) and Article 4; see also the recent study by the European network of legal experts in gender equality and non-discrimination: Eleveld, A. and Wesselius, E. (2025) *Gender Equality in Statutory Social Security: the Future of Directive 79/7*, pp. 52, 56, https://www.equalitylaw.eu/downloads/6246-gender-equality-in-statutory-social-security-the-future-of-directive-79-7.
[73] Directive of the Council 2004/113/EC of 13 December 2004 implementing the principle of equal treatment between men and women in the access to and supply of goods and services OJ L 373, 21.12.2004, 37–43.
[74] Directive 2004/113, Article 3(1).
[75] Directive 2004/113, Article 3(2).
[76] Directive 2004/113, Article 3(3).
[77] Directive 2004/113, Article 3(3).

employment and occupation;[78] self-employment if covered elsewhere in Union legislation.[79] None of these exceptions affects healthcare directly, although the media and advertising one has an indirect effect.[80]

This definition of scope gives rise to at least four potential issues:

First, unlike Directive 2000/43 (the Racial Equality Directive),[81] Directive 2004/113 does not expressly include healthcare within its scope. The lack of express inclusion is not, however, decisive. The preamble, provisions of which are persuasive when interpreting the binding provisions of a directive,[82] makes reference to healthcare by way of an example of a situation in which different treatment may not amount to discrimination, noting that 'differences between men and women in the provision of healthcare services, which result from the physical differences between men and women, do not relate to comparable situations and therefore, do not constitute discrimination'.[83] This example suggests that different treatment does not fall within the definition of discrimination, but the provision does not directly address the question of the Directive's scope. If anything, it should be read to imply that healthcare falls within the Directive's scope, because otherwise there would be no need to include the example.

Secondly, the Directive applies 'within the limits of powers conferred upon the [Union]'.[84] Union powers, or competence, in healthcare are both explicit and implicit. In terms of explicit provision, Member States are in principle responsible for 'the definition of their health policy and for the organisation and delivery of health services and medical care', including 'the management of health services and medical care and the allocation of the resources assigned to them'.[85] However, in practice and by implication, Union competence extends to many aspects of healthcare within the Member States, through the 'web of competences'[86] enjoyed by the Union in the healthcare domain.[87] The provision of Directive 2004/113 referring to the limits of Union powers does not assist in determining where those competence limits lie. The inclusion of healthcare within the Race Equality Directive can be read to suggest that regulation of healthcare in the equality domain falls within implicit Union competence.

Thirdly, when determining scope, regard should be had to the mainstreaming obligations in Articles 8 and 9 TFEU. In all its activities, the Union must seek to promote both gender equality and the protection of human health. These activities include securing gender equality in access to goods and services.

Fourthly, Directive 2004/113 covers the provision of services 'irrespective of the person concerned as regards both the public and private sectors, including public bodies'. This means that the Directive applies to service provision that is based on private contractual relationships, but also to service provision based on public or administrative law relationships. Unlike in internal market law, where a 'service' must be 'provided for

78 Directive 2004/113, Article 3(4).
79 Directive 2004/113, Article 3(4).
80 See further below, on tobacco advertising.
81 Directive 2000/43, Article 3(1)(e): 'social protection, including social security and healthcare'.
82 See: C-24/62, Federal Republic of Germany v Commission of the European Economic Community 4 July 1963, ECLI:EU:C:1963:14 para. 18; see also: Humphreys and others (2015), 'Mapping Recitals to Normative Provisions in EU Legislation to Assist Legal Interpretation' 279 Legal Knowledge and Information Systems: JURIX 2015: The Twenty-Eighth Annual Conference, https://icr.uni.lu/leonvandertorre/papers/jurix2015.pdf.
83 Directive 2004/113, Preamble, Recital 12.
84 Directive 2004/113, Article 3(1).
85 Article 168(7) TFEU.
86 Purnhagen and others (2020), 'More Competences than You Knew? The Web of Health Competence for European Union Action in Response to the COVID-19 Outbreak' European Journal of Risk Regulation 1, https://pmc.ncbi.nlm.nih.gov/articles/PMC7188958/.
87 See also Table of Legal Basis, Chapter 2, section 2.2.

remuneration',[88] Directive 2004/113 also covers services where no direct 'remuneration' is offered. This is the case for many healthcare services within the context of national healthcare systems across the European Union, where healthcare is offered to the patient free at the point of treatment. The legal basis for Directive 2004/113[89] reinforces that it is not an instrument of internal market law, provisions of which are based on Article 114 TFEU. Rather, Directive 2004/113 has a wider scope than internal market provisions in this respect. Furthermore, even if the scope were identical to that of internal market law, it is long established that services, in particular healthcare services, do not necessarily need to be paid for by those for whom they are performed,[90] so long as there is remuneration from a third party, such as a sickness insurance fund or national healthcare system funded through taxation.

Fifthly, and relatedly, the Directive only covers services 'offered outside the area of private and family life and the transactions carried out in this context'.[91] The scope of this exception is unclear, but a reasonable interpretation is that care services provided by one member of a family to another member, especially if the relevant individuals are within the same family unit or household (as the domain of 'private and family life') are not included within the Directive. Such care work is a significant burden of women's care work,[92] and the distinction between social care and healthcare in this regard is not a bright-line one.

Whether the scope of Directive 2004/113 extends to healthcare services has not yet been addressed by the CJEU. In our view, along with that of many others,[93] for the reasons given above, the best interpretation of the provisions of the Directive is that it does include within its scope healthcare provided by a national healthcare system and by private providers. Nonetheless it is possible that Member States may not share this view, or that a lack of clarity has resulted in a lack of explicit protection in implementation. The way that the scope is implemented, understood and discussed in the Member States is discussed further in the comparative part of the report.[94]

Recommendation: European Commission issue interpretative guidance confirming that the scope of Directive 2004/113 extends to healthcare services.[95]

3.1.2 Exclusions within Directive 2004/113 and its approach

Directive 2004/113 sets out three circumstances under which different treatment of women and men, generally or in relation to healthcare specifically, may be permitted.[96] Both provisions must be interpreted by reference

[88] As discussed in the case law in Hervey, T. and McHale, J. (2015) European Union Health Law, pp. 76-77.

[89] Article 13(1) TFEU.

[90] C-157/99, Geraets-Smits v Stichting Ziekenfonds en Peerbooms v Stichting CZ Groep Zorgverzekeringen, 12 July 2001, ECLI:EU:C:2001:404.

[91] Directive 2004/113, Article 3(1).

[92] European Commission (2022), 2022 Report on Gender Equality in the EU, pp. 33, https://commission.europa.eu/system/files/2023-03/annual_report_GE_2022_printable_EN.pdf.

[93] Orzechowski, M., Nowak, M., Bielińska, K. and others (2020), 'Social Diversity and Access to Healthcare in Europe: How Does European Union's Legislation Prevent from Discrimination in Healthcare?' 20 BMC Public Health 1399, 4, https://doi.org/10.1186/s12889-020-09494-8; Caracciolo di Torella, E. (2021), Directive 2004/113/EC on Gender Equality in Goods and Services – In Search of the Potential of a Forgotten Directive, European Equality Law Network, pp. 52-56, https://www.equalitylaw.eu/publications/thematic-reports; Di Federico, G. (2017) 'Access to Healthcare in the European Union: Are EU Patients (Effectively) Protected Against Discriminatory Practices?' in Rossi, L. and Casolari, F. (eds), The Principle of Equality in EU Law, Springer, https://doi.org/10.1007/978-3-319-66137-7_8, arguing that protections are insufficient and uneven in practice.

[94] See Chapter 9, section 9.2.

[95] Note a similar recommendation is made in Caracciolo di Torella, E. (2021), Directive 2004/113/EC on Gender Equality in Goods and Services – In Search of the Potential of a Forgotten Directive, European Equality Law Network, p. 100, https://www.equalitylaw.eu/publications/thematic-reports.

[96] Directive 2004/113, Article 4 (2), Article 4(5) and Article 6. See also Recital 12. See Chapter 9, section 9.2.2.

to Recital 12, which states that 'differences between men and women in the provision of healthcare services, which result from the physical differences between men and women, do not relate to comparable situations and therefore, do not constitute discrimination'. None has yet been interpreted by the CJEU and interpretations in national courts are very limited.[97]

Article 4(2) provides that 'This Directive shall be without prejudice to more favourable provisions concerning the protection of women as regards pregnancy and maternity'.

Article 4(5) provides that the Directive 'shall not preclude differences in treatment, if the provision of the goods and services exclusively or primarily to members of one sex is justified by a legitimate aim and the means of achieving that aim are appropriate and necessary'. This provision covers aspects of healthcare, and preventive health, related to women's (and men's) reproductive health that are provided only to women (or men), or more accurately, to those who have wombs, ovaries, testes and so on. The legitimate aim is to prevent illness, and to treat medical conditions that occur only in the relevant populations.[98] The differences arise from different body parts, not from gender *per se* (indeed trans men often have wombs; trans women may have testes and/or penises).

A broader question is whether the Directive requires that – overall – provision of such services should be the same to each population group. A failure to provide equivalent service provision (for example, to offer more frequent testing for prostate cancer than for breast or ovarian cancer) might constitute an unjustified breach of the Directive. Using sex or gender as a proxy for assessing the risk of individuals developing certain diseases, or their capacity to benefit in decisions about access to healthcare, such as testing or monitoring for certain diseases, might also be a breach.[99] This would especially be the case if the non-discrimination obligations in the Directive were considered to include structural discrimination.[100] Structural discrimination has historical, societal and institutional dimensions. In this context, it includes the history of under-investment in bioscience and biomedicine specifically focused on women's illness; the cultures, values, norms and discourses that underpin decision making in the determination over time of the 'basket of care' in national healthcare systems, which include a persistent notion that women's healthcare needs are somehow lesser than men's; and organisational policies, procedures and practices that lead to corresponding non-equivalent healthcare service provision on gendered grounds.

The principle of equal treatment, covered in Article 4 of the Directive, includes 'indirect discrimination based on sex'. A prohibition against indirect discrimination – or even in some circumstances direct discrimination – could be interpreted to include a prohibition against structural discrimination.[101] Another approach might be to use strategic litigation, or other enforcement processes, to tackle such structural discrimination. In this regard, the potential of the Directive has yet to be fully explored.

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97 See Chapter 9, section 9.2.2.
98 See discussion of Denmark and provision of HPV vaccine, Chapter 9, section 9.2.2.
99 Chapter 9, section 9.1.1.3.
100 Chapter 9, sections 9.1.3 and 9.1.4.
101 Mulder, J. (2021) Indirect Sex Discrimination in Employment. Theoretical Analysis and Reflections on the CJEU Case Law and National Application of the Concept of Indirect Sex Discrimination, Publications Office of the European Union, p. 24, https://op.europa.eu/mt/publication-detail/-/publication/c7a7c5be-86d1-11eb-ac4c-01aa75ed71a1; Crowley, N. (2022), To Name and Address the Underlying Problem: Structural Discrimination on the Grounds of Racial or Ethnic Origin, European Network of experts in gender equality and non-discrimination, Publishing Office of the European Union, p. 52, https://www.migpolgroup.com/wp-content/uploads/2023/03/To-name-and-address.pdf; O'Cinneide, C. (2018) 'Key Concepts in EU Discrimination Legislation', European Research Area 11 October 2018, p. 4, https://www.era-comm.eu/oldoku/Adiskri/02_Key_concepts/118DV23_O_Cinneide_EN.pdf.

Recommendation: European Commission to commission further study to explore the scope of Union law, and especially the Goods and Service Directive 2004/113, in terms of its application to structural discrimination in healthcare.

Article 6 permits positive action. It does not impose obligations on Member States, but allows for action that involves either keeping in place or introducing 'specific measures to prevent or compensate for disadvantages linked to sex'. As the experience of women and girls within healthcare systems is almost universally worse than that of men and boys,[102] this provision is an important aspect of Union equality law's ameliorative dimensions.

Recommendation: Relying on the lawfulness of such positive action, Union incentive measures for healthcare projects, trials, protocols, and other national measures which involve such 'specific measures' permitted under Goods and Services Directive 2004/113 Article 6, as positive action.

3.1.3 Directive 79/7

Directive 79/7 on the progressive implementation of the principle of equal treatment for men and women in matters of social security applies to 'statutory schemes which provide protection against the … risks' of 'sickness' and 'invalidity',[103] and 'social assistance, in so far as it is intended to supplement or replace' such schemes.[104] The Directive thus applies to all statutory schemes supporting national healthcare systems, and benefits thereunder, that are based on statutory social security.[105] Statutory social security schemes have been defined by the CJEU as 'directly governed by legislation without any element of agreement within the undertaking or the occupational branch concerned, and which are obligatorily applicable to general categories of workers'.[106]

Directive 79/7 applies to social security. In order for the benefit to fall within the scope of the Directive, there must be a link of some sort between the benefit (here a 'sickness benefit') and employment.[107] In terms of personal scope, it is enough for the relevant person to be seeking employment,[108] or to have given up work to care for someone whose ability to undertake paid work ceased because one of the covered risks in the Directive has eventuated,[109] but if there is no link to employment to all, the situation falls outside the scope of the Directive.

[102] European Parliament (2025), *Gender Gap in Health and Healthcare: Implications for Women* (EPRS), https://www.europarl.europa.eu/RegData/etudes/ATAG/2025/769519/EPRS_ATA(2025)769519_EN.pdf; Winchester, N. (2021), 'Women's Health Outcomes: Is there a Gender Gap?', House of Lords Library In Focus, https://lordslibrary.parliament.uk/womens-health-outcomes-is-there-a-gender-gap/; British Medical Association (2022), *Closing the Gender Health Gap: the Importance of a Women's Health Strategy*, https://www.bma.org.uk/news-and-opinion/closing-the-gender-health-gap-the-importance-of-a-women-s-health-strategy; Oksuzyan, A., Brønnum-Hansen, H. and Jeune, B. (2010) 'Gender Gap in Health Expectancy' 7 *European Journal of Ageing* 213, https://doi.org/10.1007/s10433-010-0170-4.

[103] Directive 79/7, Article 3(1)(a).

[104] Directive 79/7, Article 3(1)(b).

[105] Sex equality in occupational social security schemes is now covered by the 'Recast' Directive, Article 1(c) Parliament and Council Directive 2006/54/EC of 5 July 2006 on the implementation of the principle of equal opportunities and equal treatment of men and women in matters of employment and occupation (Recast) OJ L204/23.

[106] CJEU, C-109/91, Gerardus Cornelis Ten Oever v Stichting Bedrijfspensioenfonds voor het Glazenwassers- en Schoonmaakbedrijf, 6 October 1993, ECLI:EU:C:1993:158, para. 9.

[107] C-150/85, *Drake v Chief Adjudication Officer*, 24 June 1986, ECLI:EU:C:1986:257; joined cases 48/88, 106/88 and 107/88 *Achterberg-te Riele and Others v Sociale Verzekeringsbank*, 27 June 1989, ECLI:EU:C:1989:261 para. 9; C-317/93, *Nolte v Landesversicherungsanstalt Hannover*, 14 December 1995, ECLI:EU:C:1995:438 paras 21 and 22; C-444/93, *Megner and Scheffel v Innungskrankenkasse Vorderpfalz* 14 December 1995, ECLI:EU:C:1995:442 paras 18-21.

[108] C-31/90 *Johnson v Chief Adjudication Officer*, 11 July 1991, ECLI:EU:C:1991:311.

[109] C-150/85, *Drake v Chief Adjudication Officer*, 24 June 1986, ECLI:EU:C:1986:257; C-31/90 *Johnson v Chief Adjudication Officer*, 11 July 1991, ECLI:EU:C:1991:311; C-77/95, *Züchner v Handelskrankenkasse,* 7 November 1996, ECLI:EU:C:1996:298.

The Directive does not, in principle, cover 'social welfare' or 'social assistance'. The distinction between 'social security' (on the one hand) and 'social welfare' or 'social assistance' (on the other hand) is complex, and articulated through the case law of the CJEU. Arguably, the CJEU's case law interpreting Regulation 883/2004 on coordination of national social security schemes in the context of migrant workers within the Union[110] could provide some interpretative assistance, if it is accepted that the definition of 'social welfare' or 'social assistance' should be the same in both instruments.[111] Put simply, the distinction is based on whether entitlement accrues as of right, consequent upon a period of employment or affiliation under a social security scheme (more likely to be 'social security') or whether there is an element of means-testing (more likely to constitute 'social assistance').[112] The CJEU has confirmed, in the context of Directive 79/7, for example, that co-payments for prescriptions under the national healthcare system are covered by the Directive.[113] However, personal assistance care provided to enable someone to engage with education is not a 'sickness benefit'.[114]

As the CJEU has put it, 'in order to fall within the scope of the directive the benefit must be directly and effectively linked to the protection provided against one of the risks specified in in Article 3(1)' of the Directive.[115]

When applied to the context of healthcare, literally interpreted, these scope rules seem to mean that the Directive applies *only* to those Member States that organise their national healthcare systems on the basis of social insurance, and not to those which organise their national healthcare systems on the basis of taxation. Although there is CJEU case law on invalidity benefits[116] and on accidents at work/occupational diseases benefits,[117] the CJEU has interpreted Directive 79/7 explicitly in the context of sickness benefits in very few cases. The *Richardson* case, noted above, concerned pension entitlements, which included access to free prescriptions, so was not directly about sickness insurance *per se*. *Megner and Scheffel*[118] (in which the question of scope was not disputed) confirms that the scope of the Directive extends to the sickness insurance scheme in Germany.[119] But there is no case confirming definitively that 'sickness benefits' under a taxation-based national healthcare system (if such a concept exists at all in that context) are covered.

This is a gap in European Union law.

There is an argument to the effect that Directive 79/7 covers only 'sickness benefits' interpreted literally. A Member State that organises its national healthcare system through provision of healthcare services in kind, and finances those through taxation rather than social insurance, would thus avoid the obligations in the Directive, because that Member State does not provide any 'benefits' (payments, literally interpreted) against

[110] Parliament and Council Regulation 883/2004 on the Coordination of Social Security Systems [2004] OJ L 166.
[111] There is an argument to the effect that it should not be the same, because the Directive and Regulation 883/2004 have different legal bases and different aims and objectives.
[112] See, for example, C-139/82 *Paola Piscitello v Instituto Nazionale della Previdenza Sociale (INPS)* 5 May 1983, ECLI:EU:C:1983:126; C-111/91 *Commission of the European Communities* v *Luxembourg*, 10 March 1993, ECLI:EU:C:1993:92 paras 28-29 and the case law cited therein.
[113] C-137/94 The Queen v Secretary of State for Health, ex parte Richardson, 19 October 1995, ECLI:EU:C:1995:342.
[114] C-679/16 *A (Assistance for a disabled person)* 25 July 2018, EU:C:2018:51.
[115] C-243/90 *R v Secretary of State for Social Security, ex parte Smithson*, 4 February 1992, ECLI:EU:C:1992:54 para. 14; joined cases C-63/91 and C-64/91 *Jackson and Cresswell v Chief Adjudication Officer*, 16 July 1992, ECLI:EU:C:1992:329 para. 16.
[116] See, for example, C-229/89 Commission v Belgium, 7 May1991, ECLI:EU:C:1990:410; C-102/88 Ruzius-Wilbrink v Bestuur van de Bedrijfsvereniging voor Overheidsdiensten 13 December 1989, ECLI:EU:C:1989:639; C-373/89 Caisse d'assurances sociales "Integrity" v Rouvroy, 21 November 1990, ECLI:EU:C:1990:414.
[117] C-196/98 Hepple v Adjudication Officer and Adjudication Officer v Stec, 23 May 2000, ECLI:EU:C:2000:278; C-584/23 Asepeyo Mutua v INSS, TGSS and Alcampo SA (pending) ECLI:EU:C:2025:261.
[118] C-444/93, Megner and Scheffel v Innungskrankenkasse Vorderpfalz 14 December 1995, ECLI:EU:C:1995:442.
[119] C-444/93, Megner and Scheffel v Innungskrankenkasse Vorderpfalz 14 December 1995, ECLI:EU:C:1995:442.

the risk of sickness. We consider this to be an incorrect interpretation of the scope of Directive 79/7, for two reasons.

First, the distinction between European national healthcare systems based on a 'social insurance' model and those based on a 'taxation' model is not, in fact, meaningful.[120] These are 'ideal types', and no state conforms to either model. All Member States operate their healthcare systems on the basis of some taxation and some social and private insurance or private payments. Even Member States such as Germany, Austria, Belgium and the Netherlands, which are strongly associated with the 'Bismarckian' social insurance model, in fact use blends of social insurance, taxation and private insurance or private payments. Some Member States tend more towards a 'planned economy' type of healthcare system, funded by state budgets. Some tend more towards a 'neoliberal' type of healthcare system, where insurance markets mitigate the risks arising from ill health, and contracts between insurers and healthcare providers emerge through a competitive market process. All are very much in the middle of that continuum, in that they work on the basis of modified liberalism, or constrained capitalism.[121]

Secondly, the distinction between national healthcare systems based on financial benefits (reimbursement systems) and those based on benefits-in-kind, is not a meaningful distinction, in the context of European healthcare systems. This point has been confirmed in the context of internal market law.[122] It should apply equally in the context of Union equality law. The purpose of such law (as is the case with internal market law) is to extend the same rights and obligations to people within all European Union Member States who fall within the scope *ratione personae* of the relevant legislation.

Recommendation: In considering the recommendations in the 2025 Report on Gender Equality in Statutory Social Security,[123] the European Commission should take into account that distinctions between social insurance and taxation-based national healthcare systems are not meaningful in the context of Union law. As a minimum, a Commission interpretation of Directive 79/7 should clarify that the scope of the Directive applies to all national healthcare systems, irrespective of how they are funded and irrespective of whether they involve reimbursement or are based on provision of benefits in kind. A more holistic approach, also recommended in the 2025 report, involves a new Directive; or, even better, a new 'architecture', bringing together 'the statutory, occupational and private social security provisions that are currently covered by Directives 79/7, 2006/54 and 2004/113'.[124]

Directive 79/7 prohibits direct and indirect discrimination as regards the scope of social insurance schemes and conditions of access to them; the obligation to contribute and the calculation of such contributions; and the calculation of benefits.[125] In principle, men and women should enjoy the same access to healthcare benefits (whether provided, from the point of view of the patient, through reimbursement or benefits in kind and whether funded, from the point of view of the national healthcare system, through taxation or social insurance or indeed

[120] Hervey, T. and McHale, J. (2015) *European Union Health Law*, pp. 219-225.
[121] These concepts draw on Hall, P. and Soskice, D. (2001) *Varieties of Capitalism*, and were developed by Hervey and McHale ((2015) *European Union Health Law*), to apply to healthcare systems in the EU.
[122] C-368/98 Abdon Vanbraekel and Others v Alliance nationale des mutualités chrétiennes (ANMC) 12 July 2001, ECLI:EU:C:2000:271.
[123] Eleveld, A. and Wesselius, E. (2025) *Gender Equality in Statutory Social Security: the Future of Directive 79/7*, EELN, Publications Office of the European Union, pp 94-95.
[124] Eleveld, A. and Wesselius, E. (2025) Gender Equality in Statutory Social Security: the future of Directive 79/7, p. 97.
[125] Directive 79/7, Article 4(1).

private payments) within the national healthcare system. Here 'healthcare benefits' in the language of Directive 79/7 should be understood as corresponding to access to healthcare.

Contributions to the schemes that underpin such systems should not differ on the basis of the sex of the persons covered. As indirect discrimination is also covered, Directive 79/7 also prohibits national healthcare systems from operating systems of co-payment which are more likely to disadvantage women than men. National healthcare systems should ensure that co-payments for medicines that are more likely to be needed by a woman (or, more accurately, someone with ovaries) are set at the same level as co-payments for medicines that are more likely to be needed by a man (or, more accurately, someone with testes). For example, requiring higher levels of co-payment for hormone replacement therapy (most likely to be needed by women) than for Viagra (most likely to be needed by men), would in principle breach Directive 79/7.[126]

Recommendation: European Commission to undertake a review of national co-payment requirements, to ensure that 'women's medicines' do not attract higher co-payments than 'men's medicines', taking into account that 'contributions' and 'benefits' as per Directive 79/7 include co-payments in the context of healthcare.

3.1.4 Obligations under Directive 79/7, Directive 2004/113 and Directive 2006/54: prohibition of discrimination in the context of risk pooling and differentiation on grounds of relative risk

There is a lack of doctrinal and conceptual clarity on the meaning and scope of the obligation in Directive 79/7, Article 3(1) and its relationship with obligations in Directive 2004/113 and Directive 2006/54, Articles 8 and 9. All three directives potentially cover the same ground: discrimination on grounds of gender in national healthcare systems.[127]

Given the context of the different blends of taxation, social/occupational insurance and private insurance and private payments that underpin the various national healthcare systems in the Member States,[128] to what extent is it meaningful for Directive 79/7 to impose obligations with regard to 'sickness insurance' only as social insurance? We argued above that the details of the type of healthcare system that a Member State has chosen to adopt – which of course also change to some extent over time – should not mean that different Member States are under different obligations under Directive 79/7. The obligations under Directive 79/7 apply irrespective of the type of healthcare system chosen by a Member State. Following that line of thought further, to what extent do 'insurance' as used in Directive 2004/113, and 'occupational social security' as used in Directive 2006/54, equate to 'insurance' in the context of Directive 79/7, when we are talking about access to healthcare?

One important practical context in which this question arises is the extent to which gender-based risk pooling is permitted within national healthcare systems under Union law. The Goods and Services Directive explicitly prohibits 'the use of sex as a factor in the calculation of premiums and benefits for the purposes of insurance'.[129] The use of sex as an actuarial factor 'shall not result in differences in individuals' premiums and

126 Sterilisation co-payment rules in Norway may be another example, see Chapter 9, section 9.1.1.4.
127 Directive 2010/41/EU of the European Parliament and Council of 7 July 2010 on the application of the principle of equal treatment between men and women engaged in an activity in a self-employed capacity, OJ L 180, 15.7.2010, pp. 1–6, Article 1(2) explicitly covers its relationship with Directive 2004/113, providing that Directive 2004/113 covers equal treatment in access to and supply of goods and services.
128 See above as outlined in Chapter 1, section 1.2.
129 Directive 2004/113, Article 5(1).

benefits'.[130] In the context of vehicle insurance services, in *Test-Achats*,[131] the CJEU has held that the Goods and Services Directive precludes the use of sex as an actuarial factor determining insurance premiums and benefits.[132] Assuming, as we have argued above, that the scope of the Directive covers healthcare services, this obligation and prohibition applies to health insurance as much as other types of insurance. If a private health insurance scheme offered the benefit of breast cancer screening only to women, for example, on the basis that women are at significantly greater risk of breast cancer than men,[133] that would constitute provision of a benefit to women on the basis of their classification as belonging to a different risk pool than that occupied by men. If a private health insurance scheme required women to pay higher premiums, and in return offered breast screening, that would constitute determination of a premium based on sex as an actuarial factor. Or if private insurance companies only offer health insurance policies that exclude coverage of pregnancy and maternity care, or exclude coverage of accidents to women during childbirth,[134] that would exclude a group that is almost entirely[135] comprised of women. Are these instances unlawfully discriminatory on grounds of sex?

Potentially, such private health insurance provision could constitute a non-comparable situation, and fall outside the definition of direct discrimination.[136] The provision in the Directive's preamble to the effect that 'differences between men and women in the provision of healthcare services, which result from the physical differences between men and women, do not relate to comparable situations and therefore, do not constitute discrimination'[137] does not help in this instance, because both women and nearly one third of men have breasts.[138]

Even as direct discrimination,[139] such a provision in a private health insurance contract, could potentially fall within Article 4(5) of the Goods and Services Directive, and be justified by a legitimate aim. Article 4(5) applies even to provision of 'services *exclusively* … to members of one sex' (italics added). The CJEU did not explicitly discuss Article 4(5) in *Test-Achats*. Pointing out that comparability must be assessed in light of the purpose of the relevant Union measure,[140] the CJEU focused on the broader principles of non-discrimination in Union law, specifically Articles 21 and 23 EU CFR,[141] and held that 'the rule of unisex premiums and benefits'[142] precluded the continued application of a temporally limited exception in the Directive. This ruling suggests – but probably

130 Directive 2004/113, Article 5(1).
131 C-236/09 Association belge des Consommateurs Test-Achats ASBL and Others v Conseil des Ministres, 1 March 2011, ECLI:EU:C:2011:100.
132 European Parliament (2017), *Gender Equal Access to Goods and Services Directive 2004/113/EC – European Implementation Assessment*, Directorate-General for Parliamentary Research Services, p. 8, https://data.europa.eu/doi/10.2861/406667.
133 Representing approximately 1 % of all breast cancers worldwide: Gucalp, A. and others (2019), 'Male Breast Cancer: A Disease Distinct from Female Breast Cancer' 173 *Breast Cancer Research and Treatment* 37, 37-38; Gucalp, A. and others (2019), 'Male Breast Cancer: A Disease Distinct from Female Breast Cancer' 173 *Breast Cancer Research and Treatment* 37, https://doi.org/10.1007/s10549-018-4921-9; European Commission (2020), *Breast Cancer Burden in EU-27*, European Cancer Information System, https://ecis.jrc.ec.europa.eu/sites/default/files/2023-12/Breast_cancer_en-Dec_2020.pdf.
134 See Chapter 9, section 9.1.2.2; section 9.2.1.
135 Of course, trans men could be pregnant and give birth.
136 Directive 2004/113, Article 2(a).
137 Directive 2004/113, Preamble, Recital 12.
138 Blau, M., Hanzani, R. and Hekmat, D. (2016) 'Anatomy of Gynecomastia Tissue and its Clinical Significance' 4(8) *Plast Reconstr Surg Glob Open*, e854, https://doi.org/10.1097/GOX.0000000000000844.
139 Directive 2004/113, Article 2(a) and compare Article 2(b) which provides that indirect discrimination is objectively justifiable; but see Article 4(5).
140 C-236/09 Association belge des Consommateurs Test-Achats ASBL and Others v Conseil des Ministres, 1 March 2011, ECLI:EU:C:2011:100 para 29.
141 C-236/09 Association belge des Consommateurs Test-Achats ASBL and Others v Conseil des Ministres, 1 March 2011, ECLI:EU:C:2011:100 paras 30 and 32.
142 C-236/09 Association belge des Consommateurs Test-Achats ASBL and Others v Conseil des Ministres, 1 March 2011, ECLI:EU:C:2011:100 para 32.

no more than that – that no justification would be available to the health insurance company in the example outlined above.

In the Recast Directive, 2006/54, Article 9(h) provides that 'setting different levels of benefit' is discriminatory, and unlawful, 'except in so far as may be necessary to take account of actuarial calculation factors which differ according to sex in the case of defined-contribution schemes'.

Turning now to healthcare services ('benefits') falling within a national healthcare system, what is the position for an equivalent offer of breast cancer screening for women only? In the context of Directive 79/7, the CJEU has held in *X*,[143] considering a benefit pertaining to accidents at work, that Directive 79/7 precludes national legislation on the basis of which the amount of a benefit was calculated based on a difference between the average life expectancy of men and women. Such an approach was held discriminatory and not justified. There is no provision in Directive 79/7 equivalent to Article 4(5) of the Goods and Services Directive. The *X* case implies that actuarial calculations based on differences between men and women are not permitted under Directive 79/7. There is no reason to suppose that this principle does not apply to 'sickness insurance' (that is to say, if the arguments above are accepted, access to healthcare) too.

'Reading across' the CJEU's jurisprudence on risk pooling and gender equality under the Goods and Services Directive and Directive 79/7, we conclude that some Union non-discrimination law requires that both men and women are put into the same pool when determining risk for the purposes of calculation of premiums or contributions, and calculation or offering of benefits. It seems that Union law, as it currently stands, does not permit the separation of women and men into different pools for calculating risk. To deem lawful the offer of breast cancer screening to women, or HPV vaccine only to girls, or osteoporosis only for women, or semen freezing but not egg freezing,[144] by deeming it either a non-comparable situation, or a situation where a legitimate aim justified different treatment, would run counter to the principles of the CJEU's case law on the subject of risk pooling.

Yet in the Recast Directive, occupational insurance schemes providing protection against the risk of sickness,[145] do not discriminate[146] when they use actuarial factors based on sex when providing defined-contribution schemes. And when they provide funded defined-benefit schemes, 'certain elements' may differentiate on grounds of sex 'where the inequality of the amounts results from the effects of the use of actuarial factors differing according to sex at the time when the scheme's funding is implemented'.[147]

Let us accept that relevant Union equality law (Directive 79/7, the Goods and Services Directive and the Recast Directive) together cover national healthcare systems funded by social/occupational insurance and healthcare systems covered by taxation: all national healthcare systems across the Union. Under Directive 2006/54, Member States may permit the use of actuarial factors distinguishing on sex. But – in contradiction – it follows that, read in the light of Union law including CJEU jurisprudence on Directives 79/7 and 2004/113, those latter Directives impose an obligation, in the structuring of national healthcare systems ('contributions') and the

143 C-318/13 *X* 3 September 2014, ECLI:EU:C:2014:2133; C-123/10 *Waltraud Brachner v Pensionsversicherungsanstalt* 20 October 2011, ECLI:EU:C:2011:400, para 86: 'on-average longer life expectancy of women cannot be relied on' in order to justify indirect discrimination; see also: European Commission (2015), *Gender Equality Law in 33 Countries* pp. 26-27, https://eige.europa.eu/sites/default/files/ge_law_33_european_countries_2015_en.pdf.
144 Chapter 9, section 9.2.2.
145 Directive 2006/54, Article 7(1)(a).
146 Directive 2006/54, Article 9(h).
147 Directive 2006/54, Article 9(h).

benefits offered under them (as payments or in-kind benefits), to pool risks across the whole population. Member States may not discriminate in such risk pooling on grounds of sex or gender.

Such an obligation might run counter to several aspects of national healthcare policies which differentiate treatment on the basis of (assigned) gender in the context of statutory health insurance schemes/national healthcare systems, biomedical research, and/or medical treatment. Providing breast cancer screening only to women within the 'basket of care' of a national healthcare system, for example, on the basis that women are at significantly greater risk of breast cancer than men,[148] might – as with the private health insurance example above – constitute provision of a benefit to women on the basis of their classification as belonging to a different risk pool than men. Following the logic of the CJEU's case law discussed above, this would be unlawful.

However, another way to look at this situation is that, where healthcare systems cross-subsidise one aspect of healthcare provision, which is used more by one gender, from resources that would otherwise be available for other aspects of healthcare provision, in effect, they pool risks across the whole population. This kind of population-level sharing of the risks attendant upon ill health is fundamental to national healthcare systems across Europe, which have been built on the basis of solidarity principles.

Directive 79/7 includes an explicit 'without prejudice' provision for 'protection of women on the grounds of maternity',[149] Directive 2006/54 provides that it is 'without prejudice' to 'provisions concerning the protection of women, particularly as regards pregnancy and maternity',[150] and similarly, the Goods and Services Directive explicitly provides that 'in any event, costs related to pregnancy and maternity shall not result in differences in individuals' premiums and benefits'.[151] These measures ensure that reproductive healthcare provision in the Member States may lawfully distinguish between those who give birth and those who do not.

But it may be necessary to clarify whether Union law prohibits the deployment of resources in a national healthcare system on gender-based lines, where such policies and practices in effect pool risks by sharing limited resources across the pool of the whole population, but are based on average risks for men and women calculated separately. Here, the 'legitimate aim' is different from the context of private health insurance considered in *Test-Achats*. The legitimate aim is the provision of a national healthcare system – an act of solidarity – on the basis of effective use of limited resources. The circumstances in which direct discrimination on grounds of sex in Union law is lawful need to be clarified in this context.

Recommendations: European Commission to review and clarify how Directives 79/7, 2004/113 and 2006/54 relate to one another in the context of discrimination in national healthcare systems. To include a review and clarification of the application of risk pooling obligations that emerge from all Union equality law in the context of national healthcare systems. Clarify whether the exception in Directive 2004/113, Article 4 (5) and the provisions of Directive 2006/54, Article 9(h) apply in the context of discrimination covered by Directive 79/7. Clarify the extent to which Directive 2006/54, and/or Directive 2004/113, have impliedly replaced Directive 79/7 in the context of healthcare.

[148] Gucalp, A. and others (2019), 'Male Breast Cancer: A Disease Distinct from Female Breast Cancer' 173 *Breast Cancer Research and Treatment* 37, https://doi.org/10.1007/s10549-018-4921-9.
[149] Directive 79/7, Article 4(2).
[150] Directive 2006/54, Article 28(1).
[151] Directive 2004/113, Article 5(3).

3.1.5 Obligations under Directive 2004/113 and Directive 79/7: harassment

Directive 2004/113 explicitly covers harassment, defined as 'where an unwanted conduct related to the sex of a person occurs with the purpose or effect of violating the dignity of a person and of creating an intimidating, hostile, degrading, humiliating or offensive environment'.[152] Harassment is not included in the definition of discrimination in Directive 79/7.[153]

In the sense of practical access to healthcare, harassment is an area where there is significant evidence of discrimination.[154] Sexual assault, including undertaking medical procedures without a woman patient's informed consent, is a form of sexual harassment of which there is evidence in the Member States' healthcare systems.[155] The definition in Directive 2004/113 is broad, including conduct that has the *effect* of creating an 'environment' that is not only intimidating or hostile, but also degrading, humiliating or offensive. Many – and perhaps arguably all – aspects of obstetric violence[156] would be caught by this definition, interpreted in its literal sense. Disrespectful, abusive or neglectful treatment during childbirth is one example, that is prevalent across the Union[157] (and elsewhere). Where women giving birth are subjected to physical or verbal abuse, profoundly humiliated, or neglected and consequently suffer life-threatening avoidable complications, this would constitute behaviour that creates a 'degrading, humiliating or offensive' environment. The context of childbirth brings the treatment within the definition of sexual harassment, as it is 'related to the sex' of the person concerned. Another example that falls within a literal interpretation of the Directive's definition is refusal to give pain medication on the basis of a stereotyped understanding of women's pain: the well-documented 'gender pain gap'.

Clarifying that access to healthcare is covered by Directive 2004/113 (see the recommendation above) would give greater scope for enforcement of rights to gender equality in healthcare.

Recommendation: Clarify the relationship between the WHO definition of 'obstetric violence' and the concept of 'sexual harassment' in Directive 2004/113.

3.1.6 Obligations under Directive 2004/113 and Directive 79/7: composition of 'basket of care'

If the arguments on scope made above are accepted, both Directive 2004/113 and Directive 79/7 cover equality of access to healthcare in the sense of equal access without discrimination on grounds of sex to whatever is in the 'basket of care' within a national healthcare system in a Union Member State. But the composition of the 'basket of care' (that is, which healthcare treatments are available to which patients, or to any patients at all) is in principle a matter of national competence, according to Article 168 TFEU and Union internal market

[152] Directive 2004/113, Article 2(c).
[153] Directive 79/7, Article 4.
[154] Chapter 9, section 9.1.5; section 9.1.6; section 9.3. See also, for example, Geremia, C. (2024) 'Obstetric and Gynaecological Violence in Europe: when healthcare becomes control' (8 December 2024), https://wave-network.org/obstetric-and-gynaecological-violence-in-europe-when-healthcare-becomes-control/; see also: European Institute for Gender Equality (2023), *Women Fleeing the War: Access to Reproductive Healthcare in the EU under the Temporary Protection Directive* pp. 14-16, https://eige.europa.eu/sites/default/files/documents/Women%20fleeing%20the%20war%20-%20Access%20to%20sexual%20and%20reproductive%20healthcare%20in%20the%20EU%20under%20the%20Temporary%20Protection%20Directive.pdf; European Commission (2022), *Access to Health Care in EU Member States: Implementation of Temporary Protection Directive (2001/55/EC) and Council Implementing Decision (EU) 2022/382*, European Observatory on Health Systems and Policies, https://health.ec.europa.eu/system/files/2022-08/soc-det_tpd-rr-report_en.pdf.
[155] See Chapter 9, section 9.1.6.
[156] See Chapter 1, section 1,3; Chapter 9, section 9.1.5.
[157] See Chapter 9, section 9.1.5.

law/free movement law on cross-border patients' rights. Is this 'in principle' competence affected by the non-discrimination rules in either Directive?

Directive 79/7 probably does not cover the composition of the basket of care, because non-discrimination in access to 'sickness benefits' implies access to what is covered in a national healthcare scheme, rather than non-discrimination in the determination of the composition of that scheme. But at least arguably, Directive 2004/113 could also cover 'access to healthcare services' in the sense of the decision-making process by which the composition of the 'basket of care' is determined. If that were accepted, any evidence of national decision making in that regard that does not take care to ensure gender equality in the medical treatments/medicines that are covered in the basket of care potentially breaches obligations in the Goods and Services Directive.

Recommendation: European Commission to clarify the scope of Directive 2004/113 in the context of determination of the healthcare services that are available in a national healthcare system (the 'basket of care'). National implementing bodies to seek transparent information about how decisions are made, and their outcomes, to determine whether indirect discrimination has taken place, in the sense of including more medicines or medical treatments that are more likely to be needed by men, than those which are likely to be needed by women.

3.2 Union law directly providing rights to gender equality in access to healthcare (healthcare services provision) to specific categories of (vulnerable) women (and girls)

Key legal instruments

Directive (EU) 2024/1385 on combating violence against women and domestic violence (Violence Against Women Directive)

Directive 2012/29/EU establishing minimum standards on the rights, support and protection of victims of crime (Victims' Rights Directive)

Directive 2011/36/EU on victims of human trafficking (Human Trafficking Directive)

3.2.1 Access to specialist healthcare for women and girls who are victims of criminal violence

Union equality law includes provisions seeking to secure equal treatment of, and in many cases positive action or specific provision for, women and girls with particular vulnerabilities. One key example is that women and girls who are victims of violence are entitled under Union law to specialist support services[158] which include

[158] Directive of the European Parliament and of the Council 2012/29/EU of 25 October 2012 establishing minimum standards on the rights, support and protection of victims of crime, and replacing Council Framework Decision 2001/220/JHA OJ L 315, 14.11.2012, p. 57–73, Article 9 (3) (b) 'including trauma support and counselling'.

access to appropriate physical and mental healthcare services.[159] A specific instance is women and girls who are victims of human trafficking.[160] Human trafficking includes 'the exploitation of surrogacy'.[161]

These rights are found in three Directives: Directive 2012/29/EU on the victims of crime (the Victims' Rights Directive); Directive 2024/1385 on violence against women (the Violence Against Women Directive); and Directive 2011/36/EU on victims of human trafficking (the Human Trafficking Directive). The deadline for implementation of the Violence Against Women Directive is 14 June 2027.

The personal scope of Directive 2012/29 (the Victims' Rights Directive) covers 'a natural person who has suffered harm, including physical, mental or emotional harm … which was directly caused by a criminal offence', and 'family members of a person whose death was directly caused by a criminal offence and who have suffered harm as a result of that person's death'.[162] The Directive requires Member States to provide victim support services, free of charge, in accordance with victims' needs.[163] The minimum requirements of such victim support services are set out in the Directive.[164] Obligations are of three types: informational; hortative (pertaining to strong encouragement); and substantive.

The Human Trafficking Directive 'establishes minimum rules concerning the definition of criminal offences and sanctions in the area of trafficking in human beings. It also introduces common provisions, taking into account the gender perspective, to strengthen the prevention of this crime and the protection of the victims thereof.'[165] Victims' rights and consequent obligations set out in this Directive are also informational; hortative; and substantive.

The Victims' Rights Directive imposes obligations to provide 'information about or direct referral to any relevant specialist support services in place'.[166] If relevant specialist support services exist offering physical or mental healthcare, there is thus a clear obligation to inform victims about such specialist support services. The Human Trafficking Directive, is less specific, requiring Member States to provide 'necessary medical treatment, including … counselling and information'.[167]

In terms of hortative obligations, the Victims' Rights Directive requires Member States to 'encourage victim support services to pay particular attention to the specific needs of victims who have suffered considerable harm due to the severity of the crime'.[168] The Human Trafficking Directive encourages Member States to 'create specialised [human trafficking] units, within law-enforcement and prosecution services, where appropriate and in accordance with their national legal systems'.[169] Read in conjunction with the Union's gender mainstreaming

[159] Directive (EU) of the European Parliament and of the Council 2024/1385/EU of 14 May 2024 on combating violence against women and domestic violence OJ L, 2024/1385, 24.5.2024, Article 25 'information on and, where appropriate, referral to services providing medical and forensic examinations, which may include comprehensive healthcare services, and information on and, where appropriate, referral to psychosocial counselling, including trauma care'.

[160] Directive 2011/36/EU of the European Parliament and of the Council of 5 April 2011 on preventing and combating trafficking in human beings and protecting its victims, and replacing Council Framework Decision 2002/629/JHA [2011] OJ L101/1 as amended under Directive (EU) 2024/1712 of the European Parliament and of the Council of 13 June 2024 amending Directive 2011/36/EU on preventing and combating trafficking in human beings and protecting its victims [2024] OJ L1712/1.

[161] Directive 2011/36/EU, Article 2(3).

[162] Directive 2012/29, Article 2(1).

[163] Directive 2012/29, Article 8.

[164] Directive 2012/29, Article 9.

[165] Directive 2011/36/EU, Article 1.

[166] Directive 2012/29, Article 9(1)(b).

[167] Directive 2011/36/EU, Article 11(5).

[168] Directive 2012/29, Article 9(2).

[169] Directive 2011/36/EU, Article 9(3).

obligations,[170] and consistently with general principles of Union law, including the UN CRC[171] and CEDAW, and the rights protected in the EU CFR,[172] these obligations include an obligation to encourage victim support services to pay particular attention to the specific needs of women and girls who are victims of crime.

3.2.2 Access to specialist mental healthcare for women and girls who are victims of human trafficking and other criminal violence

Substantive obligations under the Human Trafficking Directive include an obligation to provide 'specialised assistance and support' to victims, 'in a victim-centred, gender- … and child-sensitive approach'.[173] 'Assistance and support' must include, at least, 'necessary medical treatment including psychological assistance, counselling and information, and translation and interpretation services where appropriate'.[174] Such assistance and support must be provided 'before, during, and for an appropriate period of time after the conclusion of, criminal proceedings'.[175] Member States are obliged 'to attend to' 'victims with special needs, where those needs derive, in particular, from whether they are pregnant, their health, a disability, a mental or psychological disorder they have, or a serious form of psychological, physical or sexual violence they have suffered'.[176] From 15 July 2026, Member States are also obliged to provide gender, disability and child-centred training to all professionals likely to come into contact with victims of human trafficking;[177] this includes healthcare professionals.

Substantive obligations under the Victims' Rights Directive include a minimum requirement to provide 'emotional support'.[178] It is unclear whether 'emotional support' includes mental healthcare. Some literature distinguishes between mental and emotional health.[179] Mental health – associated with mental wellbeing – includes rational thinking, good decision making and managing difficult situations. Emotional health concerns the ability to manage moods and feelings, to regulate emotions such as stress or anger, sadness or joy. But a better view is probably that both mental and emotional health are essential for overall psychological health,[180] 'emotional support' is essential for patient-centred care,[181] and that 'social support' (of which emotional support is a crucial facet) is an essential component of mental health and wellbeing, although the relationships between these concepts remain complex.[182]

170 Article 8 TFEU.
171 *Convention on the Rights of the Child* (adopted 20 November 1989) 1577 UNTS 3; ratified by all EU Member States and consistent with EU objectives under Article 3(3) TEU and Article 24 EU CFR.
172 Article 6(3) TEU; Preamble, recital 5 EU CFR.
173 Directive 2011/36/EU, Article 11(1).
174 Directive 2011/36/EU, Article 11(5).
175 Directive 2011/36/EU, Article 11(1).
176 Directive 2011/36/EU, Article 11(7).
177 Directive 2011/36/EU, Article 18b.
178 Directive 2012/29/EU, Article 9(1)(c).
179 Parr, H. and Davidson, J. (2009) 'Mental and Emotional Health' in T Brown, S McLafferty and G Moon (eds), *A Companion to Health and Medical Geography*, Wiley-Blackwell, https://doi.org/10.1002/9781444314762.ch15.
180 WHO (2017), 'Mental Health', 17 June 2022, https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response; see also: Keyes, C. (2002) 'The Mental Health Continuum: From Languishing to Flourishing in Life' 43(2) *Journal of Health and Social Behaviour* 207, https://www.jstor.org/stable/3090197?origin=crossref.
181 Bradshaw, J. Siddiqui, N. Greenfield, D. and Sharma, A. (2022) 'Kindness, Listening, and Connection: Patient and Clinician Key Requirements for Emotional Support in Chronic and Complex Care' 9 *Journal of Patient Experience*, https://journals.sagepub.com/doi/10.1177/23743735221092627.
182 Acoba, A. (2024) 'Social Support and Mental Health: The Mediating Role of Perceived Stress' 15 *Frontiers in Psychology* (Sec Health Psychology), https://pubmed.ncbi.nlm.nih.gov/38449744/.

The Victims' Rights Directive obliges Member States to provide 'psychological support' only 'where available'.[183] Given the relations between emotional health, mental health and overall psychological health, the distinction between the minimum obligation required of Member States to provide emotional support, and the obligation to provide psychological support only where available, is unhelpful. The Directive should be clarified in line with recent understandings of psychological health, to include all forms of mental healthcare within the minimum obligation.

Recommendation: European Commission to clarify interpretation of Article 9(1)(c) of the Victims' Rights Directive 2012/29/EU to include an obligation to provide all victims of crime with comprehensive mental healthcare. Note this would be an interpretation against the literal wording of the Directive, but in line with its spirit and changing scientific understandings. It would also be consistent with the obligation in the Human Trafficking Directive 2011/36/EU.

Recommendation: After 15 July 2026, European Commission review provision of training of healthcare professionals to ensure obligation to gender (disability and child-centred) training under the Human Trafficking Directive 2011/36/EU, and disseminate best practice.

Substantive obligations in the Victims' Rights Directive also include a minimal obligation to provide or develop 'targeted and integrated support mechanisms for victims with special needs'.[184] Such victims are explicitly stated to include 'victims of sexual violence' (statistically mainly women and girls); 'victims of gender-based violence' (also statistically mainly women and girls) and 'victims of violence in close relationships' (ditto).[185] In 2020, the European Commission found that several Member States had failed to transpose these obligations into national law.[186] Most Member States had, however, complied with the minimum services obligations.[187]

Recommendation: European Commission to undertake further review of compliance with obligations in the Victims' Rights Directive, to include ensuring that implementation in healthcare settings is complete.

3.2.3 Obligations in the Violence Against Women Directive

Directive 2024/1385 (the Violence Against Women Directive) requires Member States to ensure adequate provision of healthcare[188] for victims of violence against women and of domestic violence.[189]

The Violence Against Women Directive includes the following obligations. Appropriately trained[190] healthcare professionals must be able to report imminent risks of serious physical harm despite confidentiality duties.[191] Criminal justice authorities must assess victims' specific protection needs, which include risk of physical and

[183] Directive 2012/29/EU of the European Parliament and of the Council of 25 October 2012 establishing minimum standards on the rights, support and protection of victims of crime, and replacing Council Framework Decision 2001/220/JHA [2012] OJ L315/57.
[184] Directive 2012/29, Article 9(3)(b).
[185] Directive 2012/29, Article 9(3)(b).
[186] European Commission (2020), *Report from the Commission to the European Parliament and the Council on the implementation of Directive 2012/29/EU* COM (2020) 188 final, para. 3.4, https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:52020DC0188.
[187] European Commission (2020), *Report from the Commission to the European Parliament and the Council on the implementation of Directive 2012/29/EU* COM (2020) 188 final, para. 3.2, https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:52020DC0188.
[188] Directive 2024/1385, Article 25(1)(c)(4) and (7); Article 26; Article 27.
[189] Directive 2024/1385, Article 1(2).
[190] Directive 2024/1385, Article 36.
[191] Directive 2024/1385, Article 14(4).

psychological harm.[192] They must also refer victims to healthcare professionals as appropriate to assist with evidence gathering.[193]

Member States must ensure that specialist support – which includes 'comprehensive healthcare services', even in times of emergency – is available for victims.[194]

> 'According to the FRA survey [2014 European Union Agency for Fundamental Rights (FRA) Violence against Women survey], only one in three victims of partner violence and one in four victims of non-partner violence report their most recent serious incident to the police or some other service. A healthcare provider is likely to be the first professional contact for survivors of violence against women, including intimate partner violence and sexual assault. 22 % of the survey respondents said that they had contacted a doctor or a healthcare centre after the most serious incident of sexual violence by a partner. WHO clinical and policy guidelines (2013) on 'Responding to intimate partner violence and sexual violence against women' notes that women who have been subjected to violence often seek healthcare but might not disclose the associated abuse or violence. This stresses the importance of training for healthcare professionals on recognising and managing the effects of sexual violence.'[195]

Member States must provide victims of sexual violence access to 'appropriately equipped and easily accessible rape crisis or sexual violence referral centres', which may be part of national healthcare systems; and 'timely access to healthcare services, including sexual and reproductive healthcare services, in accordance with national law'.[196] Such services must be free of charge and well geographically distributed.[197] Victims of female genital mutilation must be entitled to free, easily accessible and age-appropriate support, including physical and mental healthcare ('psychological and trauma care and counselling').[198]

These latter obligations impose explicit obligations of access to certain types of healthcare for all women and girls who are victims of the relevant crimes. They thus impose obligations on Member States to consider the 'basket of care' of their national healthcare system, the mechanisms through which patients/victims access the relevant healthcare (free at the point of delivery; reimbursement), and the practical access, including geographical scope of provision, any referral mechanisms, and any other practical dimensions. This is a significant incursion into Member States' autonomy over access to healthcare in their national healthcare systems. It is justified by the Union's commitment to gender equality in health.

The deadline for implementation of the Directive is 14 June 2027.

Recommendation: European Commission to gather and disseminate best-practice examples in its work on national implementation of both the Victims' Rights Directive and the Violence Against Women Directive. Best-practice examples to include training of healthcare professionals in their reporting obligations under the Directives; training of criminal justice officials in their obligations to refer to healthcare professionals.

[192] Directive 2024/1385, Article 16(3)(b) and (g).
[193] Directive 2024/1385, Article 15(4).
[194] Directive 2024/1385, Article 25(1)(c)(4) and (7).
[195] European Commission (2021), *Gender Equality and Health in the EU* p. 50.
[196] Article 26(1),(2),(3) and (4).
[197] Article 26(4).
[198] Article 27.

Recommendation: European Commission to review compliance with obligations to provide healthcare to women and girls within the scope of the Violence Against Women Directive at the earliest opportunity, given the vulnerability of the women and girls involved.

3.2.4 Violence against women in healthcare settings

The rights and obligations in the Victims' Rights Directive and the Violence Against Women Directive also apply when the crime or violence takes place in a healthcare setting. To fall within the scope of the Victims' Rights Directive[199] or the Violence Against Women Directive,[200] the violence must constitute a criminal offence, under Union or national law. The Violence Against Women Directive explicitly applies not only in domestic or private settings, but also to 'all acts of gender-based violence directed against a woman or a girl because she is a woman or girl or that affect women or girls disproportionately'.[201] Sexual harassment and sexual assault are a particular concern, given evidence from the experts.[202] Acts of obstetric violence[203] also meet this definition: they either take place because the patient is a women or girl, or they are an act of violence that affect women or girls disproportionately.

Union law requires that Member States must treat certain acts as criminal offences. Some of these acts could take place in healthcare settings: female genital mutilation;[204] non-consensual sharing of sexual images online or using information technologies;[205] cyber-stalking or cyber-harassment.[206]

Where violence against women in healthcare settings is a criminal offence in national law, or where Union law requires that it constitute a criminal offence, Member States are under the informational, hortative (pertaining to strong encouragement), and substantive obligations outlined above. Member States must provide victim support services, free of charge, in accordance with victims' needs,[207] meeting the minimum requirements of such victim support services as set out in the Directive.[208] Member States must inform patients of 'any relevant specialist support services in place'.[209]

In terms of substantive obligations, Member States must ensure that women can report violence against them 'through accessible, easy-to-use, safe and readily available channels'.[210] There is also an obligation to ensure that possible third party reporting of acts of violence against women, or suspicions of acts of violence against women, or an expectation of acts of violence against women, take place 'without [the third party] fearing negative consequences'.[211] Healthcare systems in the Member States must have in place such without-prejudice reporting systems.

[199] Directive 2012/29/EU, Article 1.
[200] Directive 2024/1385/EU, Article 1.
[201] Directive 2024/1385/EU, Article 1.
[202] See Chapter 9, section 9.1.6.
[203] See Chapter 9, section 9.1.5.
[204] Directive 2024/1385/EU, Article 3. Although FGM does not take place within the national healthcare system of any Member State, it could take place in a private healthcare setting in Europe.
[205] Directive 2024/1385/EU, Article 5.
[206] Directive 2024/1385/EU, Articles 6 and 7.
[207] Directive 2012/29, Article 8.
[208] Directive 2012/29, Article 9.
[209] Directive 2012/29, Article 9(1)(b).
[210] Directive 2024/1385/EU, Article 14(1).
[211] Directive 2024/1385/EU, Article 14(3).

In addition to reporting requirements, Member States are under obligations concerning the investigation of acts of violence against women, including those taking place in healthcare settings. Investigations must take place 'without undue delay' where 'competent authorities have reasonable grounds to suspect that a criminal offence might have been committed'.[212] Given the prevalence of obstetric violence, and other violence against women in healthcare settings, at least for those forms of obstetric violence that are criminal offences, there is an argument to be made that the Violence Against Women Directive obliges Member States to undertake such investigations 'without undue delay' when the obligation to comply with the Directive bites (on 14 June 2027). Not all forms of obstetric violence are criminal offences, but given the evidence about violence against women in healthcare settings, especially obstetric violence, including in our comparative data,[213] any review of implementation of the Violence Against Women Directive should pay particular attention to implementation of the obligations it imposes in healthcare settings. There may also be a role for future Union law to clarify minimum standards as to which forms of violence against women in healthcare settings, especially obstetric violence, should be criminal offences in the Member States.

The obligation on Member States to undertake comprehensive and multi-layered measures to prevent violence against women[214] may also have particular implications in healthcare settings. Such preventive measures include research and education programmes. There may be a need to increase awareness of obstetric violence among healthcare professionals and patients alike. There may be a need for a 'targeted intervention programme … to prevent and minimise the risk of committing violence against women',[215] in the context of training of healthcare professionals, given the prevalence of obstetric violence in the context of healthcare systems. Such intervention programmes 'may [but not must] be made available for the participation of other persons who are assessed as being at risk of committing such offences'. Arguably, given embedded patterns of disrespect for women patients, and unconscious bias, many – if not all – healthcare professionals within national healthcare systems may be such persons at risk of committing offences. The training obligations in the Directive, applicable *inter alia* to healthcare professionals,[216] apply equally when the victim is a victim of a crime within the healthcare system.

There may be a need to review whether the data collection and research obligations in the Violence Against Women Directive[217] are being implemented to include data from healthcare settings.

There is also an important role for the national equality bodies[218] to play here. National bodies, which can form part of national equality bodies, are required to publish reports and make recommendations 'on any issue relating to violence against women'.[219] These reports may include evidence of good practice. National equality bodies must share information with 'relevant European bodies such as the European Institute for Gender Equality'.[220] Such evidence gathering, reporting and sharing should also pay attention to violence against women in healthcare settings. Other 'relevant European bodies' might include those with responsibilities for setting minimum training standards for healthcare professionals.

212 Directive 2024/1385/EU, Article 15(3).
213 See Chapter 9, section 9.1.5.
214 Directive 2024/1385/EU, Article 35.
215 Directive 2024/1385/EU, Article 37.
216 Directive 2024/1385/EU, Article 36(2).
217 Directive 2024/1385/EU, Article 44.
218 Set up pursuant to Directives 2004/113/EC, 2006/54/EC and 2010/41/EU.
219 Directive 2024/1385/EU, Article 22.
220 Directive 2024/1385/EU, Article 22.

Recommendation: In any future assessment of the implementation and adequacy of the Directive, the European Commission should investigate the potential of the Violence Against Women Directive to address violence against women in healthcare settings. Following such an investigation, the European Commission should consider whether there is a need to (i) issue guidance clarifying the Directive's scope and application in that context; (ii) encourage Member States and national equality bodies to launch investigations; (iii) collect data and conduct research; or (iv) to amend the text of the Directive.

Member States must, as a minimum, provide victims with 'emotional support', and must provide 'psychological support' (only) where available.[221] As argued above, 'emotional support' should be interpreted to cover all forms of mental healthcare. This would strengthen the obligation to support women victims of crime within healthcare (and other) settings. There is also an obligation to provide or develop 'targeted and integrated support mechanisms for victims with special needs'.[222] This must include 'trauma support and counselling'.[223] As argued above, women and girls who are victims of sexual violence in healthcare settings fall within this category.[224]

Recommendation: European Commission to investigate compliance with Victims' Rights Directive in the context of violence against women in healthcare settings.

[221] Directive 2012/29/EU, Article 9(1)(c).
[222] Directive 2012/29, Article 9(3)(b).
[223] Directive 2012/29, Article 9(3)(b).
[224] Directive 2012/29, Article 9(3)(b).

4 Union law indirectly having impact or potentially having impact on gender equality in access to healthcare

Union law indirectly has impact or potential impact on gender equality in access to healthcare through two connected vectors. First, Union employment equality law has an impact on equality in health, because of the connection between employment and (better) health. Better health in general means less need to access healthcare. Secondly, Union employment equality law, Union law on health and safety at work, and Union law on mutual recognition of qualifications has an indirect effect on access to healthcare because having women in the healthcare workforce makes a difference to access to healthcare as experienced by people of different genders, especially women.

Key legal instruments
Union employment equality law (Recast Directive 2006/54; Self-Employment Directive 2010/41; and Work-life Balance Directive 2019/1158)
Union health and safety law (Pregnancy and Maternity Directive 92/85 as amended; Directive 97/81 on part-time work; Directive 99/70 on fixed-term work)
Union law on professional qualifications, to the extent that it prescribes training requirements which foster provision of gender-sensitive healthcare services (Directive 2005/36 on mutual recognition of professional qualifications)

4.1 Access to employment as a vector for better (women's) health

First, Union employment equality law and health and safety law (see key instruments box above), as applicable to all people in the workforce across Europe within its scope *ratione personae*, has a positive impact on access to healthcare. It is well established that there is a positive link between (non-precarious)[225] employment and good/better physical[226] and mental[227] health; and that people who are unemployed experience worse health in general.[228] Women (and others in minority/disadvantaged groups such as racial minorities, or migrants) are more likely to be in 'non-standard' or precarious employment arrangements, which are linked to lower health

[225] See, for example Pinto, A. D., Hassen, N. and Craig-Neil, A. (2018) 'Employment Interventions in Health Settings: A Systematic Review and Synthesis' *Annals of Family Medicine* 16(5) 447 https://doi.org/10.1370/afm.2286.

[226] See, for example, Hergenrather, K.C. and others (2015), 'Employment as a Social Determinant of Health: A Systematic Review of Longitudinal Studies Exploring the Relationship Between Employment Status and Physical Health' *Rehabilitation Research, Policy, and Education* 29(1) 2 https://doi.org/10.1891/2168-6653.29.1.2.

[227] See, for example, Pinto, A. D., Hassen, N. and Craig-Neil, A. (2018) 'Employment Interventions in Health Settings: A Systematic Review and Synthesis'.

[228] See, for example, Picchio, M. and Ubaldi, M. (2023) 'Unemployment and Health: A Meta-Analysis', *Journal of Economic Surveys* 38(4): https://doi.org/10.1111/joes.12588; Jaydarifard, S. and others, (2023) 'Precarious Employment and Associated Health and Social Consequences: A Systematic Review', *Australian and New Zealand Journal of Public Health* 47(4) 100074 https://doi.org/10.1016/j.anzjph.2023.100074; European Commission (2015), *Evaluating the impact of structural policies on health inequalities and their social determinants and fostering change*, https://cordis.europa.eu/project/id/278173/reporting; European Institute for Gender Equality (EIGE), *Gender and Health* https://eige.europa.eu/gender-mainstreaming/policy-areas/health; European Commission (2024), *Women's Situation in the Labour Market*, https://commission.europa.eu/strategy-and-policy/policies/justice-and-fundamental-rights/gender-equality/women-labour-market-work-life-balance/womens-situation-labour-market_en; European Commission (2024), *Annex to the Joint Employment Report 2024* (COM(2024)701 final) https://www.eumonitor.eu/9353000/1/j4nvirkkkr58fyw_j9vvik7m1c3gyxp/vmja6t8fkxyn; OECD and European Commission (2024), *Health at a Glance: Europe 2024 – State of Health in the EU Cycle*, https://www.oecd.org/en/publications/health-at-a-glance-europe-2024_b3704e14-en.html.

outcomes, and especially among those with pre-existing psychiatric conditions, neurodivergences, or risk of depression; and there is a potential psychosomatic link between poor mental health resulting from non-standard employment arrangements and physical health.[229] Those with worse health in general are more likely to have to access healthcare.

Equal access to employment,[230] equal treatment in self-employment contexts,[231] equal treatment at work,[232] equal pay,[233] protection for maternity rights in the workplace,[234] parental workplace rights,[235] protection of part-time[236] and fixed-term workers[237] (because women are over-represented in the part-time and fixed-term workforce)[238] thus all play a crucial role in improving the underlying determinants of women's physical and mental health. Employment is among the social determinants of health.[239] Union employment equality and health and safety law, broadly defined, therefore offers an important 'upstream' prevention of ill health in women.

These important employment rights provided by Union law affect the underlying social determinants of health, particularly freedom from poverty. Enabling women to participate in the employment market, or become self-employed, decreases their chances of experiencing ill health, and therefore decreases the likelihood of those women needing to access healthcare services.

While these Union laws provide important rights, their implementation remains incomplete.[240] All work done to improve practical enforcement of these Union laws will have an indirect effect on gender equality in health.

[229] See, for example, Gunn, V. and others, (2022) 'Initiatives addressing precarious employment and its effects on workers' health and well-being: A systematic review' *International Journal of Environmental Research and Public Health* 19(4) 2232 , https://doi.org/10.3390/ijerph19042232.

[230] Directive 2006/54/EC, Article 1; Article 14.

[231] Directive 2010/41/EC, Article 4.

[232] Directive 2006/54/EC, Article 14.

[233] Directive 2006/54/EC, Article 1; Article 4.

[234] Council Directive 92/85/EEC of 19 October 1992 on the introduction of measures to encourage improvements in the safety and health at work of pregnant workers and workers who have recently given birth or are breastfeeding (tenth individual Directive within the meaning of Article 16(1) of Directive 89/391/EEC) OJ L 348, 28.11.1992, 1–7; Directive 2006/54/EC, Article 15.

[235] Directive (EU) 2019/1158 of the European Parliament and of the Council of 20 June 2019 on work-life balance for parents and carers and repealing Council Directive 2010/18/EU OJ L 188, 12.7.2019, pp. 79–93, Articles 4, 5, 6, 7, 9, 11, 12, 14; Directive 2006/54/EC, Article 16.

[236] Directive of the Council 97/81/EC of 15 December 1997 concerning the Framework Agreement on part-time work concluded by UNICE, CEEP and the ETUC - Annex: Framework agreement on part-time work OJ L 14, 20.1.1998, 9–14.

[237] Directive of the Council 99/70/EC of 28 June 1999 concerning the framework agreement on fixed-term work concluded by ETUC, UNICE and CEEP OJ L 175, 10.7.1999, 43–48.

[238] See Eurostat (2024), 'Part Time and Full Time Employment Statistics', September 2024; Eurostat (2024), Temporary and Permanent Employment Statistics).).

[239] See, for example, Pinto, A. D., Hassen, N. and Craig-Neil, A. (2018) 'Employment Interventions in Health Settings: A Systematic Review and Synthesis'.

[240] See, for example, Mulder, J. (2020) *Indirect sex discrimination in employment*, European network of legal experts in gender equality and non-discrimination, https://www.equalitylaw.eu/downloads/5362-indirect-discrimination-in-employment-pdf-1-434-kb; Iordache, R. and Ionescu, I. (2021) *Effectively enforcing the right to non-discrimination*, European network of legal experts in gender equality and non-discrimination, https://www.equalitylaw.eu/downloads/5570-effectively-enforcing-the-right-to-non-discrimination-1-02-mb; De la Corte-Rodríguez, M. (2023) *The transposition of the Work-Life Balance Directive in EU Member States: A long way ahead*, European network of legal experts in gender equality and non-discrimination, https://www.equalitylaw.eu/downloads/5779-the-transposition-of-the-work-life-balance-directive-in-eu-member-states-a-long-way-ahead and De la Corte-Rodríguez, M. (2023) *The transposition of the Work-Life Balance Directive in EU Member States (II): Considerable work still to be* done, European network of legal experts in gender equality and non-discrimination, https://www.equalitylaw.eu/downloads/6048-the-transposition-of-the-work-life-balance-directive-in-eu-member-states-ii-considerable-work-still-to-be-done.

Recommendation: Continue to support/encourage Member States to enforce rights to equal access to employment, and equal treatment within employment and self-employment. Disseminate best practices in enforcement.

4.2 Women healthcare professionals as a vector for better access to healthcare for women

Secondly, and more specifically, Union employment equality law and health and safety law, *as applicable to healthcare professionals*, plays a crucial role in securing greater gender equality in access to healthcare. In this context, by 'access to healthcare', we mean the *practical* experience of accessing healthcare services, when patients encounter healthcare professionals. Union employment equality and health and safety law may have an indirect effect on gender equality in access to healthcare in the sense of the experience of patients – especially women – when they access healthcare services. These provisions of Union law are thus a potential indirect route to improving gender equality in access to healthcare.

> 'Women's share of employment in the health and social sector is high; according to the EU Labour Force Survey, in 2018, total employment in the human health and social care sector was 25 266 300, with 76 % of these workers women (EIGE (d)). In the WHO European Region (53 Member States), 95 % of nurses are women (WHO, 2020b). Women make up 86 % of personal care workers in health services. … (Additional more recent data … suggest that the trends mentioned above also apply to specific professions). … Carers provide different types of care depending on their qualifications and job functions, including nursing care, basic medical services and helping people to eat, bathe or dress (EIGE (b)). Due to demographic change (European Commission, 2020), this 'care economy' is growing and must create a high number of jobs in the coming years. However, care work remains characterised by poor working conditions, a void of benefits and protections, low wages or non-compensation, and exposure to physical, mental and, in some cases, sexual harm (ILO, undated). Ensuring decent working conditions for care personnel can be expected to increase the quality of care and patient safety.'[241]

In general, law and policy that supports having women in the healthcare professional workforce indirectly determines greater gender equality in access to healthcare services. The quality of healthcare experienced by all patients, but especially women patients, is better when care is provided by women health professionals, who enjoy non-discriminatory treatment in the workplace.[242] More broadly, the presence of women in the healthcare workforce, especially in more prestigious and higher-paid roles, affects the androcentric nature of healthcare and indeed biomedicine and bioscience more generally.

When women patients encounter the healthcare profession (and indeed in other contexts), there is a well-documented gender gap. The gap is confirmed in our comparative data.[243] The gap is not surprising: a 2020 UN study with data from 75 countries showed that nearly 90 % of people across the globe have a gender bias against women.[244] Long-standing and persisting gender bias continues in Europe.[245] The gap is multi-faceted.

[241] European Commission (2021), *Gender Equality and Health in the EU*, p. 31.
[242] Example: Hart, R. (2024) 'Patients Fare Better with Women Doctors, Study Finds', Forbes, 22 April 2024, https://www.forbes.com/sites/roberthart/2024/04/22/patients-fare-better-with-women-doctors-study-finds/.
[243] See Chapter 9, section 9.1.4.
[244] United Nations Development Programme (UNDP) (2020), *2020 Gender Social Norms Index (GSNI)*.
[245] Damann, T., Siow, J. and Tavits, M. (2023) 'Persistence of gender biases in Europe', 120 *Proceedings of the National Academy of Sciences, USA*, 12 e2213266120, https://doi.org/10.1073/pnas.2213266120.

It includes the gender pain gap: the phenomenon that women's pain is treated less seriously than men's pain in healthcare settings.[246]

> 'An example of a health condition affecting women that often goes under-diagnosed and/or not treated is endometriosis.[247] Endometriosis is a chronic and disabling gynaecological disease affecting 10 % of women of reproductive age. It is associated with acute symptoms, mainly consisting of severe pelvic pain and infertility, imposing an annual economic burden estimated at €7 746 billion in 9 European countries. In endometriosis, women's symptoms are not always taken seriously and are often normalised or not recognised by doctors, which leads to delays in diagnosis and treatment.'[248]

The gender gap includes sexual harassment of women patients by male doctors, a point mentioned in several of our comparative questionnaires.[249] It includes the design of clinical research, where bodies with testes are treated as the norm, and bodies with ovaries are often excluded. It includes intersectional inequalities, for example the difficulties women face where their religion and belief identities mean they need access to a woman doctor.[250]

Non-discriminatory healthcare in the sense of practical access to healthcare is healthcare that takes women seriously as patients, and treats them with equal respect to the male patient 'norm'. It has been well established that healthcare professionals who treat patients with *empathy* operate more effectively in this regard, and also deliver better therapeutic outcomes.[251] 'Empathy' in this context means 'the ability to understand the personal experience of the patient without bonding with them'.[252] Where (women) healthcare professionals' life experiences are similar to those of their (women) patients, their ability to understand their patients' experiences will be enhanced. A woman healthcare professional who has experienced pregnancy, giving birth, or menopause will have a lived experience not available to a healthcare professional who has not had such experiences. But it is also the case that, in general, women healthcare professionals are more likely to offer empathetic care than men: 65 % of the studies covered in a 2018 meta-review show a positive significant correlation between empathetic care provision and female gender, and 0 % show a negative significant correlation.[253] The reasons for women's greater empathy are complex, but probably include the socialisation of girls to be more sensitive to emotional signals in other people.[254]

246 See Chapter 9, sections 9.1.4 and 9.1.5.

247 See also: Viganò, P., Casalechi, M. and Dolmans, M-M. (2024) 'European Union underinvestment in endometriosis research' 5 *Journal of Endometriosis and Uterine Disorders* 100058, https://doi.org/10.1016/j.jeud.2023.100058.

248 European Commission (2021), *Gender Equality and Health in the EU*, p. 47.

249 See Chapter 9, section 9.1.6.

250 See Chapter 9, section 9.1.3. This is for example exhibited amongst Muslim women in the UK: Mahayosnand, P., Gomez, P., Ahmed, S. and Sabra, Z.M. (2024) 'Muslim Women have a Gender Preference for Female Doctors' 16(6) *Journal of the British Islamic Medical Association*, https://www.jbima.com/article/muslim-women-have-a-gender-preference-for-female-physicians/; and more broadly amongst secular populations (US): Ballard, J. (2018) 'Nearly half of all women prefer being treated by a female doctor', YouGov, 21 August 2018, https://today.yougov.com/health/articles/21394-women-prefer-female-doctor.

251 Hojat, M. (2016) *Empathy in Health Professions, Education and Patient Care*, Springer; Moudatsu, M., Stavropoulou, A., Philalithis, A. and Koukouli, S. (2020) 'The Role of Empathy in Health and Social Care Professionals' 8(1) *Healthcare* 26, https://doi.org/10.3390/healthcare8010026.

252 Hojat, M. (2016) *Empathy in Health Professions, Education and Patient Care*; Moudatsu, M., Stavropoulou, A., Philalithis, A. and Koukouli, S. (2020) 'The Role of Empathy in Health and Social Care Professionals' (2020) 8(1) Healthcare 26, 1, https://doi.org/10.3390/healthcare8010026.

253 Elayyan, M., Rankin, J. and Chaarani, MW, (2018) 'Factors affecting empathetic patient care behaviour among medical doctors and nurses: an integrative literature review' 24 *East Mediterranean Health J* 311, https://pubmed.ncbi.nlm.nih.gov/29908027/.

254 Hojat, M. (2016) Empathy in Health Professions, Education and Patient Care, p 141.

Empathy can also be learned in adult life. There is scope here for healthcare professional training to play a role in improving women's healthcare experiences. We discuss the possibilities for Union law to play a role in healthcare professional training below.[255]

Key factors affecting healthcare professionals' ability to act with empathy – of relevance to Union law – are workload, burnout,[256] and role modelling. Union health and safety law has a role to play in protecting everyone in the healthcare workforce from unsustainable workloads. Union law on part-time and flexible working arrangements, and on work-life balance, does too. Union law also has a role to play in ensuring that women in the healthcare workforce are able to manage pregnancy and maternity alongside their working lives. And it has a role to play to support women to enter and remain in the workplace as role models. Each of these legal vectors is elaborated below.

Workload is governed in Union law principally by the Working Time Directive.[257] Subject to opt-outs,[258] and some carve-outs for whole industries, including those where there is 'a need for continuity of service or production, particularly services relating to the reception, treatment and or care provided by hospitals or similar establishments',[259] this sets maximum permissible weekly working hours.[260] It also makes provision for daily rest periods;[261] breaks;[262] a weekly rest period;[263] and annual leave entitlement,[264] subject to a complex set of derogation provisions.[265] Specific provisions protect night workers.[266] In general, it applies to the healthcare sector as much as any other sector.[267] In addition, the Pregnancy and Maternity Directive 92/85 affects women (or pregnant people's) workload by prohibiting night-work for pregnant workers,[268] and requiring employers to grant time off for antenatal appointments.[269]

Women's ability to manage their workloads is affected by their family and caring obligations, a societal burden that still falls disproportionately on women rather than men. The Work-life Balance Directive 2019/1158[270] seeks to mitigate this burden by providing for paternity leave on the birth of a child;[271] shared parental leave;[272]

[255] See chapter 4.3 and chapter 8. See also chapter 9, sections 9.1.3 and 9.1.4.
[256] Wilkinson, H., Whittington, R., Perry, L. and Eames, C. (2017) 'Examining the relationship between burnout and empathy in healthcare professionals: a systematic review', *Burnout Research* 18, https://pubmed.ncbi.nlm.nih.gov/28868237/.
[257] Directive 2003/88/EC of the European Parliament and of the Council of 4 November 2003 concerning certain aspects of the organisation of working time OJ L 299, 18/11/2003, p.9 -19, as interpreted, in the context of healthcare professional working time, for example by C-303/98 *SIMAP*, 3 October 2000, ECLI:EU:C:2000:528; C-151/02 *Kiel v Norbert Jaeger*, 9 September 2003, ECLI:EU:C:2003:437; joined cases C-397, C-399-403/01 *Pfeiffer v Deutches Rotes Kreuz*, 5 October 2004, ECLI:EU:C:2004:584. See also Report from the Commission to the European Parliament, Council and European Economic and Social Committee (2023), *Report on the implementation by Member States of Directive 2003/88/EC concerning certain aspects of the organisation of working time* COM(2023) 72 final.
[258] The Directive permits, for example, derogations by collective agreements, see Directive 2003/88/EC, Article 18.
[259] Directive 2003/88/EC, Article 17 (3) (c (i). Article 17(5) allowed for derogation from the maximum working week for doctors in training, until August 2012.
[260] Directive 2003/88/EC, Article 6.
[261] Directive 2003/88/EC, Article 3.
[262] Directive 2003/88/EC, Article 4.
[263] Directive 2003/88/EC, Article 5.
[264] Directive 2003/88/EC, Article 7.
[265] Directive 2003/88/EC, Articles 17, 18, 19, 20, 21, 22.
[266] Directive 2003/88/EC, Articles 8-13.
[267] C-303/98 *SIMAP*, 3 October 2000, ECLI:EU:C:2000:528; C-151/02 *Kiel v Norbert Jaeger* 9 September 2003, ECLI:EU:C:2003:437; joined cases C-397, C-399-403/01 *Pfeiffer v Deutches Rotes Kreuz*, 5 October 2004, ECLI:EU:C:2004:584.
[268] Pregnancy and Maternity Directive 92/85, Article 7.
[269] Pregnancy and Maternity Directive 92/85, Article 9.
[270] Directive (EU) 2019/1158 of the European Parliament and of the Council of 20 June 2019 on work-life balance for parents and carers and repealing Council Directive 2010/18/EU OJ L 188.
[271] Directive 2019/1158/EU, Article 4.
[272] Directive 2019/1158/EU, Article 5.

carers leave;[273] time off for urgent family reasons;[274] and a right to request flexible working time arrangements for care reasons.[275] Discrimination,[276] dismissal,[277] and other detriment,[278] on the grounds of exercise of these rights are all prohibited.

Unsustainable workloads are one factor that leads to burnout in the workplace. Burnout is a complex phenomenon encompassing three key domains: emotional exhaustion, depersonalisation, and loss of self-worth.[279] Many factors play into burnout; factors specifically relevant to women include: gender stereotyping, sexual harassment, work-life conflicts, isolation, hormonal fluctuations, pregnancy and the post-partum period.[280] Union health and safety law and employment equality law have an important role to play in reducing healthcare workforce burnout. Basic equal pay and equal treatment in the workplace, required by the Recast Directive,[281] secures greater self-worth among women. These obligations are among the longest-standing in Union equality law but their realisation in practice remains incomplete.[282] Freedom from harassment for women healthcare professionals is also important.[283] Again, Union equality law prohibits sexual harassment,[284] but enforcement is not guaranteed.[285] As noted above, Union law on reconciling work and family life[286] plays a role in reducing the risk of exhaustion, enabling healthcare workers to balance work commitments with other commitments, especially caring roles, which tend to fall disproportionately on women.[287]

Lack of role models is a factor contributing to workforce burnout in healthcare settings.[288] In prohibiting discrimination on grounds of sex, Union equality law increases the likelihood of the presence of women in the (healthcare) workforce as role models. Union law's provisions include protection from dismissal on grounds of pregnancy,[289] a right to return to the same or equivalent job after maternity leave;[290] non-discrimination on grounds of part-time[291] and fixed-term[292] work; as well as the general protections in the Recast Directive.[293] The presence of strong role models in the workplace also contributes to greater empathy, and thus to greater

[273] Directive 2019/1158/EU, Article 6.
[274] Directive 2019/1158/EU, Article 7.
[275] Directive 2019/1158/EU, Article 9.
[276] Directive 2019/1158/EU, Article 11.
[277] Directive 2019/1158/EU, Article 12.
[278] Directive 2019/1158/EU, Article 14.
[279] Maslach, C. and Jackson, S. (1981) 'The Measurement of Experienced Burnout', 2 *Journal of Organisational Behaviour* 99, https://onlinelibrary.wiley.com/doi/10.1002/job.4030020205; Brindley, P. and others, (2019) 'Psychological 'Burnout' in Healthcare Professionals: Updating our Understanding, and not Making it Worse' (2019) 20 *Journal of Intensive Care* 358, https://pubmed.ncbi.nlm.nih.gov/31695741/; Stonnington, C. and Files, J. (eds) (2020), *Burnout in Women Physicians: Prevention, Treatment, and Management*, Springer.
[280] See relevant chapters in Stonnington, C. and Files, J. (eds) (2020), *Burnout in Women Physicians: Prevention, Treatment, and Management*.
[281] Directive 2006/54, Article 4 (equal pay); Article 14(1)(c) (employment and working conditions).
[282] European Commission(2021), 'EU Action for Equal Pay', https://commission.europa.eu/strategy-and-policy/policies/justice-and-fundamental-rights/gender-equality/equal-pay/eu-action-equal-pay_en.
[283] Pere-Ere Ajuwa, M-E. and others (2024), 'Workplace violence against female healthcare workers: a systematic review and meta-analysis' 28 *BMJ Open*, https://pubmed.ncbi.nlm.nih.gov/39209501/.
[284] Directive 2006/54, Article 2(1)(c)(d)(2)(a).
[285] European Parliament, European Parliament resolution of 1 June 2023 on sexual harassment in the EU and MeToo evaluation (2022/2138(INI)) [2023] OJ C 1224, http://data.europa.eu/eli/C/2023/1224/oj; Zamfir, I. (2024) *Standards for Equality Bodies: Discrimination under Article 19 TFEU Grounds*, European Parliamentary Research Service Briefing 751414, 19 June 2024, https://www.europarl.europa.eu/RegData/etudes/BRIE/2023/751414/EPRS_BRI(2023)751414_EN.pdf.
[286] Directive 2019/1158/EU.
[287] European Commission (2022) *Gender Equality and Work-Life Balance Policies during and after the COVID-19 Crisis: Thematic Review 2022*, Publications Office of the European Union, pp. 1-2, https://data.europa.eu/doi/10.2767/50106.
[288] Blanchard, A. and Blanchard, J. (2020) 'Isolation, Lack of Mentorship, Sponsorship, and Role Models' in Stonnington, C. and Files, J. (eds), *Burnout in Women Physicians: Prevention, Treatment, and* Management, pp. 193-216.
[289] Directive 92/85/EC, Article 10.
[290] Directive 2006/54, Article 15.
[291] Directive 97/81/EC, Article 4.
[292] Directive 99/70/EC, Article 4.
[293] Directive 2006/54, Articles 2, 4, 14.

practical gender equality in access to healthcare. Again, Union law has a role to play in ensuring that women are able to reach all levels of the healthcare profession, and be equally represented there.[294] The Recast Directive prohibits discrimination 'whatever the branch of activity and at all levels of the professional hierarchy, including promotion'.[295] All of these interconnected and structural elements of discrimination faced by women in the healthcare workforce are matters that can be tackled by Union law. Healthcare professionals – a sector occupied by a high proportion of women[296] – are entitled under Union law to equal pay and equal treatment in the terms and conditions of their work;[297] and enjoy important health and safety protections in the workplace,[298] including when pregnant, immediately after birth and when breastfeeding.[299] Some of this Union health and safety legislation specifically concerns healthcare workplaces and medical treatment.[300] It protects all of the healthcare sector workforce.

Recommendation: Review how general Union law on (gender) equality is implemented and enforced in specific healthcare workforce domains, perhaps through commissioning a further report with comparative data on women in the healthcare workforce.

Recommendation: Secure more effective enforcement through incentivising (using Union project funding) collaboration between equality organisations and healthcare professional organisations/organisations that oversee the quality of healthcare provision within the Member States.

4.3 Training of healthcare professionals as a vector for greater gender equality in access to healthcare

Union law requires non-discrimination on grounds of nationality in access to medical education,[301] and mutual recognition of medical qualifications.[302] Some of this law imposes obligations on healthcare regulatory and supervisory bodies responsible for training of medical professionals and their recognition as competent to provide services or be employed within the national healthcare system. For some healthcare professionals, the content of training is set at Union level. This provides another *indirect* vector for improving gender equality in

[294] European Institute for Gender Equality (2021), *Gender Equality Index 2021: Health*, pp. 56-58, https://eige.europa.eu/sites/default/files/documents/gender_equality_index_2021_health.pdf.

[295] Directive 2006/54, Article 14(1)(a).

[296] This trend is particularly evident in care work, see: European Institute for Gender Equality (2020), 'Gender inequalities in care and pay in the EU', 19 November 2020, https://eige.europa.eu/publications-resources/publications/gender-inequalities-care-and-pay-eu?language_content_entity=en.

[297] Directive 2006/54/EC of the European Parliament and of the Council of 5 July 2006 on the implementation of the principle of equal opportunities and equal treatment of men and women in matters of employment and occupation (recast) OJ L 204, 26.7.2006, 23–36.

[298] European Pillar of Social Rights, Principle 10. For a list of the EU's 25 pieces of health and safety at work legislation, see https://employment-social-affairs.ec.europa.eu/policies-and-activities/rights-work/health-and-safety-work_en. Two directives specifically concern healthcare: Directive 2010/32 on medical sharps; and Directive 92/29 on medical treatment on board vessels. Many others are relevant, such as Directive 86/656 on personal protective equipment, Directive 90/269 on manual handling and Directive 2000/54 on exposure to biological agents.

[299] Council Directive 92/85/EEC.

[300] Council Directive 2010/32/EU of 10 May 2010 implementing the Framework Agreement on prevention from sharp injuries in the hospital and healthcare sector concluded by HOSPEEM and EPSU OJ L 134, 1.6.2010, pp. 66–72 and Council Directive 92/29/EEC of 31 March 1992 on the minimum safety and health requirements for improved medical treatment on board vessels OJ L 113, 30/04/1992, 19–36.

[301] C-293/83 *Françoise Gravier v City of Lieges* 13 February 1985, ECLI:EU:C:1985:69; see also C-65/03 *Commission v Belgium* 1 July 2004, ECLI:EU:C:2004:402; C-147/03 *Commission v Austria* 7 July 2005, ECLI:EU:C:2005:427.

[302] Directive 2005/36/EC of the European Parliament and of the Council of 7 September 2005 on the recognition of professional qualifications [2005] OJ L 255/22, Art. 4.

access to healthcare through improving training of healthcare professionals to be more gender-inclusive in their approach.

Directive 2005/36 on the mutual recognition of professional qualifications, chapter III, includes provisions for the automatic recognition of qualifications of a closed list of professionals. The list includes several healthcare professions: doctor with basic training; specialised doctor; nurse responsible for general care; dental practitioner; specialised dental practitioner; midwife; and pharmacist.[303] Note that for all other healthcare professionals, a different system of mutual recognition of qualifications applies. For these seven categories of healthcare professional, each Member State must automatically recognise, 'for the purpose of pursuing general medical practice in the framework of its national social security system',[304] evidence of a relevant formal qualification from another Member State. Relevant formal qualifications are listed in the Directive.[305] The Directive also lays down minimum training conditions for such qualifications.[306]

The determination at Union level of such minimal training conditions represents an opportunity to enhance gender equality in the practical access to healthcare. The details of the minimal training conditions are updated, from time to time, through Commission delegated legislation. The most recent update was in 2024.[307] Minimal training includes not only the technical or biomedical aspects of the relevant professions, but also matters such as ethics[308] and patient empowerment.[309] There is no reason why it should not include training in matters directly pertaining to gender equality in access to healthcare, especially training in empathy, and to prevent sexual harassment.[310] In addition it could include training drawing on research and evidence concerning different healthcare needs based on gender, for example effective training on menopause and endometriosis; and training about how a heart attack typically presents in women, not only in men.[311] Indeed, arguably, given the gender mainstreaming obligations in the Treaty, there is an argument to the effect that it should include such training.

Recommendation: Review healthcare professional training that is determined at Union level to secure explicit training in empathy and gender-sensitive provision of healthcare; and in general review it for gender discrimination. Include such amendments in the next Commission Delegated Legislation under this part of Directive 2005/36.

4.4 Connecting access to employment, women healthcare professionals and gender equality training of healthcare professionals: women as healthcare workers

Bringing the above insights together, Union (equality) law has an important contribution to make to ensure that women can access the healthcare professional workforce; remain within it throughout their working lives, including when they have caring obligations to children or elderly relatives; be treated with equal dignity within

[303] Directive 2005/36, Article 21(1).
[304] Directive 2005/36, Article 21(2).
[305] Directive 2005/36, Annex V, point 5.1.4.
[306] Directive 2005/36, Articles 24, 25, 26, 28, 31, 34, 35, 40.
[307] Commission Delegated Directive (EU) 2024/782 of 4 March 2024 amending Directive 2005/36/EC of the European Parliament and of the Council as regards the minimum training requirements for the professions of nurse responsible for general care, dental practitioner and pharmacist [2024] OJ L 2024/782.
[308] Directive 2005/36, Articles 31(6), 36(3), 40(3), Annex V, 5.2.1, 5.3.1, 5.5.1, 5.6.1.
[309] Directive 2005/36, Article 31(6) and (7).
[310] See Chapter 9, section 9.1.4 and 9.1.6.
[311] See Chapter 9, section 9.1.4.

that workforce; be paid equally for equal work and work of equal value within the healthcare sector; and draw on their own experiences to contribute to the training of all healthcare professionals in empathy and gender-awareness. Where women are enabled to be in the healthcare workforce, for the reasons elaborated above, the overall effect on gender equality in access to health is likely to be positive. There is, however, at present little evidence on these effects of Union law.

Recommendation: Commission further research into the position of women in the healthcare workforce in the Union, good practices, and effects on gender equality in access to healthcare.

5 Relevant Union law applicable in internal European Union cross-border situations

<table><tr><td>
Key legal instruments

Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare

Directive 2004/38/EC on the right of citizens of the Union and their family members to move and reside freely within the territory of the Member States

Regulation 883/2004 on the coordination of social security for migrants

Regulation (EU) 2021/2282 of the European Parliament and of the Council of 15 December 2021 on health technology assessment and amending Directive 2011/24/EU

Article 56 TFEU
</td></tr></table>

5.1 Rights of migrant patients within the Union to access healthcare

Three main aspects of Union law secure mobility of patients within the Union: Union legislation covering migrant workers/self-employed people and their families; Treaty law on free movement of services; and Union legislation on 'patients' rights'. Each has been interpreted by the CJEU. Together, they form a body of law that determines the circumstances under which patients have rights in Union law to access healthcare in a Member State that is not their own.

People may seek to access healthcare in another state for a range of reasons, some of which have a gendered dimension. For example, women may seek pregnancy and maternity care, and in particular may wish to give birth, in the state where their mothers are resident, especially if this is their home state where their mother tongue is used. People may seek to access treatments more quickly, if waiting times are long in their home state. People may seek to access innovative, or expensive, treatments, which are not available in their home state. The gender-relevant aspects of this body of Union law are drawn out further below. In brief, Union law should make it as easy for women to receive cross-border healthcare as men. First, we outline the legal provisions.

The relevant rules are quite complex, especially when frontier workers are concerned.[312] However, the general direction of travel of the relevant law has been to minimise the circumstances in which Member States lose control over who has access to healthcare within their national healthcare/social insurance systems. This is consistent with the Treaty's observation that Member States are responsible 'for the definition of their health policy and for the organisation and delivery of health services and medical care' and that 'the responsibilities

[312] 'Frontier workers' are defined in Union law as 'workers who have to cross the border of an EU Member State but who return on a daily basis, or at least once a week, to a third country in which they reside and of which they are nationals'. See, for example, C-57/96 *Meints* 27 November 1997, EU:C:1997:564; C-212/05 *Hartmann* 18 July 2007, EU:C:2007:437; Case C-287/05 *Hendrix* 11 September 2007, EU:C:2007:494.

of the Member States shall include the management of health services and medical care and the allocation of the resources assigned to them'.[313]

Three key exceptions apply to this general position of 'home state control'. First, migrant Union citizen workers and their families, who fall within the personal scope of Directive 2004/38/EC (the Citizenship Directive),[314] and are entitled to reside in the host Member State under Union law, are entitled to access healthcare in the Member State in which they reside, on the same basis as nationals of that Member State.[315] This exception is mainly uncontroversial, as such migrant Union citizens are employed, self-employed,[316] are students with health insurance,[317] or have independent means, including health insurance,[318] for themselves and their families. This means that the relevant patients are either contributing to the national healthcare/social insurance system through employment or self-employment, on the same solidarity basis as nationals; or they have private healthcare insurance, so are not accessing the national system. These provisions are supplemented by Regulation 883/2004,[319] which coordinates social security entitlements for migrant workers and their families, in the event that illness or disability means that they need to rely on the national healthcare system of their host state.

Regulation 883/2004 also provides for migrant *patients*. In general, patients moving in reliance upon Regulation 883/2004 must have an authorisation from their home Member State,[320] which will reimburse the Member State providing the healthcare. But a second exception to the general position that Member States retain control over access to their national healthcare systems arises where a Union citizen is *present* in another Member State for another reason (for example, a holiday or business trip) and needs to access emergency healthcare. Under the Regulation, the host Member State must provide such care:[321] this is the European health insurance card (EHIC) system.

The third exception arises where a Member State is required to grant access to healthcare services to a migrant patient who has gone to another Member State *in order to access healthcare there*. There are three sources of this obligation (and consequent patient entitlement or right of access to healthcare services) in Union law. These sources overlap and are largely consistent with one another. Article 56 TFEU applies to provision and receipt of services in the internal market: healthcare is one such service.[322] Unjustified restrictions on such free movement breach Article 56 TFEU. But this provision has been significantly affected – and in practice narrowed – by Union legislation. Under Regulation 883/2004, Article 20(2), Member States must grant authorisation to receipt of cross-border healthcare services where the treatment (a) is covered by the national healthcare/social insurance system in the home Member State; and (b) cannot be given to the patient within a 'time limit which

313 Article 168(7) TFEU.
314 Directive 2004/38/EC of the European Parliament and of the Council of 29 April 2004 on the right of citizens of the Union and their family members to move and reside freely within the territory of the Member States amending Regulation (EEC) No 1612/68 and repealing Directives 64/221/EEC, 68/360/EEC, 72/194/EEC, 73/148/EEC, 75/34/EEC, 75/35/EEC, 90/364/EEC, 90/365/EEC and 93/96/EEC [2004] OJ L 158/77.
315 Directive 2004/38, Article 24.
316 Directive 2004/38, Article 7(1)(a).
317 Directive 2004/38, Article 7(1)(c).
318 Directive 2004/38, Article 7(1)(b).
319 Regulation (EC) No 883/2004 of the European Parliament and of the Council of 29 April 2004 on the coordination of social security systems [2004] OJ L 166/1; For a corrected version of the text see OJ [2004] L 200/1-4. This replaced Regulation 1408/71/EEC OJ Sp Ed 1971 II 416 and entered into force on 1 May 2010.
320 Regulation 883/2004, Article 20.
321 Regulation 883/2004/EC, Article 19. The EU-UK Trade and Cooperation Agreement extends a version of this entitlement to residents in the EU/UK when visiting the UK/EU, see EU-UK Trade and Cooperation Agreement, Article 488, and Protocol on Social Security Coordination, Article SSC.17.
322 Joined cases 286/82 and 26/83 *Graziana Luisi and Giuseppe Carbone v Ministero del Tesoro* 31 January 1984 ECLI:EU:C:1984:35.

is medically justifiable' in the home Member State, taking into account the patient's 'current state of health and the probable course of his/her illness'. By implication, then, a patient may, exceptionally, rely on Article 20(2) to access healthcare services in another Member State, but only if the conditions ((a) and (b) above) are met.

Similarly to condition (a), under Directive 2011/24,[323] home Member States must reimburse migrant patients receiving healthcare services in a host Member State only if the treatment concerned is among the benefits to which the patient is entitled to in their home Member State.[324] Further, under the Directive, Member States are allowed to adopt a system whereby a migrant patient must be given prior authorisation for cross-border healthcare services in a wide range of situations.[325] These include:

(a) Healthcare that is 'made subject to planning requirements relating to the object of ensuring sufficient and permanent access to a balanced range of high-quality treatment in the Member State concerned or to the wish to control costs and avoid, as far as possible, any waste of financial, technical and human resources and:

 (i) involves overnight hospital accommodation of the patient in question for at least one night; or

 (ii) requires use of highly specialised and cost-intensive medical infrastructure or medical equipment';

(b) Healthcare that 'involves treatments presenting a particular risk for the patient or the population'; or

(c) Healthcare that is 'provided by a healthcare provider that, on a case-by-case basis, could give rise to serious and specific concerns relating to the quality or safety of the care, with the exception of healthcare which is subject to Union legislation ensuring a minimum level of safety and quality throughout the Union'.

Similar to (b) above, under Directive 2011/24, Article 8(5), a patient is entitled to cross-border healthcare under Union law only:

> 'when the patient is entitled to the healthcare in question in accordance with Article 7 [that is, it is in the 'basket of care' in the home Member State], and when this healthcare cannot be provided on its territory within a time-limit which is medically justifiable, based on an objective medical assessment of the patient's medical condition, the history and probable course of the patient's illness, the degree of the patient's pain and/or the nature of the patient's disability at the time when the request for authorisation was made or renewed.'

Furthermore, Member States are *not* obliged to authorise cross-border healthcare where[326]

(a) the patient will, according to a clinical evaluation, be exposed with reasonable certainty to a patient-safety risk that cannot be regarded as acceptable, taking into account the potential benefit for the patient of the sought cross-border healthcare;

[323] Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare [2011] OJ L 88/45.
[324] Directive 2011/24/EU, Article 7(1).
[325] Directive 2001/24/EU, Article 8.
[326] Directive 2011/24/EU, Article 8(6).

(b) the general public will be exposed with reasonable certainty to a substantial safety hazard as a result of the cross-border healthcare in question;

(c) this healthcare is to be provided by a healthcare provider that raises serious and specific concerns relating to the respect of standards and guidelines on quality of care and patient safety, including provisions on supervision, whether these standards and guidelines are laid down by laws and regulations or through accreditation systems established by the Member State of treatment;

(d) this healthcare can be provided on its territory within a time-limit which is medically justifiable, taking into account the current state of health and the probable course of the illness of each patient concerned.

Overall, then, the circumstances in which migrant patients may access non-emergency healthcare in another Member State without being authorised to do so by their home Member State are now extremely limited. By and large, Member States retain control over their 'basket of care' and over who may access it. The ability of women to access cross-border healthcare is equally constrained to that of men.

5.2 Provision of sexual and reproductive healthcare services within internal market law

Our comparative data shows that one key aspect of gender inequality in access to healthcare services is the practical effect of 'conscience clauses' on the provision of sexual and reproductive healthcare – particularly abortion.[327] A conscience clause permits a healthcare professional to refuse to offer healthcare – even if included in the 'basket of care' – on the basis of their 'conscience', that is to say their firmly held belief or conviction, potentially based on their religious identity. To what extent, if at all, is Union law applicable to such provisions?

In principle, Union internal market law does not apply to 'wholly internal situations'.[328] However, the CJEU has confirmed in numerous cases concerning free movement of services that Article 56 TFEU catches a rule which 'is liable to prohibit or otherwise impede the activities of a provider of services in another Member State'[329] or 'directly affects access to the markets in services in the other Member States and is thus capable of hindering intra-Union trade in services'.[330] In general, 'national measures liable to hinder or make less attractive the exercise of fundamental freedoms [i.e. free movement of goods, persons, services or capital]'[331] are suspect in Union internal market law: they must be justified and proportionate. The hindrance need not be actual; restricting a *hypothetical* movement is sufficient.[332]

Conscience clauses are potentially national measures that hinder free movement of patients, using any of the mechanisms outlined above, and also hinder free receipt of services by patients. This is because they affect

[327] See Chapter 9, section 9.1.3.
[328] See, e.g. case 175/78 *The Queen v Vera Ann Saunders* [1979] ECLI:EU:C:1979:88; but see, e.g. C-60/00 *Mary Carpenter v Secretary of State for the Home Department* 11 July 2002 ECLI:EU:C:2002:434.
[329] C-76/90 *Manfred Säger v Dennemeyer & Co Ltd* 25 July 1991 ECLI:EU:C:1991:331.
[330] C-384/93 Alpine Investments BV v Minister van Financiën 10 May 1995 ECLI:EU:C:1995:126.
[331] C-44/94 Reinhard Gebhard v Consiglio dell'Ordine degli Avvocati e Procuratori di Milano 17 October 1995 ECLI:EU:C:1995:411.
[332] Joined cases C-570 and 571/07 José Manuel Blanco Pérez and María del Pilar Chao Gómez v Consejería de Salud y Servicios Sanitarios and Principado de Asturias 1 June 2010 ECLI:EU:C:2010:300.

access to the service of abortion[333] not only for patients in the relevant state, but also for (real and hypothetical) patients from another Member State.

If this argument were accepted, the question would be whether conscience clauses are nonetheless justified and proportionate. Protecting fundamental human rights and freedoms, such as freedom of thought, conscience and religion,[334] is a potential justification for a hindrance to free movement.[335] But the justification must be proportionate: it must be suitable to meet the objective and no more restrictive of free movement than necessary. If the application of national policies allowing conscience clauses results in the practical unavailability at all of a healthcare service that is, in principle, available in a Member State, and if that lack of availability has a discriminatory effect on the grounds of gender, thus breaching fundamental Union principles and values, can it be said to be proportionate? This question is yet to be tested.

Recommendation: Relying on Article 258 TFEU, the European Commission should review the proportionality of conscience clauses, in the sense of compliance with Article 56 TFEU, Regulation 883/2004, and Directive 2011/24, given their effect on gender inequality in healthcare.

5.3 Health technology assessment: Union law on the 'basket of care'

Directive 2011/24 set up a voluntary network of national authorities or bodies responsible for health technology assessment.[336] According to the WHO,[337]

> 'Health technology assessment (HTA) is a systematic and multidisciplinary evaluation of the properties of health technologies and interventions covering both their direct and indirect consequences. It is a multidisciplinary process that aims to determine the value of a health technology and to inform guidance on how these technologies can be used in health systems around the world.'

Put simply, health technology assessment is the process through which a state determines which 'health technologies' (which treatments, medicines, and so on) are available, on what basis, within the 'basket of care' of their national healthcare/social insurance system. Health technology assessment is an assessment of 'value for money' of a particular treatment or healthcare service from the point of view of a national solidarity-based healthcare system. Such a system cannot simply offer all patients any healthcare that they would like, but, given its available resources, must determine which patients can access which treatments on a basis that is fair, transparent, and non-discriminatory.

Health technology assessment therefore has a gendered dimension, in that, given the historical and structural discrimination embedded in national healthcare systems, there is a strong danger that health technology assessment processes in effect disadvantage women and members of minority genders.[338] One way in which

[333] C-159/90 *The Society for the Protection of Unborn Children Ireland Ltd v Stephen Grogan and others* 4 October 1991 ECLI:EU:C:1991:378 confirms that abortion is a service in internal market law, see further section 5.4.
[334] Article 10 EU CFR.
[335] C-36/02 Omega Spielhallen- und Automatenaufstellungs-GmbH v Oberbürgermeisterin der Bundesstadt Bonn 14 October 2004 ECLI:EU:C:2004:614.
[336] Directive 2011/24, Article 15. See also: Hervey, T. and Trubek, L. (2007) 'Freedom to provide health care services within the EU: An opportunity for Hybrid Governance' 13(3) *Columbia Journal of European Law* 623.
[337] World Health Organization (2025), 'Health Technology Assessment', WHO, 14 July 2025, https://www.who.int/health-topics/health-technology-assessment#tab=tab_1.
[338] Culyer, A. and Bombard, Y. (2011) 'An Equity Framework for Health Technology Assessments' 32(3) *Society for Medical Decision Making* 428, https://journals.sagepub.com/doi/10.1177/0272989X11426484;

this can happen, for example, is where women are excluded from clinical trials, and therefore the available data on which health technology assessments are made does not include data about women. Culyer and Bombard describe as a 'classic case'[339] of such bias the way that women have been excluded from cardiovascular clinical trials, based on a perception that cardiovascular disease is a 'male disease', even though (in the USA) cardiovascular disease is equally prevalent among women by the age of 40, and in fact more prevalent than in men by the age of 60.[340]

In 2021, the Union deepened its involvement in health technology assessment. A new Regulation 2021/2282[341] established common rules and methodologies for the joint clinical assessment of health technologies by Member States. Further, the developers of new healthcare technologies are required only to submit relevant data and evidence for such evaluation once at Union level.[342] Some new health technologies are subject to 'joint clinical assessments',[343] by a Union-level coordination group, made up of national members.[344] These new rules take effect on various dates.[345] The procedural rules according to which the coordination group must operate are to be determined by Union tertiary law.[346] 'Joint clinical assessments' do not 'contain any value judgement or conclusions on the overall clinical added value of the assessed health technology'. They simply describe the scientific analysis of the relevant effects of the health technology as assessed on health outcomes, and the degree of certainty of those relevant effects. Member States must 'give due consideration' to joint clinical assessments when they make their health technology assessment determinations.[347]

The Union's health technology assessment therefore does not (yet) take the place of national health technology assessments. However, it does provide a process of collaboration between Member States that informs the process. Especially for smaller Member States, with less resource, the joint clinical assessments may in effect become determinative. Therefore it is worth considering the extent to which Union law, as it develops, supports gender equality in health technology assessment. In principle, Union law should enable health technology assessments to ensure treatments for common women's conditions are as readily available within the 'basket of care' covered by national health systems as those for common men's conditions.

The Commission must report on the Directive's operation no later than 13 January 2028.[348] This potentially presents an opportune moment to consider the gender dynamics of the Union's joint clinical assessments, and the ways in which the Union's health technology assessment work could better reflect the mainstreaming duty in Article 8 TFEU.

Benkhalti, M. and others (2021), 'Development of a checklist to guide equity considerations in health technology assessment' 37 *International Journal of Technology Assessment in Health Care* e17, https://doi.org/10.1017/S0266462320002275.

339 Culyer, A. and Bombard, Y. (2011) 'An Equity Framework for Health Technology Assessments' 32(3) *Society for Medical Decision Making* 428, https://journals.sagepub.com/doi/10.1177/0272989X11426484.

340 Kim, E. and Menon, V. (2009) 'Status of Women in Cardiovascular Trials' 29(3) *Arteriosclerosis, Thrombosis, and Vascular Biology* 279, https://www.ahajournals.org/doi/full/10.1161/ATVBAHA.108.179796.

341 Regulation (EU) 2021/2282 of the European Parliament and of the Council of 15 December 2021 on health technology assessment and amending Directive 2011/24/EU [2021] OJ L 458/1.

342 Regulation 2021/2282, Article 1(1)(b) and 13(1)(d).

343 Regulation 2021/2282, Article 7.

344 Regulation 2021/2282, Article 3.

345 Regulation 2021/2282, Article 7(2)(a) 12 January 2025; (b) 13 January 2028; (c) 13 January 2030.

346 Regulation 2021/2282, Article 25. See, for example, Commission Implementing Regulation (EU) 2025/117 of 24 January 2025 laying down rules for the application of Regulation (EU) 2021/2282 with regard to the procedures for joint scientific consultations on medical devices and in vitro diagnostic medical devices [2025] OJ L 2025/117; Commission Implementing Regulation (EU) 2024/3169 of 18 December 2024 laying down rules for the application of Regulation (EU) 2021/2282 of the European Parliament and of the Council with regard to the procedures for joint scientific consultations on medicinal products for human use at Union level [2024] OJ L 2024/3169.

347 Regulation 2021/2282, Article 13.

348 Regulation 2021/2282, Article 31.

Recommendation: As part of the reporting on Directive 2021/2282, there is potential to review the joint clinical assessments work undertaken by the coordination group from the point of view of gender equality in access to healthcare. Commission Implementing Regulations adopted under Directive 2021/2282 could pay explicit attention to procedural matters to improve gender disadvantage in health technology assessment, in accordance with the obligation in Article 8 TFEU.

5.4 Access to private healthcare based on Union law on free provision of services

Directive 2011/24 was a legislative response to a line of CJEU case law based on Article 56 TFEU,[349] according to which Member States to some extent lost control over who could access healthcare services within their territories, relying upon Union law. In Union law, Article 56 TFEU is constitutionally superior to a Directive, but in practice the CJEU has brought its jurisprudence into line with the provisions of Directive 2011/24.[350] Member States have thus regained significant control over access to cross-border healthcare provided within their national healthcare/social insurance systems. Consequently, this body of Union legislation cannot be relied upon to access healthcare services like abortion or gender-affirming care, that are not available in the 'basket of care' in some Member States, or are available only with certain restrictions, or indeed are criminalised.[351]

However, Article 56 TFEU at least potentially has particular relevance for private access to those kinds of healthcare services. Rather than focusing on a patient's right to access healthcare, Article 56 TFEU could be relied upon by a *provider* of healthcare, seeking to offer cross-border healthcare to a patient who cannot (lawfully) access it, even on a private basis, in their home Member State.

For example, Hervey and Sheldon[352] have shown how Union economic law could be relied upon to provide cross-border abortion by telemedicine within the Union. Their reasoning builds through the following steps. First, abortion is a 'service' in Union internal market law.[353] Secondly, a medical consultation taking place through a website is an 'electronic service' in Union internal market law.[354] Thirdly, although a 'service' in internal market law must be provided 'for remuneration', that remuneration may come from a third party;[355] and equally there is no need for a service provider to be seeking to make a profit in order to fall within internal market law.[356] Fourthly, Union law gives directly effective rights[357] to both providers and recipients of cross-border services.[358] Fifthly, Union law prohibits 'restrictions' on cross-border services, and the concept of 'restriction' is

[349] See the line of case law beginning with: C-120/95 *Decker* 28 April 1998 ECLI:EU:C:1998:167; C-158/96 *Kohll* 28 April 1998 ECLI:EU:C:1998:171; C-368/98 *Abdon Vanbraekel and Others v Alliance nationale des mutualités chrétiennes (ANMC)* 12 July 2001 ECLI:EU:C:2000:271; C-157/99 *Geraets-Smits and Peerbooms v. Stichting Ziekenfonds VGZ and Others* 12 July 2001 ECLI:EU:C:2001:456; C-385/99 *Müller-Fauré v. Onderlinge Waarborgmaatschappij VGZ* 13 May 2003 ECLI:EU:C:2003:160; C-372/04 *Watts v. Bedford Primary Care Trust and Secretary of State for Health* 16 May 2006 ECLI:EU:C:2006:424.

[350] See Hervey, T. and McHale, J. (2015) *European Union Health Law: Themes and Implications* pp. 83–97.

[351] For an overview, see Berro Pizzarosa, L., Hervey, T. and de Ruijter, A. (2023) 'Abortion law in Europe: the promise and pitfalls of human rights and transnational trade law in the face of criminalization with exceptions' in Ziegler, M. (ed), *Research Handbook on International Abortion Law*, Edward Elgar, pp. 374-393.

[352] See Hervey, T. and Sheldon, S. (2017) 'Abortion by Telemedicine in Northern Ireland: patient and professional rights across borders' 68 *Northern Ireland Law Quarterly* 33; see also Robinson, L. and Hervey, T. (2016) 'Women's Right to Choose in EU Law', YouTube, 11 Jan 2016, https://www.youtube.com/watch?v=uEuVPMleJ6Q&t=1s.

[353] C-159/90 The Society for the Protection of Unborn Children Ireland Ltd v Stephen Grogan and others 4 October 1991 ECLI:EU:C:1991:378.

[354] Directive 2000/31/EC of the European Parliament and of the Council of 8 June 2000 on certain legal aspects of information society services, in particular electronic commerce, in the Internal Market (E-Commerce Directive) OJ 2000 L 178/1, Article 1(2), 2(a), referring to Directive 98/43/EC, Article 1(2).

[355] C-352/85 Bond van Adverteerders and others v The Netherlands 26 April 1998 ECLI:EU:C:1988:196.

[356] C-281/06 *Jundt* 18 December 2007 ECLI:EU:C:2007:816.

[357] C-33/74 *Van Binsbergen* [1974] ECLI:EU:C:1974:131.

[358] Joined cases 286/82 and 26/83 *Graziana Luisi and Giuseppe Carbone v Ministero del Tesoro* 31 January 1984 ECLI:EU:C:1984:35.

very broadly construed, covering 'any national rules which have the effect of making the provision of services between Member States more difficult than the provision of services purely within a Member State'.[359] Sixthly, and finally, any justifications for such restrictions, on the basis of objective public interests,[360] must be narrowly construed.[361]

Similar arguments could be made for aspects of gender-affirming healthcare, which are not available in many Member States, but is available in some. Such applications of Union law are untested in national courts or the CJEU.

The line of argument here frames women and girls who seek to access medical abortions, or trans men, women, boys or girls who seek gender-affirming healthcare, not as patients but as economic actors receiving medical services. This approach has therefore been seen as problematic in terms of human dignity, an aspect of the human right to healthcare.[362] It is also profoundly problematic in terms of intersectional disadvantage. Only those who have sufficient economic resources are able to access Union law rights to access the desired/necessary healthcare. This disadvantage is the basis of the intersectional non-discrimination and human-rights based arguments put forward *inter alia* by the My Voice My Choice campaign.[363] In effect, the argument relies on the Union's overall obligation to promote equality wherever its competence permits, found in Article 9 TEU, 10 TFEU and Articles 20 and EUCFR. The Union has no competence to harmonise access to medical abortion. But the Union does have competence to create a solidarity-based financial mechanism in which Member States could, if they wished, participate, so as to equalise access to cross-border healthcare, and make it no longer contingent upon the ability to pay. This could be modelled on the optional joint procurement measures adopted during the COVID-19 pandemic,[364] with a dual legal basis of Articles 122(1) and 168(5) TFEU, which permits the Union legislature to adopt 'incentive measures designed to protect and improve human health'.

Recommendation: Relying on Article 122(1) and Article 168(5) TFEU, and modelled on joint procurement measures adopted in response to the COVID-19 pandemic and incentive measures such as the EU4Health programme, initiate a Commission proposal for a voluntary financial mechanism supporting cross-border healthcare for gender-based treatments (such as medical abortion, gender-affirming care) that are available in some, but not all, Member States.

[359] See C-444/05 *Stamatelaki* 19 April 2007 ECLI:EU:C:2007:231, paragraph 25; see Hervey, T. and McHale, J. (2015) *European Union Health Law: Themes and Implications* pp. 77-83; Gekiere, W., Baeten, R. and Palm, W. (2010) 'Free Movement of Services in the EU and Health Care' in Mossialos, E., Permanand, G., Baeten, R. and Hervey, T. (eds), *Health Systems Governance in Europe: The Role of European Union Law and Policy*, Cambridge University Press; Hancher, L. and Sauter, W. (2012) *EU Competition and Internal Market Law in the Healthcare Sector*, OUP.

[360] Objective public interests could include 'public policy, in particular the prevention, investigation, detection and prosecution of criminal offences … public health … the protection of consumers', or where the service presents a 'serious and grave risk of prejudice to those objectives', see E-Commerce Directive, Article 3(4).

[361] This is a long-established principle of EU law, see C-71/76 *Thieffry* 28 April 1977 ECLI:EU:C:1977:65; C-340/89 *Vlassopoulou* 7 May 1991 ECLI:EU:C:1991:193; it is also enshrined in EU legislation: Directive 2005/36/EC of the European Parliament and of the Council of 7 September 2005 on the recognition of professional qualifications [2005] OJ L255/22.

[362] Isailović, I. (2024) 'EU Abortion Law After *Dobbs*: States, the Market and Stratified Reproductive Freedom' 30(1) *The Columbia Journal of European Law* 1, https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4732837.

[363] My Voice, My Choice (2024) 'We Need 1 Million Signatures to Keep Abortion Safe and Accessible in Europe', https://www.myvoice-mychoice.org; European Commission, *My Voice, My Choice: For Safe and Accessible Abortion* (European Citizens' Initiative, Commission decision registered 10 April 2024), https://citizens-initiative.europa.eu/initiatives/details/2024/000004_en.

[364] Council Regulation (EU) 2022/2372 of 24 October 2022 on a framework of measures for ensuring the supply of crisis-relevant medical countermeasures in the event of a public health emergency at Union level [2022] OJ L 314/64, Article 8; see further below on Union responses to the COVID-19 pandemic.

6 Union law applicable at the Union's external border

Key legal instruments

Directive 2011/95/EU (Qualifications Directive); to be replaced by the Regulation (EU) 2024/1347 (Qualifications Regulation) from 1 July 2026

Directive 2013/32/EU (Procedures Directive); to be replaced by Regulation (EU) 2024/1348 (Procedures Regulation) from 12 June 2026

Directive 2013/33/EU (Reception Conditions); to be replaced by Directive (EU) 2024/1346 (Revised Reception Conditions Directive) from 12 June 2026

Regulation (EU) 2024/1349 of the European Parliament and of the Council of 14 May 2024 establishing a return border procedure, and amending Regulation (EU) 2021/1148 OJ L, 2024/1349 (Returns Directive)

Regulation (EU) 2024/1356 (Screening Regulation), from 12 June 2026, linking also to provisions on health checks and assessments of vulnerability pursuant to the Procedures Regulation and the Reception Conditions and Returns Directives; and Regulation (EU) 2024/1349 (Return Border Procedure Regulation)

Finally at this level, we consider Union asylum/refugee law that imposes explicit obligations on Member States and grants explicit rights to access (basic) healthcare services. Our comparative data shows concerns about practical access to healthcare services for this vulnerable group of women and girls.[365]

> 'Refugees, asylum seekers and migrants seem to be at the greatest risk of worse health outcomes (WHO, undated) – including most non-communicable diseases such as cardiovascular disease, cancer, diabetes and stroke. From a gender perspective, refugee, asylum seeker and migrant women frequently face specific challenges in terms of maternal, newborn and child health, sexual and reproductive health, and violence (WHO, undated). By way of example, a recent scientific review found that the prevalence of postnatal depression among migrant women (including refugees and asylum seekers) is twice that of women from host countries (Heslehurst et al., 2018). Similarly, a review found that maternal mortality rates are also twofold among migrant women in European countries – an additional 9 maternal deaths per 100,000 deliveries per year for migrant women (Pedersen et al., 2014). Research studies have also found significantly increased risks of risks of stillbirth (40 % higher), perinatal mortality (35 % higher), neonatal mortality (34 % higher) and infant mortality (33 % higher) among migrant women in European countries compared with women from the host countries (Gissler et al., 2009).'[366]

[365] See Chapter 9, section 9.1.

[366] European Commission (2021), *Gender Equality and Health in the EU* p. 20.

Women and girls who reach the Union because they are fleeing war or persecution have healthcare rights specified in Union asylum/refugee law.[367] Union asylum/refugee law is found in several legislative instruments, many of which will be replaced by new regulations, which come into force in June or July 2026.

These are the principal provisions through which the Union fulfils its obligation – and that of its Member States – to protect the human right to healthcare as a human right in international law, including in CEDAW.[368] As Peers observes, the relevant law is 'an uneasy, and possibly unstable, compromise between migration control objectives and human rights safeguards'.[369]

The relevant provisions apply to human beings reaching the Union's territory who do not enjoy rights as citizens or lawful residents of the Union. The majority[370] are among the most vulnerable people present in the Union. Women and girls in this category are more vulnerable than men, given intersectional disadvantages that flow from their distress migrant status[371] and their identities in a range of protected characteristics, including not only gender but also race, ethnicity, religion and economic status.

6.1 Arrival at the Union border

Those within the scope of the Screening Regulation,[372] who arrive at the Union's border, have the right to 'access to emergency health care and essential treatment of illness'.[373] This obligation fulfils the Union's and Member States' minimum human rights obligations to secure the right to healthcare.[374] In the context of women's rights to health, such 'essential treatment' includes basic pregnancy and maternity care. It also includes access to essential medicines, as set out in the WHO's Model List of Essential Medicines.[375] These include, for example, tamoxifen used to treat breast cancer; medroxyprogesterone acetate used to treat hormonal conditions, including heavy periods, endometriosis, polycystic ovary syndrome and menopause symptoms; propylthiouracil used for thyroid patients in the first trimester of pregnancy; and a range of oral, hormonal and implantable contraceptives, intrauterine devices, condoms and diaphragms. Mifepristone-misoprostol used for medicinal

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[367] A note on scope: put simply, Ireland, Denmark, Norway, Iceland, Switzerland and Liechtenstein have opted out of the relevant body of law. However there are exceptions to that position. For details, see Peers, S. (2024) 'The New EU asylum laws: taking rights half-seriously' 3 *Yearbook of European Law*, https://academic.oup.com/yel/advance-article/doi/10.1093/yel/yeae003/7733120; and Thym, D. (2023) *European Migration Law*, OUP; see also: Savas, S. T. and others, (2024) 'Migrant-sensitive healthcare in Europe: advancing health equity through accessibility, acceptability, quality, and trust' 41 *Lancet Regional Health – Europe* 100805, https://pmc.ncbi.nlm.nih.gov/articles/PMC11496971/; Gil-Salmerón, A. and others, (2021) 'Access to healthcare for migrant patients in Europe: healthcare discrimination and translation services' 18(15) *International Journal of Environmental Research and Public Health* 7901; Aljadeeah, S. and others (2024), 'Access to medicines among asylum seekers, refugees and undocumented migrants across the migratory cycle in Europe: a scoping review' 9 *BMJ Global Health* e015790, https://gh.bmj.com/content/9/10/e015790.

[368] See above Chapter 2.

[369] Peers, S. (2024) 'The new EU asylum laws: taking rights half-seriously' 43 *YEL*, 113-183 https://academic.oup.com/yel/advance-article/doi/10.1093/yel/yeae003/7733120.

[370] Eurostat (2024), 'Migrant Integration Statistics – At Risk of Poverty and Social Exclusion', 26 September 2024, https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Migrant_integration_statistics_-_at_risk_of_poverty_and_social_exclusion.

[371] On distress migration and the right to health, see the special issue of *Health and Human Rights* 26(2) (2024).

[372] They are '[a]… third-country nationals who, without fulfilling the entry conditions set out in Article 6 of Regulation (EU) 2016/399 [the Schengen Borders Code], have crossed the external border in an unauthorised manner, have applied for international protection during border checks, or have been disembarked after a search and rescue operation, before they are referred to the appropriate procedure; and (b) third-country nationals illegally staying within the territory of the Member States where there is no indication that those third-country nationals have been subject to controls at external borders, before they are referred to the appropriate procedure', Regulation (EU) 2024/1356 of the European Parliament and of the Council of 14 May 2024 introducing the screening of third-country nationals at the external borders and amending Regulations (EC) No 767/2008, (EU) 2017/2226, (EU) 2018/1240 and (EU) 2019/817 [2024] OJ L 2024/1356, Article 1.

[373] Regulation 2024/1356, Article 12(1).

[374] See above Chapter 1, section 1.2.

[375] World Health Organization (2023), *WHO Model List of Essential Medicines – 23rd List, 2023*, 26 July 2023, https://www.who.int/publications/i/item/WHO-MHP-HPS-EML-2023.02.

abortions are only 'essential medicines' in the WHO sense 'where permitted under national law and where culturally acceptable'.[376]

People who cross the Union's external border without fulfilling the entry conditions set out in the Union's Schengen Borders Code,[377] or who are disembarked into Union territory following a search and rescue at sea, whether they apply for asylum or not,[378] must be screened 'without delay' and in any event within seven days of arrival.[379] This screening is mainly to control the Union's external borders from unwanted migration, but it also includes health checks. The purpose of such 'preliminary health checks'[380] is Janus-faced: 'to identify persons in need of health care and persons that might pose a threat to public health …'.[381] The screening is to 'facilitate the referral of such persons to the appropriate procedure',[382] to 'identify [...] any needs for healthcare' or for 'isolation on health grounds'.[383] The screening may form part of the 'medical examination' set out in the Procedures Regulation 2024/1348, Article 24 (see further below).[384]

Member States are obliged to ensure that health checks are carried out by 'qualified medical personnel'.[385] There is no definition of 'qualified' in this sense: it presumably refers to national or Union qualifications for relevant healthcare professionals. To secure gender equality, 'qualified' should also be extended to mean specific qualifications in the healthcare needs of women and girls who seek asylum. In order to respect intersectional equality, a woman healthcare professional may be needed to screen some women or girls, in accordance with their religious and/or cultural identities.

As well as a health check, screening must include a 'preliminary vulnerability check', to determine whether the person arriving at the Union border 'might be … vulnerable, or a victim of torture or other human or degrading treatment', or have 'special needs' under the Returns Directive,[386] the Revised Reception Conditions Directive,[387] or the Procedures Regulation.[388] Where the vulnerability check suggests that the person is vulnerable or has special needs, Member States must give them 'timely and adequate support in adequate facilities in view of their physical and mental health'.[389] Support must be age appropriate.

Specific data on the healthcare experiences of women and girls who are, formally speaking, asylum seekers is difficult to find. Relevant studies tend to bring together experiences of undocumented migrants along with asylum seekers and indeed those formally recognised as refugees. However, those studies show that

[376] World Health Organization (2023), *WHO Model List of Essential Medicines – 23rd List, 2023*.
[377] Regulation (EU) 2016/399 of the European Parliament and of the Council of 9 March 2016 on a Union Code on the rules governing the movement of persons across borders (Schengen Borders Code) OJ L77/1.
[378] Regulation 2024/1356, Article 5(1).
[379] Regulation 2024/1356, Article 8(3).
[380] Regulation 2024/1356, Article 12.
[381] Regulation 2024/1356, Article 1.
[382] Regulation 2024/1356, Article 1.
[383] Regulation 2024/1356, Article 12(1).
[384] Regulation 2024/1356, Article 12(2).
[385] Regulation 2024/1356, Article 12(1).
[386] Directive 2008/115/EC of the European Parliament and of the Council of 16 December 2008 on common standards and procedures in Member States for returning illegally staying third-country nationals OJ L 348/98, Article 14.
[387] Directive (EU) 2024/1346 of the European Parliament and of the Council of 14 May 2024 laying down standards for the reception of applicants for international protection OJ L 2024/1346, Article 25.
[388] Regulation 2024/1348 of the European Parliament and of the Council of 14 May 2024 establishing a common procedure for international protection in the Union and repealing Directive 2013/32/EU OJ L 2024/1348, Article 20.
[389] Regulation (EU) 2024/1356 of the European Parliament and of the Council of 14 May 2024 introducing the screening of third-country nationals at the external borders and amending Regulations (EC) No 767/2008, (EU) 2017/2226, (EU) 2018/1240 and (EU) 2019/817 [2024] OJ L 2024/1356, Article 12(4).

migrant/asylum-seeking women and girls experience worse healthcare than women and girls resident in the relevant state. For example, a 2018 systematic review of 29 systematic reviews showed that:

> 'Migrant women's experiences of care included negative communication, discrimination, poor relationships with health professionals, cultural clashes and negative experiences of clinical intervention. Additional data for asylum seekers and refugees demonstrated complex obstetric issues, sexual assault, offspring mortality, unwanted pregnancy, poverty, social isolation and experiences of racism, prejudice and stereotyping within perinatal healthcare.'[390]

A systematic review on asylum seekers[391] covering data from 2002-2012 found that asylum seekers were more likely to experience sexual assault and unwanted pregnancies in comparison with women in the host countries. In 2018, it was found that 17 Member States did not provide free or subsidised maternal healthcare to undocumented migrant women.[392] Lack of consistency as to whether childbirth, labour, and other aspects of pregnancy and maternity constitute 'emergency healthcare' compounds exclusion.[393] A 2020 systematic review of 51 studies across 14 European countries showed that women were routinely denied access to basic maternity care while held in detention centres[394] (see further below). Several of these studies showed experience of 'unfriendly' and 'disrespectful' healthcare professionals, failing to respond to the concerns of migrant women, 'ignoring them, and not taking their complaints seriously'.[395]

Specifically on people fleeing Ukraine, a European Union Agency for Fundamental Rights report drawing on data gathered in 2022 noted 'a challenging situation with regard to … access to healthcare, including mental health services'.[396] Most people displaced from Ukraine are women and children, and the same survey revealed that two-thirds of women respondents reported mental ill health, including panic attacks, anxiety and depression, suggesting that the 'challenging situation' is having a particular impact on women.

A 2025 systematic review of 57 studies, mainly involving data from Europe, found access to healthcare was significantly compromised or hampered for migrant women.[397] In nine studies, women 'experienced direct denial or exclusion from maternal healthcare – meaning they were not allowed to access it at all regardless of their situation'.[398] Two of those nine studies involved Union Member States; one involved Norway, and one the UK.

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[390] Heslehurst, N., Brown, H., Pemu, A., Coleman, H. and Rankin, J. (2018), 'Perinatal health outcomes and care among asylum seekers and refugees: A systematic review of systematic reviews', *BMC Medicine*, Vol. 16, available at: https://doi.org/10.1186/s12916-018-1064-0, pp. 1 and 5-21 for details.

[391] Hadgkiss EJ, Renzaho AMN (2014) 'The physical health status, service utilisation and barriers to accessing care for asylum seekers residing in the community: a systematic review of the literature', *Australian Health Review*; 38(2):142–59.

[392] Center for Reproductive Rights (2018), *Perilous journeys: Barriers in access to affordable maternal healthcare for undocumented migrant women in the European Union*, https://reproductiverights.org/sites/default/files/documents/Perilous-Pregnancies-Health-Care-For-Undocumented-Migrant-Women-EU.pdf, pp. 33-3 .

[393] Center for Reproductive Rights (2018), *Perilous journeys: Barriers in access to affordable maternal healthcare for undocumented migrant women in the European Union*, pp. 33-35.

[394] Fair, F., Raben, L., Watson, H., Vivilaki, V., van den Muijsenbergh, M. and Soltani, H. (2020) 'Migrant women's experiences of pregnancy, childbirth and maternity care in European countries: A systematic review' *PLos One* 11 February 2020 https://doi.org/10.1371/journal.pone.0228378, p 11.

[395] Fair F., Raben, L., Watson, H., Vivilaki, V., van den Muijsenbergh, M. and Soltani, H. (2020) 'Migrant women's experiences of pregnancy, childbirth and maternity care in European countries: A systematic review', p. 13; see also Arcilla, J.T., Nanou, A., Hamed, S. *et al.* (2025) 'Racialized migrant women's discrimination in maternal care: a scoping review', *Int J Equity Health* 24, 16, https://doi.org/10.1186/s12939-025-02384-8, p. 9.

[396] European Union Agency for Fundamental Rights (FRA) (2023), *Asylum and Migration: Progress Achieved and Remaining* Challenges, p. 19.

[397] Arcilla, J.T., Nanou, A., Hamed, S. *et al.* (2025) 'Racialized migrant women's discrimination in maternal care: a scoping review', pp. 7-8.

[398] Arcilla J.T., Nanou, A., Hamed, S. *et al.* (2025) 'Racialized migrant women's discrimination in maternal care: a scoping review', p. 8.

Of the 57 studies, 22 found verbal or physical abuse.[399] Of those, ten involved Union Member States; one involved each of Norway, Switzerland and the UK. Nineteen studies explicitly found discriminatory care when compared to women in the host state: involving 11 Member States, Norway, Switzerland and the UK.[400] This kind of intersectional discrimination is an important site for improving gender equality in healthcare across the Union.

Taken together, these reports suggest a profound lack of effective enforcement of obligations under Union asylum and refugee law.

Recommendation: There is scope for the European Commission to take action to enforce relevant obligations, taking into account the position of women and girls, and the Union's gender mainstreaming obligations.

6.2 Access to healthcare while application for asylum is considered

While their application for asylum is being considered, asylum seekers are entitled to informational and some substantive rights to healthcare. Member States are entitled to require medical screening of such applicants, on public health grounds.[401]

Member States must provide information, in writing, and in an appropriate language, about organisations that 'might be able to help or inform' about what is available 'including healthcare'.[402] This is a very weak obligation.

The key substantive right to healthcare is found in Article 19 of the Reception Conditions Directive, which provides that:

1. Member States shall ensure that applicants receive the necessary health care which shall include, at least, emergency care and essential treatment of illnesses and of serious mental disorders.

2. Member States shall provide necessary medical or other assistance to applicants who have special reception needs, including appropriate mental health care where needed.

This provision has been amended and significantly further specified in the Revised Reception Conditions Directive, Article 22, which reads:

1. Member States shall ensure that applicants … receive the necessary health care, whether provided by generalists or, where needed, specialist practitioners. Such necessary health care shall be of adequate quality and include, at least, emergency care, essential treatment of illnesses, including of serious mental disorders, and sexual and reproductive health care which is essential in addressing a serious physical condition.

2. Member States shall ensure that the minor children of applicants and applicants who are minors receive the same type of health care as provided to their own nationals who are minors. Member States shall ensure that specific treatment provided in accordance with this Article which started before the minor

[399] Arcilla J.T., Nanou, A., Hamed, S. *et al.* (2025) 'Racialized migrant women's discrimination in maternal care: a scoping review', p. 11.
[400] Arcilla J.T., Nanou, A., Hamed, S. *et al.* (2025) 'Racialized migrant women's discrimination in maternal care: a scoping review', p. 11.
[401] Directive 2013/33/EU of the European Parliament and of the Council of 26 June 2013 laying down standards for the reception of applicants for international protection (recast) OJ L 180/96, Article 13; Directive 2024/1346, Article 15.
[402] Reception Conditions Directive 2013/33, Article 5; Revised Reception Conditions Directive 2024/1346, Article 5.

reached the age of majority and is considered to be necessary, is received without interruption or delay after the minor reaches the age of majority.

3. Where needed for medical reasons, Member States shall provide necessary medical or other assistance, such as necessary rehabilitation and assistive medical devices, to applicants who have special reception needs, including appropriate mental health care.

Unlike the Screening Regulation obligations, obligations in the Reception Conditions Directive and Revised Reception Conditions Directive explicitly refer to mental healthcare, as well as physical healthcare. Given the circumstances of applicants for asylum, who are fleeing war or persecution, this is highly appropriate. The points made above about 'essential treatment of illnesses', including access to essential medicines, also apply here. From the point of view of women and girls, the explicit provision about 'sexual and reproductive health care which is essential in addressing a serious physical condition' is welcome. The precise meaning of this wording may need to be tested: does it, for example, cover hormone replacement therapy for menopause symptoms? The explicit provision in the Revised Reception Conditions Directive for healthcare of minors, providing that it must be the same as provided for minors who are nationals, is also welcome, especially where applicant girls need to receive sexual and reproductive healthcare.

Furthermore, the conditions in which asylum applicants must wait while their claims are processed must 'provide an adequate standard of living', 'which … protects their physical and mental health'.[403] The Revised Reception Conditions Directive adds that reception conditions, which may vary between Member States, must 'in any event ensure access to healthcare … and a standard of living for all applicants in accordance with Union law, including the [EU] Charter [of Fundamental Rights] and international obligations',[404] and must respect applicants' rights under the EU Charter of Fundamental Rights.[405] This includes rights to equality and non-discrimination, within the scope of the Charter. A provision in the Revised Reception Conditions Directive specifies which applicants are more likely to have 'special reception needs'. This list includes pregnant women, trans and intersex people, victims of human trafficking, people with serious illnesses, people with 'mental disorders including post-traumatic stress disorder', and people 'who have been subjected to torture, rape or other serious forms of psychological, physical or sexual violence, for example victims of gender-based violence, of female genital mutilation, of child or forced marriage, or violence committed with a sexual, gender, racist or religious motive'.[406] All are likely to need to access healthcare in the relevant Member State, and the Directive entitles them to the minimum healthcare necessary for their condition. Women and girls who fall within the scope of the Human Trafficking Directive, Victims' Rights Directive and the Violence Against Women Directive are also entitled to the rights provided there (see above Chapter 3, section 3.2).

Provision of healthcare may be means tested,[407] and applicants may be required to contribute towards the costs of healthcare if they are able to do so,[408] but the implication is that applicants who cannot afford to access the requisite healthcare must be offered it free of charge. The Revised Reception Conditions Directive

[403] Reception Conditions Directive 2013/33, Article 17(2); Revised Reception Conditions Directive 2024/1346, Article 19 (2).
[404] Revised Reception Conditions Directive 2024/1346, Article 20(10).
[405] Revised Reception Conditions Directive 2024/1346, Article 19(2).
[406] Revised Reception Conditions Directive 2024/1346, Article 24.
[407] Reception Conditions Directive 2013/33, Article 17(3), Revised Reception Conditions Directive 2024/1346, Article 19 (3).
[408] Reception Conditions Directive 2013/33, Article 17(4); Revised Reception Conditions Directive 2024/1346, Article 19(4) and (5).

conditions the ability of Member States to means-test access to healthcare by requiring that Member States doing so 'respect the principle of proportionality', and ensure respect for 'dignity or personal integrity'.[409]

Where vulnerable applicants are detained, their health, including mental health, 'shall be of primary concern to national authorities'.[410] This obligation is not enforceable in practice: what does it mean to say that someone's health is 'of primary concern'? The Reception Conditions Directive includes a more specific obligation to monitor such individuals regularly, taking account their individual situation and health.[411] This obligation has been improved in the Revised Reception Conditions Directive, which prohibits the detention of 'applicants with special reception needs', where such detention 'would put their physical and mental health at serious risk'.[412] The word 'and' in this provision is unfortunate, as it implies that both physical and mental health must be at serious risk, and it is not enough that mental health alone is at serious risk. This drafting makes what would be an important right to protection of mental health from the stressors of detention a much narrower entitlement. It should be revisited.

Member States may, in defined circumstances, and following designated procedures, reduce or withdraw the provisions they make in which asylum applicants wait for the processing of their claims.[413] However, 'Member States shall under all circumstances ensure access to health care in accordance with Article 19 and shall ensure a dignified standard of living for all applicants.'[414] The Revised Reception Conditions Directive, requires that 'Member States shall ensure access to health care in accordance with Article 22 and shall ensure a standard of living in accordance with Union law, including the Charter, and international obligations for all applicants'.[415]

Again, there is significant evidence showing that these obligations are not effectively enforced in the Member States.[416]

> 'An estimated 500,000 women in the EU will go through their first months of pregnancy with no access to health services. Women belonging to vulnerable social groups are particularly affected by these gaps in availability, access and use of resources and adequate services (European Parliament, 2019). In several Member States, vulnerable groups of pregnant women (i.e. non-resident and irregular resident pregnant women) have only limited access to prenatal and postnatal healthcare or they are provided all necessary care and billed afterwards (European Observatory of Health Systems and Policies, 2017). In 11 EU Member States, laws and policies provide for undocumented migrant women's access to maternal healthcare throughout pregnancy free of charge or for subsidised fees. The laws and policies in Belgium, Estonia, France, Germany, Greece, Italy, the Netherlands, Portugal, Romania, Spain and Sweden all provide for undocumented migrant women's access to affordable maternal

[409] Revised Reception Conditions Directive 2024/1346, Article 19(6).
[410] Reception Conditions Directive 2013/33, Article 11(1); Revised Reception Conditions Directive 2024/1346, Article 13.
[411] Reception Conditions Directive 2013/33, Article 11(1); see also Revised Reception Conditions Directive 2024/1346, Article 13(1).
[412] Revised Reception Conditions Directive 2024/1346, Article 13(1).
[413] Reception Conditions Directive 2013/33, Article 20.
[414] Reception Conditions Directive 2013/33, Article 20.
[415] Revised Reception Conditions Directive 2024/1346, Article 23(4).
[416] Hervey, T. and Ververidou, F. (2024) 'Securing the Right to Health of Asylum-seekers: a small-scale qualitative study in Thessaloniki, Greece' 26 (2) *Health and Human Rights Journal* 91-104; see also: Gil-Salmerón, A. (2021) and others, 'Access to healthcare for migrant patients in Europe: healthcare discrimination and translation services' 18(15) *International Journal of Environmental Research and Public Health* 7901; De Vito, E. and others, (2016) 'Are undocumented migrants' entitlements and barriers to healthcare a public health challenge for the European Union?' 37 *Public Health Reviews* 13, https://doi.org/10.1186/s40985-016-0026-3; Chiarenza, A. and others, (2019) 'Supporting access to healthcare for refugees and migrants in European countries under particular migratory pressure' 19 *BMC Health Serv Res* 513, https://doi.org/10.1186/s12913-019-4353-1; Allegri, C., Barbiano di Belgiojoso, E. and Lorenza Rimoldi, SM (2025) 'Immigrants' self-perceived barriers to healthcare: A systematic review of quantitative evidence in European countries' 154 *Health Policy* 105268, https://doi.org/10.1016/j.healthpol.2025.105268.

healthcare by providing free or subsidised access to all maternal healthcare, including both antenatal care and care during labour and childbirth. In the other 17 Member States, laws and policies do not provide for undocumented migrant women's access to free or subsidised maternal healthcare throughout pregnancy. Instead, although approaches differ significantly across these jurisdictions, 25 laws and policies in Austria, Bulgaria, Croatia, Cyprus, Czechia, Denmark, Finland, Hungary, Ireland, Latvia, Lithuania, Luxembourg, Malta, Poland, Slovakia, Slovenia and the United Kingdom require undocumented migrant women to cover the costs of some, or in most cases all, maternal healthcare themselves (Center for Reproductive Rights, 2018).'[417]

Recommendation: European Commission to take action to enforce obligations on access to healthcare while an application for asylum is considered.

6.3 'Safe countries' and health

European Union asylum law operates on the basis that someone arriving in the Union from a 'safe country' does not have a right to refugee status in the Union: they are supposed to claim asylum in that 'safe country'. The Procedures Directive[418] and Regulation[419] cover the concept of 'safe country'. A safe country is one that has 'ratified and respects' the Geneva Convention on Refugees 1951, or, where a country has applied a geographical limit to the Refugee Convention,[420] provides 'effective protection'.[421] Under the Directive, 'sufficient protection' is not further defined.[422] Neither was it further specified by the CJEU in the context of a preliminary reference involving a woman leaving Gaza and reaching the Union via Jordan, because she was under threat from Hamas, the organisation that controls Gaza, because of her work informing women of their rights. The CJEU held that Jordan could constitute a 'safe country', the final determination being left to the national court.[423]

The Regulation specifies the concept of 'effective protection' further. Effective protection must include, 'as a minimum', that asylum applicants must 'have access to healthcare and essential treatment for illnesses under the conditions generally provided for in that third country'.[424] Providing access to essential healthcare is therefore an integral part of what makes a country 'safe', for the purposes of Union asylum law. This provision is particularly relevant to women or girls who reach the Union via countries that do not provide essential sexual and reproductive healthcare, or trans and intersex people who reach the Union via countries which do not provide gender-affirming healthcare.

Recommendation: European Commission to produce interpretative guidance to clarify that a 'safe' country is one which provide access to essential healthcare for women and girls.

[417] European Commission (2021), *Gender Equality and Health in the EU*, p. 41.
[418] Directive 2013/32/EU of the European Parliament and of the Council of 26 June 2013 on common procedures for granting and withdrawing international protection (recast) OJ L 180/60.
[419] Regulation (EU) 2024/1348.
[420] As Peers, S. (2024) 'The new EU asylum laws: taking rights half-seriously' 43 *YEL*, 113-183 https://academic.oup.com/yel/advance-article/doi/10.1093/yel/yeae003/7733120, p. 162 explains, this provision is particularly aimed at Turkey, which has invoked the geographical limit in Article 1.B of the Refugee Convention, so that people fleeing Asian or African countries may not claim refugee status. The Union's Member States, in practice, assume that Turkey is a 'safe country' (see, for instance, the argument of the Commission in its Communication on the state of play of the EU migration agenda (COM (2016) 85, 10 February 2016). However, this point has not been tested before the CJEU.
[421] Procedures Directive, Article 38; Procedures Regulation 2024/1348, Article 57.
[422] Procedures Directive, Article 38 (b).
[423] C-585/16 *Alheto* 25 July 2018 ECLI:EU:C:2018:584.
[424] Procedures Regulation 2024/1348, Article 57(2)(c).

6.4 Qualifying as a refugee: health rights in Union law

If someone qualifies as a refugee under the relevant Union asylum law,[425] they are entitled to access the national healthcare/social insurance system of the Member State granting refugee status. This access must be 'under the same eligibility conditions as nationals'.[426] There is an explicit inclusion of 'adequate healthcare' for 'mental disorders', people with 'special needs', 'pregnant women', and people 'who have undergone torture, rape or other serious forms of psychological, physical or sexual violence'.[427]

If someone's application is rejected, Member States must require them to reside for no longer than 12 weeks in designated locations, before being returned. The conditions under which they reside must be equivalent to the conditions and healthcare applicable while their application was being processed.[428]

The studies cited above (sections 6.1 and 6.2) suggest that, even when formally recognised as refugees, women and girls do not enjoy full non-discriminatory access to national healthcare systems in the European Union.

Recommendation: European Commission take action to enforce the obligations to grant refugees access to national healthcare on the same basis as nationals, and to provide adequate healthcare for those explicitly listed, including for 'mental disorders', people with 'special needs', 'pregnant women', and people 'who have undergone torture, rape or other serious forms of psychological, physical or sexual violence'.

[425] Directive 2011/95/EU of the European Parliament and of the Council of 13 December 2011 on standards for the qualification of third-country nationals or stateless persons as beneficiaries of international protection, for a uniform status for refugees or for persons eligible for subsidiary protection, and for the content of the protection granted (recast) (Qualifications Directive) [2011] OJ L 337/9; Regulation (EU) 2024/1347 of the European Parliament and of the Council of 14 May 2024 on standards for the qualification of third-country nationals or stateless persons as beneficiaries of international protection, for a uniform status for refugees or for persons eligible for subsidiary protection and for the content of the protection granted, amending Council Directive 2003/109/EC and repealing Directive 2011/95/EU of the European Parliament and of the Council [2024] OJ L 2024/1347.

[426] Qualifications Directive 2011/95, Article 30(1); Qualifications Regulation 2024/1347, Article 32(1).

[427] Qualifications Directive 2011/95, Article 30(2); Qualifications Regulation 2024/1347, Article 32(2).

[428] Regulation 2024/1349 of the European Parliament and of the Council of 14 May 2024 establishing a return border procedure, and amending Regulation (EU) 2021/1148 [2024] OJ L 2024/1349, Article 4(2).

7 European Union health law with gendered dimensions

European Union health law, based on internal market,[429] public health[430] and other competences,[431] covers a wide range of areas of substantive law. This section of the report considers those aspects with the most obviously gendered dimensions.

7.1 Union law on quality and safety of human organs and substances of human origin

Key legal instruments
SOHO Regulation 2024/1938 applies from 7 August 2027, repeals Directives 2002/98/EC (blood) and 2004/23/EC (human tissue and cells)
Directive 2010/45 on the quality and safety of human organs

Union law seeks to ensure the quality and safety of all substances of human origin (human blood, tissues, cells) and organs within the Union.[432] The basic aim of this legislation is to secure a sufficient supply of safe and high quality substances for the needs of patient populations across the Union. The ideal would be that the Union would be self-sufficient in this regard. The legislation assumes that, in principle, substances of human origin and organs are not commodities, and that therefore the giving of such substances or organs is an act of solidarity, not of commerce. Nonetheless, supply of blood and especially plasma, to the Union is in fact big business, and the Union relies on the USA for up to 30 % of its needs.[433]

This aspect of Union health law has a gendered dimension, not because women particularly need blood, plasma, organs and so on, but because of the way that the Union legislation has affected national policies that discriminate against men on grounds of their sexual orientation. The *Léger* case[434] concerned the question of whether a provision of French law that prohibited all men who have sex with men from donating blood was consistent with the relevant Union directive. The CJEU held that such a provision could be consistent with Union law, if on the basis of a proportionate application of current medical, scientific and epidemiological information, such sexual behaviour put men who have sex with men at a high risk of acquiring infectious diseases which could not be detected effectively or proportionately. The discrimination on grounds of sexuality could be justified by the need to protect blood recipients. The decision has been criticised for its overly broad approach,[435] and for its perpetuation of gender-based stereotypes.[436] As the Advocate General pointed out, the requirement in

429 Article 114 TFEU.
430 Article 168 TFEU.
431 See also Table of Legal Basis, Chapter 2, section 2.2.
432 For a history and details, see Hervey, T. and McHale, J. (2015) *European Union Health Law*, pp. 348-360.
433 Pijuan, S. (2025) 'Pay in Blood: the worrying EU dependency on US plasma', *euobserver*, 26 May 2025, https://euobserver.com/health-and-society/ar31abb718.
434 C-528/13 Geoffrey Léger v Ministre des Affaires socialies, de la Santé et des Droits des femmes and Établissement français du sang 29 April 2015, ECLI:EU:C:2015:288.
435 See, for example: Dunne, P. (2015) 'A Right to Donate Blood? Permanent Deferrals for "Men who have Sex with Men" (MSM): Léger' 52 *CML Rev* 1661; see also the discussion surrounding organ donation from women with a history of breast cancer: Mathelin, C., Domínguez-Gil, B., Özmen, V. and Lodi, M. (2023) 'European Guidelines Concerning the Transplantation of Organs from Donors with a History of Breast Cancer' 19 *European Journal of Breast Health* 106–109, https://pmc.ncbi.nlm.nih.gov/articles/PMC9806936/.
436 Hurley, R. (2009) 'Bad Blood: Gay Men and Blood Donation' 338 *British Medical Journal* 569, https://pubmed.ncbi.nlm.nih.gov/19246551/.

Directive 2004/33 for the behaviour to be 'high risk' was not met by a general and non-specific ban. Showing high risk behaviour needs evidence of specific 'habits and practices',[437] not simply being a man who has, or has had, sex with men.[438] When developing their national policies, which could be more protective than the 'floor' provided by the Directive, Member States are obliged to comply with general principles of Union law, including protection of fundamental human rights and non-discrimination on grounds of sex and sexuality. France had not done so.[439]

By making an assumption about the behaviours of all men who have or have had sex with men, the CJEU reinforces stereotypes of gay and bisexual men as promiscuous, untrustworthy, and carriers of disease, judged against a 'straight norm'.[440] Given the state of medical, scientific and epidemiological knowledge, even considering that a blanket ban could ever be justified in the name of protecting public health is unjustifiable, and disappointing.[441] Allowing a focus on the prevalence of sexually transmitted diseases such as HIV/AIDS is insufficiently protective of individual rights to non-discrimination. As Dunne points out:

> ... [P]revalence can only be one factor in determining HIV transmission risks. If one takes two groups of men – consisting of 10 MSM [men who have sex with men] and 10 MSW [men who have sex with women] – it would be logical to presume, without knowing more, that the MSM, by virtue of general prevalence rates, are a greater risk to the national blood supply. However, should it later be revealed that all the MSM engage in monogamous, protected intercourse, while all the MSW have recently had anonymous, unprotected sex, the risk analysis would have to shift. The higher prevalence rate among MSM is overshadowed by the high risk sexual practices among the MSW group.[442]

However, Dunne goes on to show that other aspects of the CJEU's approach are more equality-supportive. The focus on proportionality, and on scientific evidence of risk, point to a way in which Union law could be used to challenge overly broad exclusions from blood donation based on stereotyping, rather than on assessing risks of individual behaviour. Member States seeking to impose more stringent measures than in Union legislation must nonetheless comply with 'Union law' (which includes principles of non-discrimination and protection of fundamental human rights), and must consider proportionate risk, based on 'relevant scientific knowledge'. This obligation is carried forward in the new SOHO Regulation.[443] Explicit reference to the rights of donors, including a right to non-discrimination, is also made in the new Regulation.[444]

[437] Opinion of AG in C-528/13 Geoffrey Léger v Ministre des Affaires socialies, de la Santé et des Droits des femmes and Établissement français du sang 29 April 2015 ECLI:EU:C:2014:2112, para 32.
[438] Opinion of AG in C-528/13 Geoffrey Léger v Ministre des Affaires socialies, de la Santé et des Droits des femmes and Établissement français du sang 29 April 2015 ECLI:EU:C:2014:2112, para 37.
[439] Opinion of AG in C-528/13 Geoffrey Léger v Ministre des Affaires socialies, de la Santé et des Droits des femmes and Établissement français du sang 29 April 2015 ECLI:EU:C:2014:2112, paras 44-46.
[440] Hurley, R. (2009) 'Bad Blood: Gay Men and Blood Donation' 338 *British Medical Journal* 569, https://pubmed.ncbi.nlm.nih.gov/19246551/; Belavusau, U. and Isailovic, I. (2015) 'Gay blood: Bad blood? A brief analysis of the Léger case', European Law Blog, 26 August 2015, https://research.vu.nl/en/publications/gay-blood-bad-blood-a-brief-analysis-of-the-l%C3%A9ger-case-blog.
[441] Tryfonidou, A. (2015) 'Block exclusion on blood donation by gay and bisexual men: A disappointing CJEU ruling', EU Law Analysis Blog, 30 April 2015, http://eulawanalysis.blogspot.com/2015/04/block-exclusion-on-blood-donation-by.html.
[442] Dunne, P. (2015) 'A right to donate blood? Permanent deferrals for "men who have sex with men" (MSM): Léger' 52 *CML Rev* 1661, 1670-1671, https://kluwerlawonline.com/journalarticle/Common+Market+Law+Review/52.6/COLA2015135.
[443] Regulation (EU) 2024/1938 of the European Parliament and of the Council of 13 June 2024 on standards of quality and safety for substances of human origin intended for human application and repealing Directives 2002/98/EC and 2004/23/EC OJ L 2024/1938, Article 4.
[444] Regulation (EU) 2024/1938, Article 53(1)(c).

Recommendation: European Commission to undertake an investigation of the implementation of the new SOHO Regulation, with a view to ensuring that Union and Member State policy does not discriminate on the basis of gender stereotyping.

7.2 Gendered health data in the 'European Health Data Space'

Key legal instruments

General Data Protection Regulation 2016/679

European Health Data Space Regulation 2025/327

The literature suggests that there is a need for more, and better, data in order to be able to address gender gaps and inequalities in healthcare provision and a need for better understanding and dissemination of the differential gendered consequences and symptoms of diseases.[445] For example, the European Commission's 2021 report on *Gender and Health*,[446] discusses the EUGenMed (2013-15) and GenCAD (2015-2017) projects, which sought to improve biomedical and health research by introducing sex and gender. Key findings from EUGenMed include the need for research into cardiovascular diseases, diabetes, stroke, asthma and lung cancer to take sex and gender differences into account; and that sex and gender are important in the modifiable risk factors for major non-communicable diseases, so should be taken into account in such research.[447] In addition to confirming these findings, GenCAD further found gender differences in mental health and auto-immune and inflammatory diseases. Despite such differences, on reviewing numerous databases, GenCAD found that most have a limited use for analysing sex and gender differences, and 'a "true gender score", reflecting a psychosocial construct for gender, was not found in any database'.[448]

Potentially significant opportunities for improvements to human health are offered by applications of artificial intelligence in health domains: so-called 'big health data' studies. Such opportunities must also be attentive to inequalities, in terms of both the quality of datasets and the solidarity-basis of such freely given health data. To what extent, if at all, does Union data law address these health data gender gaps?

Union law as applicable to health data includes the General Data Protection Regulation 2016/679 (GDPR) and the European Health Data Space (EHDS) Regulation 2025/327, much of which comes into effect on 27 March 2027.[449] Other relevant Union law, such as the Clinical Trials Directive,[450] is discussed below. The GDPR protects health data as a special category of personal data.[451] 'Processing' of such data is lawful only within certain circumstances, such as where the person whose data is processed has given consent, or it is in the public interest.[452] The EHDS Regulation seeks to facilitate access to health data across the Union, for both primary and secondary use. Primary use of health data is where the data is used for the person to whom the data relates.[453] From the point of view of gender equality and health, what is more important is secondary use:

[445] See Chapter 9, section 9.1.4.
[446] European Commission (2021), *Gender Equality and Health in the EU*.
[447] European Commission (2021), *Gender Equality and Health in the EU* p. 48.
[448] European Commission (2021), *Gender Equality and Health in the EU* p. 48.
[449] Some provisions do not come into effect until 2029 or as late as 2035, see EHDS Regulation, Article 105.
[450] Regulation (EU) No 536/2014 of the European Parliament and of the Council of 16 April 2014 on clinical trials on medicinal products for human use, and repealing Directive 2001/20/EC OJ L 158/1.
[451] GDPR, Article 9(1).
[452] GDPR, Article 9(2)(a) and (j).
[453] EHDS Regulation, Article 2(2)(d).

where health data is used not for the initial purposes for which it was gathered,[454] but for another use, such as public health surveillance;[455] policy-making or regulation;[456] healthcare sector statistics;[457] healthcare education;[458] and scientific research to improve healthcare in a range of ways.[459]

In principle, under the EHDS Regulation, electronic health data is to be made available for secondary use in the Union,[460] where it is necessary for a purpose set out in the Regulation.[461] Health data users must have a data permit, issued in accordance with the Regulation,[462] and may only process health data consistently with that permit. The Regulation prohibits certain uses, such as using health data to take decisions with a legal, social, economic or similar significant detrimental effect on a group of persons.[463] However, there is no obvious provision in the EHDS Regulation that mandates, or even encourages, the use of health data in ways which promote improved understanding of the differential gendered consequences and symptoms of diseases. This is a missed opportunity.

It might be possible to interpret the provisions of the EHDS Regulation in line with the gender mainstreaming obligations of the Union,[464] and the general principles of equality and non-discrimination,[465] so as to require the permissions to use health data for secondary uses granted under the Regulation to take into account whether the proposed use of the health data will pay sufficient attention to the gender gaps in health research.

Recommendation: Further research is needed to determine the extent to which Union data law is, and could be, interpreted in such a way as to lessen gender gaps in health research. This could be undertaken as Member States and the Union bring their law and policy into line with the EHDS Regulation.

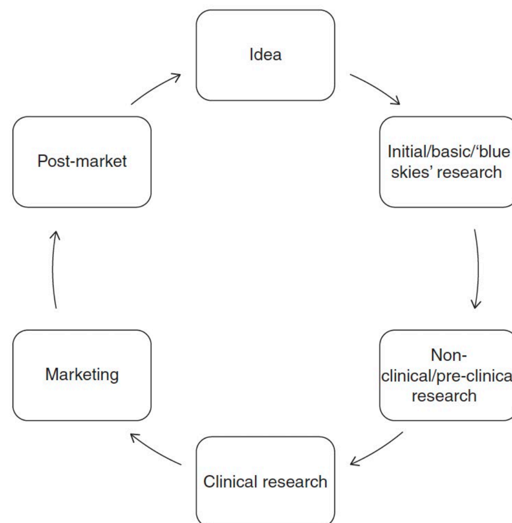
454 EHDS Regulation, Article 2(2)(e).
455 EHDS Regulation, Article 53(1)(a).
456 EHDS Regulation, Article 53(1)(b).
457 EHDS Regulation, Article 53(1)(c).
458 EHDS Regulation, Article 53(1)(d).
459 EHDS Regulation, Article 53(1)(e).
460 EHDS Regulation, Article 51.
461 EHDS Regulation, Article 53(1).
462 EHDS Regulation, Article 68.
463 EHDS Regulation, Article 54(a).
464 Article 8 TFEU.
465 Articles 20 and 21 EU CFR.

7.3 Gendered impacts of Union law on the 'regulatory life cycle' for medicines and medical devices

Key legal instruments
Clinical Trials Regulation 536/2014
Supplementary Protection Certificate Regulation 469/2009
Legislation on paediatric and rare diseases trials and supplementary protection: Regulation 1901/2006 and Regulation 141/2000
Directive 2001/83/EC ('The Community Code' on medicines)
Medical Devices Regulation (EU) 2017/745

Union law covers almost every stage of the 'regulatory life cycle' for medicines and medical devices and equipment.

Figure 5: The regulatory life cycle for medicines, medical devices and equipment[466]



The Union regulates research processes; clinical trials; marketing authorisation; marketing and advertising of medicines; quality and safety of medicines, medical devices and equipment; and post-market surveillance. If the European Commission's proposed new pharmaceuticals regulation package is adopted, the Union will also to some extent regulate supply of medicines.

To what extent does the relevant Union law promote gender equality?

[466] From Bache, G., Hervey, T. and Flear, M. (2013) 'The defining features of the European Union's approach to regulating new health technologies' in Flear, M. and others (eds), *European Law and New Health Technologies*, OUP, p. 12.

As already noted above, historically, medical research has been insufficiently attentive to gender differences.[467] Male bodies are the main site for testing new medicines and other novel medical technologies, leaving their effects on women under-investigated. Studies have shown that this means that adverse side effects that are more prevalent in women remain undiscovered,[468] putting women patients at greater risk than men.

All clinical trials taking place in the Union must comply with the Clinical Trials Regulation 536/2014.[469] Perhaps more importantly, given the proportion of clinical trials that take place outside the Union,[470] if a company wishes to market its medicine in the Union, the application for a Union marketing authorisation must show compliance with the Clinical Trials Regulation.[471]

The Regulation requires, in its application dossier, a protocol,[472] which describes the objective, design, methodology, statistical considerations, purpose and organisation of the clinical trial. Among the minimum requirements required in the protocol is 'a description of the groups and subgroups of the subjects participating in the clinical trial, including, where relevant, groups of subjects with specific needs, for example, age, gender, participation of healthy volunteers, subjects with rare and ultra rare diseases'.[473] It is unfortunate that this obligation is tempered by the phrase 'where relevant', including with respect to gender. Given the gender gap in health research, gender of participants is *always* relevant, and so this phrase is either redundant, or permits a continued lack of attention to the gender gap. This should be clarified.

More promising is the requirement that the protocol must include 'a justification for the gender and age allocation of subjects and, if a specific gender or age group is excluded from or underrepresented in the clinical trials, an explanation of the reasons and justification for these exclusion criteria'.[474]

Clinical trial results must include, within the summary of results, 'population of subjects (including information with actual number of subjects included in the clinical trial in the Member State concerned, in the Union and in third countries; age group breakdown, gender breakdown)',[475] and these must also be reported in the lay summary.[476] Gender is one of the required baseline characteristics to be included in clinical trial results.[477]

The Regulation entered into force on 31 January 2022,[478] following a long delay during which the new Union Clinical Trials Information System (CTIS) became operational. New trials taking place after 31 January 2023 must use the CTIS.

[467] See Chapter 9, section 9.1.4.
[468] European Institute for Gender Equality (EIGE) (2020), *Beijing +25: The Fifth Review of the Implementation of the Beijing Platform for Action in the EU Member States*, https://eige.europa.eu/publications/beijing-25-fifthreview-implementation-beijing-platform-action-eu-member-states, cited in European Commission (2021), *Gender Equality and Health in the EU* p. 47; Storer Jones, F (2025) 'Investing in women's health research and innovation' 31(2) *Eurohealth* 8-11.
[469] Regulation (EU) No 536/2014 of the European Parliament and of the Council of 16 April 2014 on clinical trials on medicinal products for human use, and repealing Directive 2001/20/EC [2014] OJ L 158/1, Article 1.
[470] See: https://www.who.int/observatories/global-observatory-on-health-research-and-development/monitoring/number-of-clinical-trials-by-year-country-who-region-and-income-group.
[471] Clinical Trials Regulation 536/2014, Article 8(3)(i) and (ib).
[472] Clinical Trials Regulation, Annex I, D, 14.
[473] Clinical Trials Regulation, Annex I, D, 17(h).
[474] Clinical Trials Regulation, Annex I, D, 17(y).
[475] Clinical Trials Regulation, Annex IV, A, 7.
[476] Clinical Trials Regulation, Annex V, 4.
[477] Clinical Trials Regulation, Annex IV, C, 2.
[478] See: https://www.ema.europa.eu/en/human-regulatory-overview/research-development/clinical-trials-human-medicines/clinical-trials-regulation.

For access to the Union market, medicines must comply with Union-level rules on post-marketing surveillance and pharmacovigilance. Member States are obliged to operate a pharmacovigilance system to collect and assess information on the risks of medicines, through gathering data on adverse reactions.[479] Holders of marketing authorisations are also obliged to gather such data.[480] Data must be shared with a central Union-level electronic portal. Nothing in these measures requires gathering gender-specific data about adverse reactions.

Recommendation: Further research is needed to determine the extent to which the revisions to the Union's clinical trials law have improved gender reporting in clinical research. In particular, it should specified that gender is generally relevant in clinical trials, and the wording in the Clinical Trials Directive to the effect that gender data is only required in the minimum trial protocol reporting requirements 'where relevant' should be reconsidered.

The extent to which Union law on medicines marketing authorisations, and post-market surveillance, supports gender equality in access to healthcare could be the subject of further research.

In principle, medicines and medical devices that are marketed within the Union must meet basic requirements of efficacy and safety. Unlike the USA, the Union's approach to safety of medical devices is very different to that pertaining to medicines. In order to be lawfully marketed in the Union, medicines must have a marketing authorisation. Various aspects of Union pharmaceuticals law operate to incentivise industry behaviour, especially to seek to encourage the development of new treatments for rare diseases and for children. These include supported pathways to marketing authorisation, access to Union funding for research, and enhanced intellectual property protection.[481] However, no equivalents exist for development of new health technologies, including medicines, that seek to fill gender gaps and make provision for women.

Recommendation: A review of EU pharmaceuticals law could be undertaken, to determine how it could be amended to incentivise equally the development and licensing of medicines for women's health conditions with those for men, and to close the gender gap.

Medical devices are subject to different rules, which are in essence a special version of the Union's general system of 'CE' product safety requirements.[482] Rather than having a marketing authorisation (licence), granted by the European Medicines Agency or a national agency, medical devices must conform to EU standards, as evidenced by the 'CE' mark, which demonstrates the manufacturer's claim that the product complies with minimum safety and performance requirements. The 'CE' mark acts as a 'passport' for the product, and means it may lawfully circulate freely on the Union's internal market. For most medical devices, CE marking is carried out by a 'notified body' – a private and for-profit entity, supervised by national 'competent authorities'.

This approach in Union law turned out to be highly flawed when it came to protecting thousands of women from a widespread use of unsafe breast implants, causing physical harm and mental distress.[483] The relevant

[479] Directive 2001/83, Title IX.
[480] Directive 2001/83, Title IX.
[481] Regulation 2006/1901, Article 36-40; Regulation 141/2000, Articles 6-9.
[482] Regulation (EU) 2017/745 of the European Parliament and of the Council of 5 April 2017 on medical devices, amending Directive 2001/83/EC, Regulation (EC) No 178/2002 and Regulation (EC) No 1223/2009 and repealing Council Directives 90/385/EEC and 93/42/EEC [2017] OJ L 117/1.
[483] C-219/15 *Elisabeth Schmitt v TÜV Rheinland LGA Products GmbH* 16 February 2017 ECLI:EU:C:2017:128; Hervey, T. and McHale, J. (2015) *European Union Health Law*, pp. 3 and 377-378; Verbruggen, P. and van Leeuwen, B. (2018) 'The Liability of Notified Bodies under the EU's new Approach: The Implications of the PIP Breast Implants Case (C219/15)' 43 *EL Rev* 394; see also: Martindale, V.

Union law was amended, but the amendments kept the basic approach in place. Arguably this was insufficient to comply with the Union's obligations to mainstream gender in all its policies and activities,[484] and to comply with the general principle of equality and non-discrimination.[485]

Recommendation: Further research is needed to determine the extent to which the revisions to the Union's medical devices law have improved Union law's equal treatment of risks from such products on the basis of gender.

7.4 Gendered dimensions of Union regulation of products especially harmful to health

Key legal instruments
Directive 2003/33/EC on tobacco advertising
Directive 2014/40/EU on tobacco products
Regulation 1169/2011/EU on food labelling
Regulation 432/2012/EU on permitted health claims on food

Union law indirectly supports access to healthcare in the Union by regulating products and services that are particularly harmful to health: tobacco, alcohol, food, and gambling. This legislation has effects on broader public health, especially non-communicable diseases, and therefore indirect effects on whether and the extent to which women need to access healthcare. For example, Union law on tobacco advertising[486] has eradicated the kinds of gendered advertisements of the 1950s and 60s that encouraged so many girls and women to become addicted to smoking.[487]

Recommendation: Further research is needed to investigate the gendered dimensions of Union law on products and services that are especially harmful to health, and the extent to which the gender-mainstreaming obligations require interpretations of the obligations therein with particular attention to women's health.

7.5 Gendered dimensions of Union law on communicable diseases

Key legal instruments
Regulation 2022/2371/EU on serious cross-border threats to health
Regulation 2022/123/EU on crisis preparedness for medicines and medical devices

and Menache, A. (2013) 'The PIP Scandal: an Analysis of the Process of Quality Control that Failed to Safeguard Women from Health Risks' 106 *Journal of the Royal Society of Medicine* 173.

484 Article 8 TFEU.

485 Articles 20 and 21 EU CFR.

486 Directive 2003/33/EC of the European Parliament and of the Council of 26 May 2003 on the approximation of the laws, regulations and administrative provisions of the Member States relating to the advertising and sponsorship of tobacco products OJ L 152/16.

487 US Surgeon General (2001), 'Women and Smoking: Virginia Slims: A Case Study in Marketing Success', CDC.

Union law on communicable diseases, particularly emerging Union law on responding to cross-border health threats such as pandemics and health threats preparedness law, could also play a role in addressing the gender gap in access to healthcare.

The Union has legal powers to respond to a health emergency such as a pandemic, including responding to critical medicines shortages.[488] Furthermore, Union stockpiling of critical medicines in advance of such a health crisis is to be supported by a proposed Critical Medicines Act,[489] which, if adopted in its current form, will draw on the Union List of Critical Medicinal Products, which is established in the proposed revision to the Union's Pharmaceutical Regulation.[490] The extent to which the Union List of Critical Medicinal Products supports healthcare equally inclusive of women's needs deserves further investigation.

Recommendation: Further research is needed to investigate the gendered dimensions of Union law on communicable diseases, and health crisis preparedness.

[488] Regulation (EU) 2022/2371 of the European Parliament and of the Council of 23 November 2022 on serious cross-border threats to health and repealing Decision No 1082/2013/EU OJ L 314/26, Article 12, 28.

[489] European Commission (2025), Proposal for a Regulation of the European Parliament and of the Council laying a framework for strengthening the availability and security of supply of critical medicinal products as well as the availability of, and accessibility of, medicinal products of common interest, and amending Regulation 2024/795. COM(2025)102 final, Brussels, 11 March 2025.

[490] Regulation (EC) No 726/2004 of the European Parliament and of the Council of 31 March 2004 laying down Community procedures for the authorisation and supervision of medicinal products for human and veterinary use and establishing a European Medicines Agency [2004] OJ L 136/1.

8 Union law incentivising investment in healthcare systems

Key legal instruments

EU4Health Regulation 2021/522

Next Generation EU legislation: EU Recovery Instrument Regulation (EU) 2020/294; Recovery and Resilience Facility Regulation (EU) 2021/241; Council Decision (EU, Euratom) 2020/2053 on Own Resources

The COVID-19 pandemic revealed significant under-investment in national healthcare systems across the Union. There is no 'Union healthcare system' and the Union has no competence to undertake the kind of wide-scale redistribution of resources necessary to organise healthcare at Union level. However, the Union does have competence to support and complement national endeavours in this regard, and to incentivise actions that support the aims of the Treaty on the Functioning of the European Union, especially those in Article 168 TFEU.

Currently there are two main legal sources enabling such Union incentive measures: the EU4Health programme[491] and Next Generation EU. The EU4Health programme provides relatively modest[492] Union support for projects or activities that meet one of four overarching objectives, one of which is to strengthen health systems by improving their resilience and resource efficiency. Within that objective, Member States may seek support from the Union to contribute to enhancing access to healthcare, alongside digital transformation of healthcare, evidence-based decision making and integrated work between national healthcare systems.

Next Generation EU is a much more ambitious COVID-19 recovery plan for the Union. Its legal basis is complex,[493] and draws on the Union's 'emergency powers'[494] competences,[495] as well as the Union's cohesion policy,[496] allowing the Union to borrow funds on capital markets.[497] Next Generation EU operates through national Recovery and Resilience Plans, which are agreed between the Member States and European Commission and monitored by the European Commission. Recovery and Resilience Plans involve multiple projects across the whole range of areas ('pillars') covered by the Union's wide-reaching recovery plan. One of the pillars is 'health and economic, social and institutional resilience'. The Commission's monitoring is based on common indicators,[498] which are consolidated into a Recovery and Resilience Scoreboard. Relevant indicators

[491] Regulation (EU) 2021/522 of the European Parliament and of the Council of 24 March 2021 establishing a Programme for the Union's action in the field of health ('EU4Health Programme') for the period 2021–2027, and repealing Regulation (EU) No 282/2014 OJ L 107/1.

[492] Total of EUR 5.3 billion: European Commission (2024), 'EU4Health Programme 2021–2027 – A Vision for a Healthier European Union', https://health.ec.europa.eu/funding/eu4health-programme-2021-2027-vision-healthier-european-union_en.

[493] Council Regulation (EU) 2020/2094 of 14 December 2020 establishing a European Union Recovery Instrument to support the recovery in the aftermath of the COVID-19 crisis (EURI Regulation) OJ L433I/23; Regulation (EU) 2021/241 of the European Parliament and of the Council of 12 February 2021 establishing the Recovery and Resilience Facility (RRF Regulation) OJ L57/17; Council Decision (EU, Euratom) 2020/2053 of 14 December 2020 on the system of own resources of the European Union and repealing Decision 2014/335/EU, Euratom (Own Resources Decision) OJ L424/1. For further discussion, see Delhomme, V. and Hervey, T. (2022) 'The European Union's response to the Covid-19 crisis and (the legitimacy of) the Union's legal order' 41 *Yearbook of European Law*, 48, https://doi.org/10.1093/yel/yeac011.

[494] De Witte, B. (2022) 'Guest Editorial: EU Emergency Law and Its Impact on the EU Legal Order', 59 *Common Market Law Review* 3.

[495] Article 122 TFEU.

[496] Article 175 TFEU.

[497] Own Resources Decision, Article 5.

[498] Commission Delegated Regulation (EU) 2021/2106 of 28 September 2021 on supplementing Regulation (EU) 2021/241 of the European Parliament and of the Council establishing the Recovery and Resilience Facility by setting out the common indicators and the detailed elements of the recovery and resilience scoreboard OJ L 429, 1.12.2021, p. 83–91, Annex I.

include ‘capacity of new or modernised health care facilities’, including hospitals, clinics, outpatient care centres, specialised care centres, and so on. However, the only indicator that is to be disaggregated by gender is the ‘number of young people aged 15-29 years receiving support’. This is a missed opportunity.

The Scoreboard for health[499] shows that nearly 50 % of the Next Generation EU spending under that pillar is on ‘healthcare resilience, sustainability, adequacy and availability’. The Commission’s ‘Thematic Analysis on Healthcare’ of December 2024[500] shows that Member States are using the availability of Union support to develop their healthcare systems, including in ways that would respond to aspects of the gender gap in access to healthcare, such as investing in new primary care facilities, especially in rural areas.[501]

There is scope to embed gender equality more explicitly in these Union programmes, and indeed, at least arguably there is an obligation to do so under Article 8 TFEU. This is particularly the case given the disproportionate impact of the COVID-19 pandemic on women.[502] For example, enhancing gender equality could be a specific key performance indicator[503] under the EU4Health programme.[504] Healthcare professional training could explicitly include training to reduce the gender gap in access to healthcare.[505] The Union could support Member States in public awareness and education about gender and specifically women’s healthcare, to encourage women (and men) to seek early healthcare interventions.[506] The regular stakeholder consultation on EU4Health[507] could include specific questions on gendered aspects of access to healthcare and the extent to which they have been improved by activities funded by EU4Health. Reporting for Next Generation EU’s Recovery and Resilience Scoreboard in the area of healthcare system resilience could include data disaggregated by gender.

Recommendation: Further research is needed to investigate the impact of EU4Health and Next Generation EU on the gender gap in access to healthcare.

499 European Commission, Recovery and Resilience Scoreboard – health, https://ec.europa.eu/economy_finance/recovery-and-resilience-scoreboard/health.html
500 European Commission (2024) ‘Recovery and Resilience Scoreboard – thematic analysis – health’, https://ec.europa.eu/economy_finance/recovery-and-resilience-scoreboard/assets/thematic_analysis/scoreboard_thematic_analysis_healthcare.pdf.
501 See Chapter 9, section 9.1.3.
502 European Parliament Resolution of 2021 on gender perspective in COVID-19 recovery.
503 European Commission (2025), ‘EU4Health Programme Performance: Archived Versions from Previous Years’, https://commission.europa.eu/strategy-and-policy/eu-budget/performance-and-reporting/programme-performance-statements/eu4health-performance_en#archived-versions-from-previous-years.
504 Storer Jones, F (2025) ‘Investing in women’s health research and innovation’ 31(2) *Eurohealth* 8-11 has called for the Union to deploy its research and innovation funding to close the gender gap in biomedical research.
505 See Chapter 9, section 9.1.4.
506 See Chapter 9, section 9.1.4.
507 European Commission (2025), ‘EU4Health 2024 Consultation Report’, https://health.ec.europa.eu/document/download/64f28955-a8ff-40a5-b79f-2d90df58813b_en?filename=funding_eu4health_2024-consultation_report_en.pdf.

9 Part II: Comparative analysis

The data for this comparative analysis was drawn from the responses to a questionnaire which was distributed to the national gender experts in the European network of legal experts in gender equality and non-discrimination, covering all the 27 European Union Member States plus the UK and three European Free Trade Association (EFTA) countries (Iceland, Liechtenstein and Norway). The cut-off date for the questionnaire was 9 May 2025. A copy of the questionnaire can be found in Annex 2 to the report.

The purpose of the analysis is threefold. First, it highlights some of the key problems with gender equality in access to healthcare identified by experts in the states covered in this report. Secondly, it outlines and reviews the relevant legal and regulatory frameworks across the respondent states in order to identify common or significant gaps and difficulties, including in enforcement. Finally, it notes current and recent legislative and policy initiatives in the states, highlighting examples of good practice. Given the breadth of the subject matter, the analysis is not intended to be comprehensive. Rather it seeks to identify key examples, provided by the national experts, to illustrate and categorise the nature of the challenges to be addressed and to understand the legislative and policy steps that have been taken, or could be taken, to address them.

9.1 Evidence of problems of gender inequality and discrimination in access to healthcare

9.1.1 Lack of coverage in national health care systems

As expected, given the differences in the ways state or state-subsidised healthcare is funded across the states,[508] there is variation in the degree of coverage available – both in relation to *who* is covered and in relation to what *treatments or medical interventions* are covered. Gaps in coverage create problems for gender equality in two main ways. First, where the costs of obtaining unfunded treatment privately mean that treatment is inaccessible for the economically disadvantaged and the unemployed, this can exacerbate gender inequality, particularly where an intersectional approach is taken, because women are generally more likely than men to be in a position of economic vulnerability. Most states report gaps in coverage across a range of different medical conditions or treatments (either where treatments are not covered at all, or where only part of the cost is reimbursed) and several experts reported concerns about a lack of, or limited, coverage under national health insurance schemes (coupled with often prohibitively expensive 'top ups' under private insurance). In **France**, for example, while the social security system covers approximately 70 % of healthcare costs, the rest are covered by complementary private insurance arrangements.[509] There is evidence of the gendered impact of the need to fund healthcare privately in **Lithuania**, where research shows that women (especially older women) are more likely than men to report unmet medical needs due to cost, especially concerning dental and specialist care.[510] Likewise, in **Slovenia** the 2021 Gender Equality Index shows that women are less likely than men to be able to afford healthcare expenses.[511]

[508] As outlined in Chapter 1.2 above.

[509] See: https://www.lassuranceenmouvement.com/2023/09/07/les-inegalites-de-sante-femmes-hommes-persistent/.

[510] EIGE (2021) 'Gender and intersecting inequalities in access to health services', https://eige.europa.eu/publications-resources/publications/gender-equality-index-2021-health.

[511] European Institute for Gender Equality (EIGE), Gender Equality Index 2021: Slovenia, 2021, https://eige.europa.eu/gender-equality-index/2021/SI, SI_2021_factsheet.pdf.

A second problem for gender equality arises where treatments which are needed only or primarily by women or men are not provided or not fully reimbursed. Gaps in coverage of particular relevance to gender equality include abortion, contraception, preventative care and other conditions as outlined in the following sections.

a. Coverage of abortion

In a number of states, abortion is funded only where it is deemed to be necessary for medical reasons or where the relevant authorities believe the woman to be a victim of violence, even where abortion is lawful in a wider range circumstances. In **Croatia**, for example, the Croatian Health Insurance Fund covers the cost of abortion only where deemed to be necessary for medical reasons[512] – where it is not, the cost is set by the relevant hospital and this may vary substantially.[513] Similar restrictions in access to funding exist in **Cyprus**, **Latvia**,[514] and **Romania.**[515]

b. Contraception

Women tend to bear the cost of contraception[516] but there is no provision of free contraception in **Cyprus**, **Malta**[517] (although this is likely to be addressed in the 2025-30 National Sexual Health Strategy) and **Romania**,[518] and limited provision in several other states. In the **Netherlands**, contraception is only reimbursed for young people up to the age of 21 because it is not deemed to be necessary medical care.[519] Likewise, there is limited provision in **Austria** (where a trial for free contraception is underway in one state only) and in **France**, **Lithuania**,[520] **Poland**[521] and **Portugal**, where not all common forms of contraception are free. In **Poland**, fees are often charged in practice despite an entitlement to fee provision.[522] In the **Netherlands** in 2020 a claim was made by a group of NGOs that exclusion of contraception from the basic health insurance package was indirect gender discrimination (using Article 14 of the European Convention on Human Rights and Articles 21

512 See Council of Europe (2024) *Sexual and Reproductive Health and Rights in Europe. Progress and Challenges. Follow-up Report to the 2017 Issue Paper*, available at: https://rm.coe.int/follow-up-report-on-the-2017-ip-on-srhr-sexual-and-reproductice-health/1680aea9b4, p. 19.

513 Hrabre sestre (Brave Sisters), *Pobačaj u Hrvatskoj* (Abortion in Croatia), available at: https://hrabra.com/popis-bolnica/. See also Faktograf.hr, 10 July 2024, https://faktograf.hr/2024/07/10/istrazivanja-javnog-mnijenja-tijekom-godina-pokazuju-da-vecina-gradana-hrvatske-podrzava-pravo-na-pobacaj/.

514 The Cabinet of Ministers Regulation No. 555 Procedure on organisation and payment of health-care services' (*Veselības aprūpes pakalpojumu organizēšanas un samaksas kārtība*), Official Gazette No. 176, 5 September 2018 at 2.3.

515 Human Rights Watch (2025), Report "It's Happening Even Without You Noticing". Increasing Barriers to Accessing Sexual and Reproductive Health Care in Romania, 7 April 2025, available at: https://www.hrw.org/report/2025/04/07/its-happening-even-without-you-noticing/increasing-barriers-accessing-sexual-and.

516 See, for example, research from the Netherlands: VUNieuws (2024) 'Vrouwen met vaste relatie betalen de kösten van anticonceptie grotendeels zelf,' 8 May 2024; and from Austria: Federal Ministry for Social Affairs, Health, Carework and Consumer Protection (BMSGPK) (2024) *Verhütungsbericht 2024* (Contraception report).

517 See: https://www.mmsjournals.org/index.php/mmj/article/view/664; https://health.gov.mt/wp-content/uploads/2024/12/National_Sexual_Health_Strategy_2025_2030.pdf.

518 Press release 'Over 200 Romanian and European civil society organizations call on the Minister of Health and CNAS to ensure free and universal access to contraceptive methods, emergency contraception and protection: Protect women, girls and young people in Romania from unwanted pregnancies and sexually transmitted infections' (*'Peste 200 de organizații ale societății civile din România și europene cer ministrului Sănătății și CNAS să asigure acces gratuit și universal la metode de contracepție, contracepție de urgență și protecție: Protejați femeile, fetele și tinerii din România de sarcini nedorite și infecții cu transmitere sexuală'*), of 16 November 2023.

519 VUNieuws (2024) 'Vrouwen met vaste relatie betalen de kösten van anticonceptie grotendeels zelf', 8 May 2024.

520 Lrytas.lt. (2019) 'Flawed family-planning-policy-leads-to-high-teen-pregnancy-and-abortion-rates in Lithuania', 8 June 2019.

521 Federa (2024) 'Atlas Antykoncepcyjny 2024: Polska po raz czwarty z najgorszym dostępem do antykoncepcji w Europie' (Contraception Atlas 2024: Poland fourth with worst access to contraception in Europe), https://federa.org.pl/atlas-antykoncepcyjny-2024/ ; Federa (2024) Contraception Policy Atlas Europe, https://federa.org.pl/wp-content/uploads/2024/02/CCInfoEU_A3_EN_2024_FEB12.pdf.

522 Federa (2018) 'Martwe prawo. Komentarz do sprawozdania rządu z wykonania w 2016 r. ustawy o planowaniu rodziny' (Dead Law. Commentary on the Government's Report on the Implementation of the Family Planning Law in 2016), https://federa.org.pl/wp-content/uploads/2018/05/komentarz_sprawozdanie_RM_ustawa_planowaniu_rodziny2016.pdf.

and 23 of the Charter of Fundamental Rights of the European Union). This claim was rejected by all domestic courts – it was held that the state had not caused the inequality as market determines availability and pricing and the Supreme Court confirmed that there was no general right to free contraception.[523]

c. Preventive care and Public Health Programmes

Population wide public health screening and vaccination programmes sometimes target, or are only provided to, men or women. For example in **Denmark**, measures to prevent HIV are focused on men who have sex with men and not other high risk groups such as female sex workers.[524] On the other hand, targeting of screening and prevention for postnatal depression is primarily targeted at women, despite research suggesting it affects approximately 10 % of women and men. As a result, fathers experiencing postnatal depression are significantly less likely to be identified and receive appropriate care, reinforcing gendered patterns of access to mental health services in the early stages of parenthood.[525] Breast screening is generally available to women, but not to men, although it is possible for men get breast cancer too.[526] And while cervical screening is covered everywhere (at least in principle) there is a lack of free and routine prostate cancer screening in some countries (**UK**, for example). There is room for disagreement over whether targeted programmes such as these improve, or create, gender inequalities in health.[527] While focused intervention may ameliorate inequalities by targeting resources at those most likely to be vulnerable to particular health problems or to be disadvantaged in access to treatment for them, any inaccurate use of sex and gender as proxies for risk, or capacity to benefit from health prevention measures, risks unjustified discrimination.[528]

d. Other conditions

Other relevant examples of interventions which are not covered or are not fully covered by state funded provision include:

- Maternity care in **Belgium**, where core but not comprehensive care is covered. Research shows that only 6 in 10 women find care related to childbirth to be affordable and women leave hospital sooner than they otherwise would as a result.[529]

- Treatment for endometriosis or adenomyosis[530] in **Portugal**, where the state supports 69 % of the cost of medicines for the treatment and relief of symptoms of these conditions, with the patient required to cover

[523] The Hague Court of First Instance, 6 October 2021, ECLI:NL:RBDHA:2021:10737; Netherlands Supreme Court, 21 February 2025, https://uitspraken.rechtspraak.nl/details?id=ECLI:NL:HR:2025:321.
[524] Danish Regions (2021), *Opdaterede retningslinjer for udlevering af PrEP*, (Updated guidelines for the dispensing of PrEP), https://www.regioner.dk/media/15029/opdateret-retningslinje-for-udlevering-af-prep_25321.pdf.
[525] Danish Institute for Human Rights (2021), *Fædre bør screenes og sikres behandling for fødselsdepressioner*, (Fathers should be screened and treated for postpartum depression), https://menneskeret.dk/files/media/document/F%C3%A6dre_b%C3%B8r_screenes_og_behandles_for_f%C3%B8dselsdepressioner_Rapport_november_2021_tilg%C3%A6ngelig.pdf.
[526] WHO, 'Factsheet: breast cancer', https://www.who.int/news-room/fact-sheets/detail/breast-cancer.
[527] See Chapter 3, section 3.1.4.
[528] And see discussion of relevant EU legal provisions under 3.1.4 above.
[529] Vancorenland, S., Avalosse, H., Vandeleene, G. (2025) *L'accessibilité du trajet de soins autour d'un accouchement*. Enquête auprès des membres MC ayant accouché en 2022-2023, https://presse.mc.be/nouvelle-etude-mc--les-soins-autour-de-laccouchement-encore-trop-peu-accessibles.
[530] Endometriosis is a disease in which tissue similar to the lining of the uterus grows outside the uterus. It is a chronic disease affecting about 10 % of women and girls of reproductive age globally (https://www.who.int/news-room/fact-sheets/detail/endometriosis); adenomyosis is a condition where the lining of the uterus grows inside the muscle wall of the uterus, causing pelvic pain and heavy bleeding (https://www.nhs.uk/conditions/Adenomyosis/).

the remaining cost. According to media reports, the cost of these medicines doubled following the introduction of this co-payment system.[531]

- Gender-affirming care. In **Latvia**, gender reassignment is excluded from paid medical services.[532] Sex reassignment surgery is not available within the public health system in **Lithuania**[533] where only hormone therapy is funded and there is no coverage of hormonal therapy for trans patients by public health insurance in **Romania**.[534]

- Sterilisation which is part funded in **Norway** for women, but not funded for men. The result is that women still have to pay more for sterilisation than men because of the differences in the relative costs of the procedure.[535]

9.1.2 Gaps in the personal scope of coverage

e. Public/state insurance coverage

Certain groups face difficulty in accessing state-funded healthcare. A 2018 study found that the law and policies of 17 Member States did not provide access to free or subsidised healthcare, including pregnancy and maternity care, for undocumented migrant women and this was confirmed in the reports of several experts.[536] A 2021 study on **Cyprus** found that while their applications are pending, asylum seekers can only access emergency healthcare and screenings required for their applications and are unable to access state-funded specialist care, including appropriate care for victims of violence.[537] Rejected asylum seekers also face significant difficulties in accessing healthcare and are dependent on services provided by NGOs.[538] In **Malta**, while refugees are entitled to free medical care on the same basis as Maltese nationals, other third country nationals are charged for care during the first year even where employed and paying national insurance contributions.[539] Likewise the expert from **Czechia** notes that many third country nationals are not covered by free or subsidised state provision and are required to take out private health insurance, which often does not cover the costs of pregnancy or maternity care. In the **Netherlands** undocumented migrants are unable to access (mandatory) health insurance and are therefore required to pay privately for healthcare services, including abortion, where the costs may be prohibitive.

In **Bulgaria**, while all Bulgarian citizens are required to have health insurance, research has found that irregular and interrupted payments result in a large number of people (20.6 % in 2022) losing access to basic preventive

531 See: https://www.jn.pt/2780192701/preco-de-medicamento-para-a-endometriose-duplicou-quando-se-tornou-comparticipado/#iss=https%3A%2F%2Fsso.noticiasilimitadas.pt%2Frealms%2FNI_PRD.

532 The Cabinet of Ministers Regulation No. 555 'Procedure on organisation and payment of health-care services' (*Veselības aprūpes pakalpojumu organizēšanas un samaksas kārtība*), Official Gazette No.176, 5 September 2018.

533 The Decree No. V-1307 of 4 August 2022 on the approval of the procedure for the diagnosis and treatment of gender identity disorder (transsexualism). Registry of Legal Acts, 2022, No. 16729. See also, Lithuania releases Protocol on Trans-specific Healthcare. Available at: https://tgeu.org/lithuanian-protocol-on-trans-specific-healthcare/.

534 Accept Association (2020), Trans in Romania, November 2020, p.81.

535 See article from the magazine *Sykepleien* (Nursing) of 9 October 2021; https://sykepleien.no/meninger/2021/10/vi-ma-ha-kjonnsnoytral-pasientbetaling-ved-sterilisering.

536 European Commission (2021), *Gender Equality and Health in the EU*, p. 41.

537 See discussion the relevant EU legal provisions in Chapter 6, above.

538 Mediterranean Institute of Gender Studies (2021), 'Mind the Gap: COALESCE for support in Cyprus. Analysis of integration needs for migrant women victims of trafficking for sexual exploitation and abuse'.

539 Malta Independent (2025) 'Anti-Poverty Forum concerned over third country nationals', 17 March 2025, https://www.independent.com.mt/articles/2025-03-17/local-news/Anti-Poverty-Forum-concerned-over-third-country-nationals-being-charged-for-healthcare-in-first-year-6736268672.

health care and planned hospitalisation (including restrictions on free examinations during pregnancy); 18.33 % of women giving birth in 2022 were uninsured, resulting in limited access to monitoring during pregnancy and preventive care.[540] Likewise, research in **Romania** found that rural women, particularly those who work in the informal sector as day labourers, face significant difficulties in obtaining insurance for many reasons including lack of information and stereotyping, discrimination and lack of concern on the part of the relevant authorities. One in four do not have health insurance, and 20 % of the women who are insured are co-insured, making them financially dependent on the income of a partner or a family member.[541]

Even for groups where the costs of healthcare are covered by the state, access to the funded healthcare to which they are entitled is not a reality for some because of administrative and other barriers. In **Croatia**, for example, the expert reports that, although registered unemployed persons under international protection are entitled to healthcare to the same extent as all mandatory insured persons, they are not entered into the system as mandatory insured persons and do not possess a personal insurance number. This significantly complicates their administrative handling within the healthcare system and results in refusals of care by general practitioners (including care of children) as well as difficulties in accessing voluntary supplementary health insurance.[542] As noted above, particularly when an intersectional perspective is taken, these barriers to access to funded care, which may result in individuals having to pay for healthcare from private funds, can give rise to problems of gender inequality because women are generally more likely than men to be in a position of economic vulnerability.

f. Private insurance coverage

Concerning private insurance, most, but not all, experts reported that the *Test-Achats* judgment had been implemented in such a way as to result in an end to overt gender discrimination in insurance premiums and reimbursements, although some difficulties remain. The relevant legal provisions are discussed in more detail in section 9.2.1.4 below.

Significantly, some states (**Czechia**, **Latvia** and **Romania**) reported that it is still difficult to access private insurance to cover pregnancy and maternity care adequately or at all. A 2022 report by the **Danish** Institute for Human Rights found that, despite formal revision of terms across the insurance sector following successful legal and regulatory actions against insurance companies in recent years, pregnant and postpartum women are still having claims rejected by insurance companies. The report notes that this arises, for example, because 'even though the terms and conditions of a specific insurance policy do not specifically exempt claims due to pregnancy or childbirth … practice has been that injury to a woman during childbirth cannot constitute an accident in the context of insurance law.'[543] There are currently cases pending before the Board of Equal Treatment and the courts.[544]

540 Kostadinov, S Stefanova, P Georgiev, A Vasileva, R Kamburova, M Stoilova, I (2023) 'Restrictions on access to medical care for the uninsured in Bulgaria', *European Journal of Public Health*, Volume 33, Issue Supplement 2, October 2023.

541 FILIA Centre (2025), Research Report: Rural women access to health insurance and screening for prevention of cervical cancer (*Raport de cercetare: Accesul femeilor din mediul rural la asigurări medicale şi screening pentru prevenirea cancerului de col uterin*), pp. 29-31.

542 Croatian Ombudswoman (2025), Annual Report for 2024, p. 173.

543 Danish Institute of Human Rights (2022) *Insurance must not discriminate on grounds of pregnancy and childbirth* https://www.humanrights.dk/files/media/document/2022_11_11_InsurancePolicies_EN_V3.pdf.

544 Board of Equal Treatment, decisions from the Board of Equal Treatment (Afgørelser fra Ligebehandlingsnævnet), available at: Afgørelser fra Ligebehandlingsnævnet.

Some travel insurance policies exclude reproductive care from their healthcare coverage. In **Latvia**, no insurance company provides standard travel insurance covering risks relating to pregnancy and maternity[545] – in the view of the expert this is because of a perception that an obligation to cover the risks of pregnancy and maternity is not specified, or required by Article 5 of Directive 2004/113,[546] and a consequent lack of a clear obligation in national legislation. In **Denmark** there are examples of travel insurance policies excluding abortion, other than in the event of risk to life or physical health. The Danish Institute for Human Rights found that blanket exclusions of this kind are direct sex discrimination but the extent to which appropriate remedial action has subsequently been taken by insurance companies is not known.[547]

9.1.3 Other barriers to access

In addition to financial barriers, other largely systemic and structural barriers impede access to healthcare in a way that engages questions of gender equality.[548]

First, there is a lack of adequate provision of healthcare services generally – including a lack of facilities and appropriately trained professionals – and services for women's health in particular, including obstetric and maternity units and screening services for cancers of the reproductive system. Increasing centralisation of obstetric and maternity services in recent years has been driven by concerns about efficiency[549] and safety.[550] Across the states, lack of provision is a particular concern in some geographical locations, especially rural areas – patients must travel long distances to access appropriate treatment where public transport is limited and the cost of private transport prohibitive for some. These concerns were raised by the experts in **Finland**, **Germany**, **Hungary** (where the Roma Rights Centre has reported that Roma women are often disadvantaged in this way)[551] **Iceland**, **Ireland**, **Poland**, **Romania** and **Slovakia**.[552] In **Hungary**, access to obstetric services has been made worse by the closure of maternity wards due to staff shortages.[553] Research by the Commission on Women's Health in **Norway** found that 'disease prestige' results in some conditions that affect women (including chronic vulval pain and maternal healthcare) not being sufficiently prioritised in resourcing. The Commission believes that this has had an impact on priority setting.[554]

545 Latvian Public Media, Apdoršināšanas aģentūras atsaka ceļojumu apdrošināšanu topošajām māmiņām (Insurance companies refuse trave insurance to pregnant persons), 2016 https://www.lsm.lv/raksts/dzive--stils/veseliba/apdrosinataji-atsaka-celojumu-polises-toposajam-maminam.a214244/.

546 See Chapter 3, section 3.1.1.

547 '»Jeg tænker 'shit, jeg er midt ude på Stillehavet, og jeg er gravid – hvad i alverden gør jeg?'«' ('I think "shit, I'm in the middle of the Pacific Ocean and I'm pregnant - what on earth do I do?"'), *Politiken*, 3 March 2024, https://politiken.dk/danmark/art9773498/%C2 %BBJeg-t%C3 %A6nker-%E2 %80 %99shit-jeg-er-midt-ude-p%C3 %A5-Stillehavet-og-jeg-er-gravid-%E2 %80 %93-hvad-i-alverden-g%C3 %B8r-jeg%C2 %AB.

548 See also discussion of structural discrimination in 3.1.2 above.

549 See Chapter 1, section 1.3, definition of national healthcare systems.

550 Rechel, B. et al. (2016) 'Hospitals in rural or remote areas: an exploratory review of policies in 8 high income countries.' *Health Policy* 120 (7) 758-69.

551 European Roma Rights Centre (2020), 'Reproductive rights of Romani women in Hungary', Cause of Action series, http://www.errc.org/uploads/upload_en/file/5228_file1_reproductive-rights-of-romani-women-in-hungary.pdf.

552 A 2023 joint submission to CEDAW by various civil society organisations in Slovakia highlights barriers to reproductive healthcare including legislative, financial, unavailability of medical abortion, geographical inaccessibility, lack of information on contraception and conscience clauses: Freedom of Choice (Možnosť voľby), InTYMYta and Center for Reproductive Rights (2023), *Joint submission to the Committee on the Elimination of Discrimination Against Women's 85th session, periodic review of Slovakia April 2023*, https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=INT%2FCEDAW%2FCSS%2FSVK%2F52443&Lang=en.

553 European Roma Rights Centre (2020), 'Reproductive rights of Romani women in Hungary', Brussels, http://www.errc.org/uploads/upload_en/file/5228_file1_reproductive-rights-of-romani-women-in-hungary.pdf.

554 Commission on Women's Health (2023) 'The big difference of Women's health in Norway', English summary: https://www.regjeringen.no/contentassets/0d48005b5c144e95b87471c86bba2577/summary_the-big-difference-on-womens-health-in-norway-and-why-sex-and-gender-matter.pdf.

The shortage of specialist facilities is compounded by a lack of specialist health professionals across a range of disciplines including specialists in women's health such as gynaecologists, obstetricians and midwives, particularly in some geographical locations (**Croatia**,[555] **Poland**, **Portugal**,[556] **Slovenia**,[557] **Sweden**,[558] and the **UK**[559]) or in specialisms which affect women in particular, such as rheumatology or some forms of mental health (**Portugal**).[560] These shortages can result, among other things, in very long waiting lists for these conditions. In the **UK**, a 2024 report by the Royal College of Obstetricians and Gynaecologists found that there are currently around 750,000 women on the waiting list for treatment (excluding those awaiting diagnostic tests or follow-up care). The report noted that 'women waiting for care are commonly in constant, chronic, and debilitating pain, struggling to manage worsening physical and mental health symptoms. A quarter of the women we surveyed for this report said they had attended A&E [accident and emergency facilities] because of their symptoms'.[561] In addition to a general lack of specialist healthcare professionals, some countries reported that a shortage of female health professionals (**Germany**) or from different cultures (such as doulas in **Norway**)[562] acts as a further barrier to access for some women and particularly first generation migrant workers.

In abortion services, the prevalence of 'conscience clauses' means that the shortage of specialist health professionals available and willing to carry out abortion is particularly chronic in some areas (**Belgium**, **Croatia**, **Italy**, **Poland**, **Portugal**, **Romania** and **Slovakia**). Conscience clauses also act as a barrier in the same way for gender-affirming healthcare, assisted fertility (**Belgium**)[563] and contraception (**Slovakia**[564]). In **Croatia**, studies have estimated that as many as 60 % of healthcare workers and 20 % of institutions authorised to perform medical termination of pregnancy procedures raise a conscientious objection, and do not always have an available replacement or alternative, meaning that access to timely and appropriate abortion care is in practice being denied.[565] Many of these hospitals are in rather remote areas, meaning that women in need of

[555] Ombudsperson for Gender Equality (2025), 'Annual Report for 2024', p. 31.
[556] Women's Health in Portugal Working Group (2022) 'Recommendations', https://www.spdc.pt/images/A_SAUDE_DAS_MULHERES_EM_PORTUGAL_RECOMENDACOES_5abr.pdf.
[557] 24ur.com (2024) 'Do leta 2026 bi lahko brez ginekologa ostalo še 150.000 Slovenk' (By 2026, 150 000 Slovenian women could be left without a gynaecologist), 10 May 2024; National Institute of Public Health (NIJZ), Inequalities and Vulnerabilities in Slovenia – MoST Project, 2022. Available at: https://nijz.si.
[558] National Health Competence Council (2023) 'Skills supply of midwives in obstetric care. Assignment to propose measures to strengthen the attractiveness and skills supply of midwives in obstetric care' (*Kompetensförsörjning av barnmorskor i förlossningsvården Uppdrag att föreslå insatser för att stärka attraktiviteten och kompetens- försörjningen av barnmorskor i förlossningsvården* S2022/00902), available at https://www.nationellavardkompetensradet.se/globalassets/radets-kunskapsunderlag/2023-3-kompetensforsorjning-av-barnmorskor-i-forlossningsvarden.pdf.
[559] Department for Health and Social Care (2022) 'Women's Health Strategy for England'.
[560] Women's Health in Portugal Working Group (2022) 'Recommendations'.
[561] Royal College of Obstetricians and Gynaecologists (2024) waitingwaiting-for-a-way-forward.pdf.
[562] Commission on Women's Health (2023) 'The big difference of women's health in Norway', English summary: https://www.regjeringen.no/contentassets/0d48005b5c144e95b87471c86bba2577/summary_the-big-difference-on-womens-health-in-norway-and-why-sex-and-gender-matter.pdf.
[563] Datoussaid S. and Delwiche, E. (2020) 'Procréation médicalement assistée et liberté reproductive', in *Codes commentés 20/20, Droit des femmes,* p. 149.
[564] A 2023 joint submission to CEDAW by various civil society organisations in Slovakia highlights barriers to reproductive healthcare including legislative, financial, unavailability of medical abortion, geographical inaccessibility, lack of information on contraception and conscience clauses: Committee on the Elimination of Discrimination Against Women's 85th session Periodic review of Slovakia April 2023. Joint submission by the Freedom of Choice (Možnosť voľby), InTYMYta and Center for Reproductive Rights (2023), p. 6 - 8, available in English at: https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=INT%2FCEDAW%2FCSS%2FSVK%2F52443&Lang=en.
[565] European Parliament resolution of 11 April 2024 on including the right to abortion in the EU Fundamental Rights Charter (2024/2655(RSP)), https://www.europarl.europa.eu/doceo/document/TA-9-2024-0286_EN.html#def_1_15. See also Human Rights Committee, Concluding observations on the fourth periodic report of Croatia on implementation of International Covenant on Civil and Political Rights, available at: https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CCPR%2FC%2FHRV%2FCO%2F4&Lang=en.

such a service have to travel to another facility far from their place of residence,[566] adding to intersectional disadvantage for women in rural areas. In **Romania** the willingness of doctors to perform abortions is also impacted by the exclusion of abortion from medical malpractice insurance.[567]

Several experts noted that legal barriers impede access to abortion in restricting the circumstances in which abortion is permitted and creating additional obstacles to access to timely and effective care, leading the Polish expert to conclude that law and regulation on reproductive rights in **Poland** embed, rather than remedy, gender inequality. Likewise the expert from the **Netherlands** notes that the language of the legislative provisions on abortion is paternalistic and patronising and characterises the pregnant person as unable to make decisions for themselves. Legal barriers include mandatory 'reflection periods' (**Belgium, Netherlands**) and conscience clauses (**Belgium**, **Croatia**, **Greece**, **Italy**, **Netherlands, Poland**, **Portugal**). In **Poland**, there is no longer an obligation for health professionals or institutions who refuse to provide services in exercise of the conscience clause to indicate viable options for the patient to obtain healthcare services. According to information from NGOs, the failure to introduce effective mechanisms for informing patients where they can obtain a service is a barrier to access to legal abortion.[568]

Barriers tend to impact those with intersectional disadvantage the most – and in particular girls, very young or older women, those with disabilities, and women with migrant or refugee status.

9.1.4 Gender-sensitive healthcare

Many experts identified evidence of or raised concerns about a lack of gender-sensitive healthcare. This can arise where there is lack of understanding of, or stereotypical assumptions made about, gender differences in health or healthcare needs, leading to failures or delays in diagnosis or treatment. A lack of gender-sensitive care can result in poor provision of care for conditions that affect only or mainly one gender. Delays in diagnosis and treatment of endometriosis in particular were commonly reported (**Austria**, **Belgium**, **France, Hungary**,[569] **Iceland**,[570] **Malta**,[571] **Netherlands**,[572] **Norway**,[573] **Portugal**, **UK**). A lack of gender-sensitive healthcare can also result in poor outcomes for conditions which may present differently in women and men, such as cardiovascular disease (**Belgium**, **France**, **Netherlands**,[574] **Portugal**). In **Portugal** for example, data shows that women generally receive fewer prognosis-modifying therapies for myocardial infarction than men, and women have a higher incidence of in-hospital complications (including death) than men. While this is partly due to the delay in the woman patient's recognition of symptoms (more often atypical), it is also due to the lower

[566] For more information see Country report Gender equality Croatia 2022, pp. 100 – 101. See Ombudsperson for Gender Equality (2019), Annual Report for 2018, pp. 80-83. See also research conducted by the Platform for Reproductive Justice in 2020, available at: https://www.reproduktivna-pravda.hr/#.
[567] Human Rights Watch (2025), Report "It's Happening Even Without You Noticing". Increasing Barriers to Accessing Sexual and Reproductive Health Care in Romania, 7 April 2025, available at: https://www.hrw.org/report/2025/04/07/its-happening-even-without-you-noticing/increasing-barriers-accessing-sexual-and.
[568] Information on the Polish Commissioner's activities in 2023, pp. 297-299.
[569] Csákvári, T., Pónusz-Kovács, D., Kajos, LF., Elmer, D., Pónusz, R., Kovács, B., Várnagy, Á., Kovács, K., Bódis, J., Boncz, I. (2023), 'Prevalence and Annual Health Insurance Cost of Endometriosis in Hungary: A Nationwide Study Based on Routinely Collected, Real-World Health Insurance Claims Data', *Healthcare*, vol. 11, no. 10, pp. 1448–1459, https://doi.org/10.3390/healthcare11101448.
[570] Endometriosis Association Iceland (2025) 'Over 500 signatures delivered to the Minister for Health', https://endo.is/2025/04/10/heilbrigdisradherra-tekur-a-moti-yfir-5000-undirskriftum/.
[571] TVM News (2025) 'New centre for women suffering from endometriosis', 8 March 2025, https://tvmnews.mt/en/news/new-centre-for-women-suffering-from-endometriosis-that-affects-fertility/.
[572] Broersen (2019). Diagnose endometriose meestal pas na jaren. *Medisch Contact*, 4 October 2019; www.endometriose.nl.
[573] Commission on Women's Health (2023) 'The big difference of women's health in Norway'.
[574] UMC Utrecht, Signalen van hart- en vaatziekten bij vrouwen.

level of timely recognition by health professionals.[575] Reports in the **Netherlands** highlight that women experience delays in treatment, incorrect diagnosis, and more frequent side effects from medication (resulting in hospital admission) than men, and up to 80 % of individuals with unexplained conditions are women.[576] A report by the Danish Institute for Human Rights found gendered patterns of mental health support in **Denmark**, where men are much less likely to be offered screening and treatment for postnatal depression, despite research suggesting that it affects approximately 10 % of both men and women.[577]

At least four overlapping reasons explain the lack of gender-sensitive healthcare provision, many of them structural. First, a lack of adequate *research and data* was widely reported (**Austria**, **Belgium**, **France**, **Netherlands**,[578] **Norway**,[579] **UK**). In the **UK**, the Women's Health Strategy published by the Department of Health and Social Care in 2022 raised concerns about a 'male as default' approach to research design and scope (including underrepresentation in clinical trials, especially among some subgroups of women such as pregnant women, women from ethnic minorities and lesbian or bisexual women).[580] This approach to research design has resulted in a lack of data and understanding of conditions that only or primarily affect women such as menopause or endometriosis; and a lack of understanding of the ways in which conditions which affect everybody, such as cardiovascular disease, may affect men and women differently. These gaps in knowledge are even more significant at the intersections of different characteristics.[581] Secondly, and relatedly, there is also a lack of *training* of health professionals in women's health. In **Norway**, a Commission established in 2021 to report on women's health found that sex and gender perspectives are not being systematically included in guidelines and frameworks, or integrated into medical training.[582]

A third factor is a *lack of public awareness* and understanding of both health and healthcare which prevents patients seeking relevant healthcare or doing so in a timely way. This awareness and understanding deficit means that patients are less likely to be able to challenge a lack of gender-sensitive care when they encounter it. Examples include a lack of understanding of menstrual pain and of endometriosis (in **Austria**,[583] for example). In **Poland**, the Commissioner has explicitly called for improvement in education about menstruation. The UN CEDAW Committee has recommended improvement in education on reproductive health in **Bulgaria**.[584] A 2024 survey in **Estonia** found a lack of sufficient information about menopause.[585] Research in **France** suggests that a lack of public awareness of the different presentation of cardiovascular disease in men and

[575] Women's Health in Portugal Working Group (2022) 'Recommendations', p. 18.
[576] College ter Bevordering van Geneesmiddelen, Man-vrouwverschillen bij medicijnverbruik.
[577] Danish Institute for Human Rights (2021)*, Fædre bør screenes og sikres behandling for fødselsdepressioner*, (Fathers should be screened and treated for postpartum depression), https://menneskeret.dk/files/media/document/F%C3 %A6dre_b%C3 %B8r_screenes_og_behandles_for_f%C3 %B8dselsdepressioner_Rapport_november_2021_tilg%C3 %A6ngelig.pdf.
[578] Van Hagen, Muntinga, Appelman & Verdonk (2020) 'Sex and gender-sensitive public health research: analysis of research proposals in a research institute in the Netherlands', *Women & Health* 61 (9).
[579] Commission on Women's Health (2023) 'The big difference of women's health in Norway'.
[580] Department for Health and Social Care (2022) 'Women's Health Strategy for England'.
[581] Rojas-Garcia, A. et al, (2022) 'Use of intersectionality theories in interventional health research in high-income countries: a systematic scoping review' *The Lancet* 400(1): S58.
[582] Commission on Women's Health (2023) 'The big difference of women's health in Norway'.
[583] Sozialministerium, (2024) *Menstruationsgesundheitsbericht 2024,* Menstruationsgesundheitsbericht 2024.
[584] CEDAW (2020) Concluding observations on the eighth periodic report of Bulgaria, https://www.ohchr.org/en/documents/concluding-observations/cedawcbgrco8-concluding-observations-eighth-periodic-report (at para. 34).
[585] Part, K., Laanpere, M., Lõhmus, L. (2025), 'Karmid faktid ja üllatavad suundumused: põhjalik ülevaade Eesti naiste tervisest' (Harsh Facts and Surprising Trends: A Comprehensive Overview of Women's Health in Estonia). In: Marling, R. (ed) *Naistel on õigus: 30 aastat naiste õiguste deklaratsiooni vastuvõtmisest Pekingis* (Women Have Rights: 30 Years Since the Adoption of the Beijing Declaration on Women's Rights, Office of the Gender Equality and Equal Treatment Commissioner, pp. 10-13. https://www.volinik.ee/infomaterjalid/artiklikogumik-naistel-oigus-30-aastat-naiste-oiguste-deklaratsiooni-vastuvotmisest.html.

women results in an average and potentially critical 15 minute delay for women to seek treatment for myocardial infarction compared with men.[586] Health awareness is particularly low among certain vulnerable populations including Roma (**Romania**).[587]

Fourth, in addition to these structural reasons for a lack of gender sensitive healthcare, there is evidence that *systemic stigma and stereotyping* by healthcare professionals can lead to inaccuracies and delays in diagnosis and failures in healthcare. As the expert from **Belgium** put it, social barriers and biases may prevent women from being heard and from having their healthcare needs met. Research suggests that it is not uncommon for female patients to report that they are not taken seriously by health professionals and especially male doctors (**Slovenia**,[588] **Luxembourg**[589]), particularly for reproductive healthcare. Examples include diminishing of experiences of endometriosis (**Iceland**[590]) or dismissal of menstrual pain in the **Netherlands** where a 2025 report found that 68 % of Dutch women have had complaints dismissed as 'whining' or had experienced 'medical gaslighting' where physical pain is minimised and/or is attributed to mental ill health.[591] These experiences are often intersectional with black and other ethnic minority women (and particularly migrant women) more likely to experience misdiagnosis due to bias and much more likely to report experience of discrimination. Pain is sometimes attributed to culture rather than medically investigated.[592] A 2023 review of hospital policies in **Slovenia** revealed that, although discrimination is officially prohibited, healthcare workers often lack cultural competency training, particularly regarding sexual and gender minorities, leading to stereotyping and demeaning interactions.[593] Finally, it is important to note that men too experience stereotyping and stigma as barriers to care, particularly in relation to mental health.[594]

9.1.5 Obstetric violence

Obstetric violence has featured relatively recently in academic literature and there remains some disagreement as to what forms of behaviour the term includes.[595] For the purposes of this report – and reflecting the range of evidence provided under the national reports – a broad understanding of the term 'obstetric violence' is adopted here, in line with the WHO definition set out in section 1.3 above, which includes (but is not limited to) overt physical and psychological abuse, physical intervention without consent (including forced sterilisation), failure to secure informed consent, refusal of pain relief, and lack of other basic healthcare.[596] Barriers to access

586 See: https://cardiolarib.com/linfarctus-du-myocarde-chez-les-jeunes-femmes-une-premiere-a-lariboisiere/.

587 SASTIPEN, E-Romnja (2022), Research report "Roma women's access to maternity and reproductive health services" (*Raport de cercetare "Accesul femeilor rome la serviciile de maternitate si sanatatea reproducerii"*).

588 Advocate of the Principle of Equality (2023), *Annual Report for 2024* (*Raziskava o diskriminaciji na področju zdravstvenega varstva*), https://zagovornik.si/wp-content/uploads/2024/03/ZNE_DiskriminacijaZdravstvenoVarstvo_POROCILO-za-objavo.pdf/.

589 This was reported by civil society representatives on https://www.rtl.lu/radio/background/a/2267681.html. Unfortunately, this TV show exists only in Luxembourgish.

590 Endometriosis Association Iceland (2025) 'Over 500 signatures delivered to the Minister for Health'.

591 De Jong (2025) 'Women still do not receive the same healthcare as men' VUStories, 16 February 2025; Otten (2024) 'Medicine still subjects to male bias', RUGNews, 16 July 2024.

592 Zemouri et al (2024) 'Exploring discrimination and racism in healthcare: a qualitative phenomenology study of Dutch persons with migration backgrounds' *BMJ Open* 14 (6).

593 Ramšak M. (2023), *Healthcare Provision of Sexual and Gender Minorities in Slovenia*, Etnološka tribina.

594 Macdonald, J.A., Mansour, K.A, Wynter, K., Francis, L. M., Rogers, A., Angeles, M.R., Pennell, M., Biden, E., Harrison, T., & Smith, I. (2022) *Men's and Boys' Barriers to Health System Access. A Literature Review*, Australian Government Department of Health and Aged Care, Canberra.

595 Goudsmit Samaritter, M., Herring, J., & Pickles, C. (2024) 'The shadowy boundaries of obstetric violence', *Journal of Gender-Based Violence* Volume 8 Issue 3.

596 Although it should be noted that concerns have been raised that an over broad definition may risk undermining legal and policy strategies to address the most serious forms of violence, see Pickles, C., (2024) ' "Everything is Obstetric Violence Now": Identifying the Violence in 'Obstetric Violence' to Strengthen Socio-legal Reform Efforts', *Oxford Journal of Legal Studies* Volume 44 Issue 3, pp. 616-644.

to sexual and reproductive health and rights, which it has also been argued represent a specific form of violence against women, have already been outlined above.[597] The CEDAW Committee has recognised obstetric violence as a form of gender-based discrimination.[598]

The vast majority of experts reported evidence of obstetric violence (including refusal of pain relief, lack of other basic care, problems with consent and choice, and harassment/abuse.) In **Portugal** obstetric violence is described as a public health problem, with research suggesting that one in three women have experienced this form of violence, despite the existence of relevant legislation to address it.[599] The same report notes that the lack of legal recognition of the phenomenon has contributed to the invisibility of domestic violence in the courts. In the **Netherlands** over 50 % of women in a 2022 study reported at least one form of disrespect or abuse during childbirth, with 36 % experiencing a form of treatment that they considered upsetting.[600]

In many cases these forms of discrimination are intersectional – in particular ethnic minority or migrant women appear more likely to experience obstetric violence and other forms of harassment and stigma. In the **UK**, the Women and Equalities Committee of the House of Commons inquiry into Black maternal health found that black women are four times more likely to die in childbirth than white women, with significant disparities also present for Asian women and women of mixed ethnicity. The Committee noted that 'the reasons for ethnic disparities in mortality are not fully understood. Across aggregated ethnic groups, women are dying from the same causes, but Black and Asian women are dying more frequently. We heard that there were many possible reasons for the disparity in the frequency of deaths, including pre-existing conditions and co-morbidities; socio-economic factors including deprivation; and factors impacting on the care that women received, including ignorance, bias, microaggressions and racism.'[601] Research from **Portugal**[602] and from the **Netherlands** shows that migrant women are particularly likely to report upsetting disrespect and abuse, including physical violence. In the Netherlands, mortality is significantly higher at birth for infants with a migrant background (something not fully explained by other relevant factors).[603] Maternal mortality among women with Surinamese or Dutch Caribbean background is up to three times higher than women with no migrant background, and in at least half of these cases better healthcare could have changed the outcome.[604] In **Hungary** a report by the European Roma Rights Centre found that Roma women are subject to stereotyping, harassment and obstetric violence

[597] C_202502005EN.000101.fmx.xml. See definition of Obstetric Violence by the WHO in 1.3 above.

[598] Committee on the Elimination of Discrimination against Women, *S.F.M.* v. *Spain*, Communication No. 138/2018. UN Doc CEDAW/C/75/D/138/2018. 2020.

[599] According to statistics from the 2nd edition of the survey of childbirth experiences in Portugal 2015-2019 carried out by the Portuguese Association for Women's Rights in Pregnancy and Childbirth. See Simões, V. (2022) 'Violência Obstétrica – tendências legislativas em Portugal', *Observatório Almedina*, 14 March 2022, available at: https://observatorio.almedina.net/index.php/2022/03/14/violencia-obstetrica-tendencias-legislativas-em-portugal/.

[600] Van der Pijl *et al.* (2022), 'Disrespect and abuse during labour and birth amongst 12 239 women in the Netherlands: a national survey' *Reproductive Health* 19, 160.

[601] Women and Equalities Committee (2023) *Black Maternal Health: Third Report of Session 2022-2023* (House of Commons, HC 94, 19 April 2023) at p.7.

[602] See Holanda Rusu, M. (2024) *Violência Obstétrica em Portugal: polifonia dos corpos brasileiros racializados,* Dissertação apresentada no Mestrado em Psicologia das Organizações, Social e do Trabalho, Faculdade de Psicologia e de Ciências da Educação da Universidade do Porto, available at: https://repositorio-aberto.up.pt/bitstream/10216/159352/2/677726.pdf; Faria, I., Brito, L. and Costa, K. (2023) 'Prejudiced Rationales for Stereotyping: On the Experiences of Black and African-Descended Women in Reproductive Care in Portugal and Mozambique', in Botrugno, Mocellin Raymundo and Re (eds.) *Bioethics and Racism: Practices, Conflicts, Negotiations and Struggles*, pp. 149-164. https://doi.org/10.1515/9783110765120-011; Oliveira da Costa, K. Figueiredo Brito, L., da Silva Coimbra, C., Costa Lopes, N., Oliveira dos Santos Depuydt, D., Nunes Correia, R. (2022) 'Racismo obstétrico em Portugal: Relato de experiência de um coletivo antirracista' (Obstetric racism in Portugal: Experience report of an anti-racist collective), *Forum Sociologico*, No. 41, pp. 7-14, available at: https://journals.openedition.org/sociologico/10662.

[603] RIVM, 'Sterfte rond de geboorte | Herkomstland' (Perinatal mortality), Volksgezondheid en Zorg.

[604] Kallianidis AF, Schutte JM, Schuringa LEM, et al. (2022) 'Confidential enquiry into maternal deaths in The Netherlands, 2006-2018', *Acta Obstet Gynecol Scand*; 101(4): 441-449.

within the healthcare system.[605] Indeed in 2016, the **Hungarian** Equal Treatment Authority established harassment in the case of a Roma woman who claimed that she was verbally abused by some members of the medical staff when she was giving birth in a public hospital.[606] Notably, the Equal Treatment Authority assessed this case on the basis of her ethnic origin and skin colour but did not recognise the intersectional discrimination stemming from her ethnicity and her status as a pregnant woman, despite the fact that the harassment was explicitly linked to the combination of these features.

9.1.6 Sexual harassment/sexual assault

Sexual harassment and sexual assault take place in healthcare settings, where victims are particularly vulnerable. A 2023 report from the **UK** found that more than 6,500 rapes and sexual assaults have been recorded in hospitals in England and Wales, over the course of four years, with only 4.1 % of suspects known to have been charged.[607] **Cyprus**, **Czechia**, **Germany**, and **Latvia** also report problems of sexual assault and sexual harassment, the **Greek** expert noting additionally that a lack of available data on incidents of harassment is an important concern.

9.2 Legal frameworks

9.2.1 Constitutional and legislative provisions

g. Constitutional provisions

Most states surveyed have some form of constitutional guarantee of gender equality in access to healthcare, most commonly derived from separate provisions on equality and non-discrimination and a right to healthcare, which must be read together. There is a lack of reported case law, however, on which to judge the scope of these protections or the extent to which they can be deployed to address the problems identified above. Some constitutions (**Croatia**, **France**, **Poland**) provide specific protections for motherhood, which could in principle extend to aspects of reproductive care, although again case law has not confirmed that they do so.

h. Anti-discrimination legislation

Anti-discrimination legislation (which in most cases is the legislation that transposes Directive 2004/113) appears to prohibit discrimination on grounds of sex or gender in the provision of healthcare in all but one of the states (**Poland**). In just under half of states the coverage of healthcare within the material scope of the legislation is made *explicit* in the legislation itself (**Belgium**, **Croatia**, **Czechia**, **France**, **Hungary**, **Latvia**,[608]

[605] European Roma Rights Centre (2020), 'Reproductive rights of Romani women in Hungary', Brussels, http://www.errc.org/uploads/upload_en/file/5228_file1_reproductive-rights-of-romani-women-in-hungary.pdf.

[606] Equal Treatment Authority (Egyenlő Bánásmód Hatóság) Decision No. EBH/349/2016. See the description of the case in English, EELN (2017), Flash report (Hungary), 18 April 2017: https://www.equalitylaw.eu/downloads/4069-hungary-roma-woman-harassed-in-hospital-while-giving-birth-pdf-110-kb. See also: European Roma Rights Centre (2020), 'Reproductive rights of Romani women in Hungary'.

[607] Phoenix, J. (2023) *When we are at our most vulnerable: the sickening extent of rapes and sexual assaults in* hospitals, Women's Rights Network.

[608] In Latvia there is no dedicated anti-discrimination legislation but a prohibition on gender discrimination in the provision of healthcare services is instead found across different pieces of legislation: the Law on Social Security prohibits gender discrimination in relation to social security; the Law on the Protection of Consumer Rights provides for prohibition of discrimination in respect of consumer transactions including private healthcare services; and the Patients' Rights Law provides for the prohibition of discrimination in access to healthcare (and is detailed in this respect, including specific prohibition of direct and indirect discrimination, harassment, victimisation and instructions to discriminate).

Netherlands, **Portugal**, **Romania**, **Slovakia**, **Slovenia**, **Spain**, **Sweden**, **UK**).[609] In other states, coverage of healthcare is not explicit although in most cases, the experts believe that it is included within scope implicitly: because healthcare falls within the broader definition of services or sectors of society to which the legislation applies (**Austria**, **Estonia**, **Ireland**, **Norway**, **Finland)**; because healthcare is not in a list of specifically excluded sectors (**Cyprus**, **Greece**); because healthcare has been understood to be covered in decisions of the national equality bodies (**Lithuania**, **Malta**); because the relevant legislation makes explicit reference to CEDAW (**Bulgaria**);[610] or for other reasons (**Denmark**, **Italy**). The experts in **Germany** and in **Liechtenstein** report that the scope of coverage remains unclear. The **German** expert notes that while the equality body understands healthcare to fall within the scope of the relevant legislation, uncertainty remains and it has been suggested that the effective protection of patients within the field of health care, requires a clarification that the medical treatment contract (section 630a German Civil Code) falls within the scope of section 19(1) of the General Equal Treatment Act (AGG).[611]

In **Poland**, anti-discrimination legislation applies to healthcare but only in relation to ethnicity, race and nationality. Gender discrimination in access to healthcare is therefore not covered. The Polish expert notes that those who experience discrimination in access to healthcare services may be able to benefit from relevant provisions of the Civil Code, but this does not, in the view of the expert, offer protection equivalent to that provided in respect of race discrimination under the anti-discrimination legislation. The Civil Code does not, for example, include provisions which reverse the burden of proof under relevant circumstances.

Most national equality bodies reported in 2014 that they understood national legislation implementing Directive 2004/113 to cover discrimination in the provision of healthcare, although there was less confidence that the definition of goods and services in national legislation covered all healthcare-related goods and services, including services funded publicly rather than by direct transfer from the patient.[612] A lack of case law in the Member States means that this uncertainty remains.[613] In this context it is worth noting that the **Netherlands** Institute for Human Rights, the Dutch equality body, decided that it did not have jurisdiction to decide whether the non-inclusion of gender-affirming healthcare (beard hair removal) from the basic healthcare insurance was sex discrimination (sex discrimination including discrimination based on sex characteristics, gender identity and gender expression) because that was a matter for the Government. The equality body decided that it only had jurisdiction to decide whether the claimant had been treated differently because of

609 In Romania and in Spain, gender discrimination in the provision of healthcare services is covered under two sets of different instruments – both anti-discrimination legislation (which explicitly covers healthcare) and separate legislation introduced specifically to transpose Directive 2004/113/EC (which covers healthcare only implicitly).

610 Article 12(1) of CEDAW provides that: 'States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning'.

611 Antidiskriminierungsstelle des Bundes (09/2020), Standpunkte Nr. 01 Ist das Allgemeine Gleichbehandlungsgesetz auf medizinische Behandlungsverträge anwendbar? (Is the General Equal Treatment Act applicable to medical treatment contracts?) https://www.antidiskriminierungsstelle.de/SharedDocs/downloads/DE/publikationen/Standpunkte/01_Behandlungsvertraege.pdf?__blob=publicationFile&v=6; Deutscher Bundestag (2021), Vierter Gemeinsamer Bericht der Antidiskriminierungsstelle des Bundes und der in ihrem Zuständigkeitsbereich betroffenen Beauftragten der Bundesregierung und des Deutschen Bundestages (Fourth Joint Report of the Federal Anti-Discrimination Agency and the Commissioners of the Federal Government and the German Bundestag within its Competence), Drucksache 19/32690 https://dserver.bundestag.de/btd/19/326/1932690.pdf, p.157.

612 European Network of Equality Bodies (Equinet) (2014), *Equality Bodies and the Gender Goods and Services Directive*; http://www.equineteurope.org/Equality-Bodies-and-the-Gender.

613 See discussion in Caracciolo di Torella, E. (2021), *Directive 2004/113/EC on Gender Equality in Goods and Services – In Search of the Potential of a Forgotten Directive*, European Equality Law Network, pp. 40-41.

gender identity in the evaluation of her request.[614] The enforcement activity and case law of equality bodies is discussed in more detail in section 9.3.3 below.

i. Patients' rights legislation

With only a few exceptions, states also have separate patients' rights or healthcare legislation, which includes general guarantees of equality in access to healthcare, although these tend to be very non-specific in form.

j. Private insurance

In relation to gender discrimination by private insurers, most states report that legislation prohibits discrimination in the provision of private health insurance and that the decision in *Test-Achats* has been incorporated into the relevant provisions so that insurers are prohibited from discriminating on grounds of gender. There are a few exceptions. There is no such provision in the **Czechia**. In **Latvia** the expert reports that there is a widespread view that Article 5 of Directive 2004/113 (on the use of sex as an actuarial factor)[615] does *not* require the inclusion in insurance programmes of risks related to pregnancy and maternity and such practices persist as a result.

GOOD PRACTICE
In **Belgium**, legislation promotes transparency in insurance underwriting by requiring that insurers make public on their websites the criteria used to assess risk. The law also requires that these be objective, reasonable, and proportionate, helping to identify and prevent indirect discrimination.[616]

9.2.2 Different treatment and positive action

The survey of problems of gender discrimination and gender equality in section 9.1 above, demonstrates the importance of healthcare services delivering healthcare in a gender-sensitive way, recognising the different health and healthcare needs that arise from biological and social differences. At the same time, there is a need to eliminate differential treatment which creates or exacerbates gender inequalities. If legislation is to provide an effective framework to achieve these two aims, clarity is needed as to the circumstances in which it is necessary, and permissible, to treat patients differently because of their gender.

As noted in section 3.1.2 of this report, Directive 2004/113 includes provisions that permit different treatment between women and men without this amounting to discrimination in specified circumstances: Article 4(2) states that the Directive 'shall not be without prejudice to more favourable provisions concerning the protection of women as regards to pregnancy and maternity;' Article 4(5) provides that the Directive 'shall not preclude differences in treatment, if the provision of the goods and services exclusively or primarily to members of one sex is justified by a legitimate aim and the means of achieving that aim are appropriate and necessary'; and Article 6 permits positive action to prevent or compensate for disadvantages related to sex. Further, Recital 12 states that '... differences between men and women in the provision of healthcare services, which result from

[614] NIHR, decision number 2024-49, 11 June 2024.
[615] See discussion in Chapter 3, section 3.1.4.
[616] Belgium, Law of April 4 2014 on Insurance, *Moniteur belge/Belgisch Staatsblad*, 30 April 2025, eli/loi/2014/04/04/2014011239/moniteur.

the physical differences between men and women, do not relate to comparable situations and therefore, do not constitute discrimination'.[617]

As discussed in the 2021 EELN report on the Goods and Services Directive,[618] and above in Chapter 3, a lack of case law means that there is still some doubt as to the effect of these provisions in the context of healthcare services. Recital 12 gives rise to questions about whether most forms of sexual and reproductive healthcare are excluded from the protection of the Directive. It is also unclear whether Recital 12 would preclude a claim of direct or indirect discrimination – where differences in treatment would require justification under Article 4(5) – in circumstances where there is a lack of provision for one or both sexes, or poor provision of a treatment which is capable of benefiting both men and women, but which may benefit women significantly more than men because of physical differences between them. Nor is it clear whether it precludes a claim for discrimination where the treatment in question results partly, but not only, from physical difference. In this context, it is important also to remember that not all women (or all men) share the same physical qualities.

The uncertainty is translated in most cases to the national legislation of the states. Indeed many states report that these provisions were transposed by copying across the language of the Directive into national legislation. There has been very limited case law at national level to clarify the circumstances under which different treatment related to biological differences will be prohibited or permitted.

One example which provides a useful illustration of this problem has arisen in the provision of the human papillomavirus (HPV) vaccine where case law in different countries has reached different conclusions about the legality of providing the vaccine to girls but not to boys. The **Danish** Equal Treatment Board has assessed a complaint of alleged gender discrimination in the public offer of free HPV vaccination. Free HPV vaccination for girls was introduced in 2009 and included a catch-up programme for those over the age of 12. A similar offer for boys began in 2019 but without a catch-up scheme. The Equal Treatment Board found that this did not constitute discrimination under the Gender Equality Act. The decision not to include a catch-up programme for boys was based on medical risk assessment and public health priorities. According to the Danish Health Authority's 2019 evaluation, women face a higher documented risk of HPV-related cancers. Referring to Recital 12 of Council Directive 2004/113/EC, the Board concluded that differences in healthcare provision due to biological differences do not involve comparable situations and therefore do not amount to discrimination. A catch-up programme was later introduced in 2020 for boys who turned 12 between January 2018 and June 2019.[619]

By contrast in **Belgium** in 2022, the Dutch-speaking Labour Court of Brussels ruled that the reimbursement scheme for HPV vaccination was in breach of the Gender Act and the Anti-Discrimination Act. The judgment declared that the refusal of the defendant (the National Healthcare Insurance Institute) to meet the cost of the HPV vaccine in favour of boys constituted prohibited direct discrimination within the meaning of Article 19 of the Gender Act in conjunction with Article 14 of the Anti-Discrimination Act (in the case of homosexual boys), notwithstanding that Article 10 of the Gender Act has incorporated the language of Recital 12. Following this decision, as of 1 August 2022, boys as well as girls now have access to reimbursement of HPV vaccination up to and including the age of 18.

617 Recitals are not formally binding but persuasive in interpretation of binding provisions.
618 Caracciolo di Torella, E. (2021), *Directive 2004/113/EC on Gender Equality in Goods and Services – In Search of the Potential of a Forgotten Directive*, European Equality Law Network.
619 Danish Board of Equal Treatment, ruling No. 9416 of 25 June 2020, https://www.retsinformation.dk/eli/retsinfo/2020/9416.

The **Belgian** expert reports that national legislative provisions concerning the reimbursement of certain drugs exclusively for women — on the ground of different physiological characteristics between men and women — have also been examined in insurance case law. Mandatory health insurance initially covered osteoporosis or breast cancer treatment only for women. In later cases, some courts found that, based on Directive 79/7, this approach amounted to sex discrimination, while others upheld the distinction as justified by scientific or physiological reasons. Finally, a related example in the **UK** involved a challenge to a policy of the local health authority to fund services to freeze semen but not oocytes (eggs) for the purposes of future assisted fertility treatment. The claimant sought the treatment as a matter of urgency before undertaking a course of chemotherapy which was likely to bring on early menopause and leave her infertile. Rejecting the claim of direct sex discrimination the court noted that there were 'obvious relevant differences' between semen and oocytes such that it could not be accepted that 'differentiating between gametes in this context means the same as differentiating between men and women'.[620]

9.2.3 Case law

Aside from the small number of cases discussed above, there is a striking lack of case law on gender discrimination in the provision of healthcare (or indeed discrimination on any protected characteristic) (cases investigated by the equality bodies are discussed in section 9.3.3 below). The reasons for the lack of case law are discussed below in section 9.4 on enforcement.

9.2.4 Positive duties beyond the obligations in the Goods and Services Directive

There are examples across several countries of positive duties or institutional obligations that go beyond the requirements of the Good and Services Directive. Given the structural and systemic nature of many of the problems of gender inequality and discrimination identified above, these approaches provide potentially important mechanisms to address the root causes of some forms of gender discrimination and of gender inequality.

GOOD PRACTICE

In **Italy**, legislation in 2018 provided for the creation of a national plan to promote gender medicine, including through research, dissemination and training and an observatory dedicated to gender medicine to monitor the implementation of the plan and to provide institutional coordination.[621]

In **Slovenia**, the Government is subject to a positive duty to submit proposals on gender equality, including gender equality in healthcare.[622]

In **Spain**, both the General Law on Health and the Law on Effective Equality include principles of gender mainstreaming.[623] Since 2019, the Ministry of Health has been advised by the Observatory on the Health of Women, whose role is to analyse health policies and propose action to reduce gender inequalities, in

[620] *Rose, R (on the application of) v Thanet Clinical Commissioning Group* [2014] EWHC 1182 (Admin).
[621] Italy, Law No. 3/2018, Article 3(5).
[622] Slovenia, Act on Equal Opportunities for Women and Men, Article 15.
[623] Spain, Law 14/2003 on the Cohesion and Quality of the National Health System, Article 76f; Law 3/2007 on Effective Equality, Article 27.

collaboration with all relevant stakeholders. Its work relates to four strategic areas of action: gender mainstreaming, gender violence, sexual and reproductive health, and training.[624]

In the **UK**, the public sector equality duty puts obligations on all public authorities (including health authorities) to have 'due regard' to the need to eliminate discrimination and advance equality in carrying out their functions.[625]

9.3 Regulatory bodies

Provisions on the prohibition of gender discrimination and the promotion of gender equality are widely found in the regulations, codes of practice and ethical guidelines of health service and professional regulators (although the concepts of discrimination are generally not well explained/developed in these contexts). These bodies have the potential to make at least two important contributions to reducing gender discrimination and advancing gender equality. First, they are well placed to identify and monitor systemic problems that cannot be easily addressed through a system relying primarily on individual complaints for enforcement. They will often have powers to implement systemic remedial actions. Secondly, they may offer a more accessible alternative to litigation for some individuals wishing to complain about experiences of discrimination in access to healthcare.

9.3.1 Regulation of health care services

In several states, healthcare regulatory bodies appear to have an express remit to consider problems of equality and discrimination in their assessment of quality and compliance. In the **UK** for example, the Care Quality Commission ('CQC') is an independent statutory body with responsibility for monitoring the safety, effectiveness and quality of adult health and social care in England. Its remit includes responsibility for monitoring the compliance of registered healthcare providers with relevant statutory regulations, which include a specific obligation to treat service users (patients) with dignity and respect and to have due regard to the protected characteristics in the Equality Act 2010.[626] CQC guidance on the interpretation of this provision is comprehensive and makes clear that the obligation includes both ensuring that there is no discrimination within the meaning of the Equality Act, and having due regard to protected characteristics in the way they meet their other regulatory requirements.[627] The CQC does not have the power to take forward individual complaints, but does have power to ensure that individual service providers (hospitals, clinics and so on) have effective complaints mechanisms. Its powers of enforcement include the ability to require improvement, to issue fines, and to remove registration. While variable, comparable arrangements exist in **Croatia**, **Greece**, **Italy**, **Netherlands**, **Portugal**, **Romania**, **Slovenia** and **Spain**. In **Poland** the Commissioner for Patients' Rights has no explicit responsibility for monitoring discrimination but does monitor and hear complaints about issues of poor healthcare where gender equality is at issue (although the expert notes that concerns have been raised about the independence of this body). Experts in other countries were unable to find evidence that the relevant bodies have a clear remit to monitor discrimination and equality in the provision of healthcare, although this does not mean that discrimination is necessarily excluded.

624 Spain, Law 14/2003 on the Cohesion and Quality of the National Health System, Article 63.
625 United Kingdom, Equality Act 2010, Section 149.
626 United Kingdom, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 10: The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
627 Regulation 10: Dignity and respect - Care Quality Commission.

There is very little evidence of relevant enforcement action taken by regulatory bodies in respect of discrimination, in part because of an absence of clear, published and searchable data. There are some isolated examples. In **Slovenia**, for example, the Health Inspectorate took steps to investigate a complaint of disability discrimination referred to it by the equality body (although no violation was found).[628] In **Portugal**, the Health Regulatory Authority (the ERS) referred two complaints (from a total of 65,669 complaints received) to the equality body in 2024 and six in 2023.[629] No further details are known. In addition the ERS has issued several deliberations after complaints of obstetric violence, and sent instructions to the relevant institutions (with power to issue an administrative sanction for non-compliance). However, the expert notes that they are not explicitly identified or referred to by the ERS as examples of gender discrimination.

Some experts raised a general concern that existing complaints mechanisms within the healthcare system itself are unlikely to provide an effective mechanism to raise concerns about discrimination. In **Germany**, complaints procedures are highly fragmented across a number of organisations and there is a general lack of information and advice about where, and how, to bring forward a complaint about discrimination. In **Italy**, patients are encouraged to report problems with the quality of healthcare, including discrimination, to local health authorities and hospitals but the expert notes that the quality and effectiveness of these complaints procedures will be highly variable as they will typically depend on the personnel who work there. In some instances, the inadequacy of complaints procedures has been subject to investigation by the relevant equality bodies (see further section 9.3.3 below).

9.3.2 Regulation of health care professionals

In around half of the states covered in this report, (**Belgium**, **Croatia**, **Cyprus**, **Denmark**, **France**, **Germany**, **Greece**, **Ireland**, **Italy**, **Netherlands**, **Poland**, **Portugal**, **Romania**, **Sweden**, **UK**) the bodies responsible for registration and regulation of medical professionals include provisions on discrimination and equality in their ethical guidance, codes of practice or regulations, although these tend to be brief and expressed in general terms without detail on the meaning of discrimination or equality. In **Croatia** for example, Article 1(3) of the Code of Medical Ethics and Deontology provides that a physician must provide medical assistance equally to everyone, regardless of age, gender, race, nationality, religion, political belief, social status, or any other circumstances, while respecting human rights and the dignity of the individual.[630] In the **Netherlands**, the Code of Conduct for Doctors includes as one of its core principles that 'as a physician you contribute to the availability and accessibility of healthcare. You treat everyone equally in equal cases and unequally in unequal cases, and therefore, you do not discriminate'. The explanatory note which accompanies the code provides some, brief, elaboration.[631]

Enforcement of these codes is normally limited to the issuing of sanctions to the healthcare professionals involved. Additionally, concerns were raised by some experts that the effectiveness of this mechanism for addressing gender discrimination may be compromised by the lack of independence of the regulatory organisations, which are predominantly self-regulatory, and the lack of involvement of the victims of discrimination in the process. Again, limited data means that it is difficult to assess the frequency with which

628 Advocate of the Principle of Equality (2025), Annual Report for 2024 (*Redno letno poročilo za leto 2024*), p. 97.
629 See: https://www.ers.pt/media/kb1p5ayg/relat%C3 %B3rio-sgrec-2024.pdf; ERS (2024) *Annual report 2023*, https://www.ers.pt/pt/flipbooks/relatorio-2023-sistema-de-gestao-de-reclamacoes-elogios-e-sugestoes/.
630 Croatia, Code of Medical Ethics and Deontology (*Kodeks medicinske etike i deontologije*) NN Nos. 55/2018 and 139/2015.
631 Netherlands, KNMG, Code of Conduct for Doctors (*Gedragscode voor artsen*), February 2022, pp. 10 – 11 (https://www.knmg.nl/).

complaints involving gender discrimination are referred, investigated and upheld, or the type of gender discrimination involved. There were no known examples from the majority of states. Examples that are available relate to complaints of sexual harassment (**Cyprus**, **UK**) or to discrimination on other grounds (**Netherlands**).[632] Recent research in the **UK** has identified serious failings in the approach of the relevant regulatory bodies to handling complaints of sexual harassment, particularly in the leniency of the sanctions given, and has called for reform.[633]

9.3.3 Equality bodies

While almost all national equality bodies believe that gender discrimination and gender equality in the provision of healthcare comes within their remit (the equality bodies in **Iceland** and **Liechtenstein** being the exceptions), many do not appear to have been engaged in any relevant monitoring or enforcement activities. Nor do they appear to have produced any research or reports which specifically include gender equality and discrimination in a healthcare context (**Austria**, **Bulgaria**, **Cyprus**, **Czechia**, **Finland**, **Hungary**, **Italy**, **Latvia**, **Luxembourg**, **Malta**) although the bodies in **Czechia**, **Italy**, **Latvia** and **Malta** have taken enforcement action or published research or guidelines in respect of discrimination based on other protected characteristics in access to healthcare.

Several equality bodies have produced recent research on gender equality and healthcare (including intersectional discrimination). The **Danish** Institute for Human Rights, for example, published four separate relevant reports between 2016 and 2022 covering discrimination in insurance due to pregnancy and maternity; the need to screen and treat fathers, as well as mothers, for postpartum depression; ethnicity and coercion in psychiatry; and health rights of unregistered migrants. The Defender of Rights in **France** published a comprehensive report on discrimination in access to healthcare (related to all protected characteristics) in 2025 based on a series of interviews and investigations in the health sector and on its own decisions, and covering both individual risks of discrimination and structural barriers across every stage of the healthcare process.[634] There are other examples of recent research in **Croatia**,[635] **Germany**,[636] **Portugal** and **Sweden**.[637] Some equality bodies have also taken a key role in advocating for gender equality rights in healthcare. Examples include **Slovakia**, where the Slovak National Centre for Human Rights sent a report to the UN Committee against Torture in 2023, addressing a number of key issues and challenges including involuntary sterilisation of Roma women and trans people and has been actively involved in the United National periodic review

[632] Cyprus Medical Association, Disciplinary Committee, Decision Number 1/2024 https://cyma.org.cy/wp-content/uploads/2025/09/%CE%91%CE%A5%CE%A4%CE%9F%CE%A5%CE%A3%CE%99%CE%91-%CE%97-%CE%91%CE%A0%CE%9F%CE%A6%CE%91%CE%A3%CE%97.pdf; Netherlands, Regional Medical Disciplinary Board The Hague (Regionaal Tuchtcollege voor de Gezondheidszorg Den Haag), case number 2019-035, 13 August 2019, ECLI:NL:TGZRSGR:2019:133.

[633] Newlands, C. et al. (2025) 'Professional Regulation in the UK: Future of the GMC under challenge' *British Medical Journal* 390, 1933.

[634] France, Defender of Rights, Preventing discrimination in health care process 2025 (*Prévenir les discriminations dans les parcours de soins 2025*) https://www.defenseurdesdroits.fr/sites/default/files/2025-05/ddd_rapport_discriminations-parcours-de-soins_20250430.pdf.

[635] Ombudsperson for Gender Equality (2020), *Results of the research of association RODA and the Ombudsperson for Gender Equality on accessibility of reproductive healthcare for women during COVID-19 pandemic* (Rezultati istraživanja udruge Roditelji u akciji i Pravobraniteljice za ravnopravnost spolova o dostupnosti skrbi za reproduktivno zdravlje žena u vrijeme pandemije bolesti COVID-19), available at: https://prs.hr/application/uploads/Rezultati_istraživanja_o_dostupn.pdf.

[636] Bartig, S., Kalkum, D., Le, HM., Lewicki, A. (2021) Diskriminierungsrisiken und Diskriminierungsschutz im Gesundheitswesen – Wissensstand und Forschungsbedarf für die Antidiskriminierungsforschung (Discrimination risks and protection against discrimination in the healthcare system – state of knowledge and research needs for anti-discrimination research), available online: www.antidiskriminierungsstelle.de/SharedDocs/downloads/DE/publikationen/Expertisen/diskrimrisiken_diskrimschutz_gesundheitswesen.pdf?__blob=publicationFile&v=5.

[637] Swedish Gender Equality Body, https://swedishgenderequalityagency.se/gender-equality-in-sweden/sub-goal-5-equal-health/.

process.[638] In **Ireland**[639] and in **Poland**, the equality bodies have pushed for access to safe and appropriate reproductive healthcare and the equality body in **Belgium** has issued opinions on menopause policy[640] and guidance on sexual violence and female genital mutilation.[641] In **Portugal**, the equality body has funded a national communication campaign on reproductive rights including a 'Guide to good practices for the media in preventing and combating obstetric violence'.[642]

In terms of enforcement activity, many equality bodies are limited by a lack of powers, including powers to receive or support individual claims. Even where relevant powers exist, however, there are only few examples of relevant enforcement action. Recent examples include **Croatia**, where the Ombudsperson for Gender Equality received a complaint from a woman concerning misconduct by healthcare professionals during childbirth, which included a violation of her right to be informed and to make independent decisions (an episiotomy was performed without her consent). The Ombudsperson requested an investigation by the relevant health authorities (the Croatian Chamber of Midwives) and monitored the course of the investigation. The investigation took over two years and, while it was found that no violation had occurred in this case, the Ombudsperson alerted the Ministry of Health that the investigation processes took too long (this was not an isolated case) and recommended an amendment to procedures.[643] Similarly, in **Lithuania**, the equality body responded to a complaint that a clinic had not properly investigated a claim by a patient that they had been subject to derogatory behaviour during a health consultation (in this case the doctor had ignored the patient and spoken to her husband). The clinic was found liable for gender discrimination both in respect of the original complaint, and in its subsequent failure to investigate.[644] The complaints process was also subject to investigation in **Greece** where the equality body investigated the Athens Medical Association for charging a EUR 50 fee to file a complaint for sexual harassment. The fee was subsequently abolished, following a recommendation from the equality body.[645] Other examples of enforcement action include claims related to

638 Slovak National Centre for Human Rights (2023) Observations of the in relation to the fourth periodic report of Slovakia to the Committee against Torture, available in English at: https://www.snslp.sk/wp-content/uploads/CAT_submission_SNCHR.pdf.

639 Irish Human Rights and Equality Commission, Oireachtas must now legislate to vindicate the human rights of women and girls in accessing healthcare, Press Release 26 May 2018, at https://www.ihrec.ie/news-press/oireachtas-must-now-legislate-to-vindicate-the-human-rights-of-women-and-girls-in-accessing-healthcare.

640 Institute for Equality for Women and Men, Opinion n°2024-A/010 on the development of a (peri) menopause policy, available in French and Dutch, in French at https://igvm-iefh.belgium.be/fr/documentation/lelaboration-dune-politique-en-matiere-de-perimenopause, and Menopause at Work: Guidance for an Inclusive Workplace, available in French and Dutch, in French at https://igvm-iefh.belgium.be/fr/documentation/la-menopause-au-travail.

641 Institute for Equality for Women and Men, Handbook for Professionals on Understanding the Istanbul Convention, 2025, available in French and Dutch at https://igvm-iefh.belgium.be/fr/documentation/manuel-destination-des-profesionnelles-pour-comprendre-la-convention-distanbul and Institute for Equality for Women and Men, Handbook on the Reporting Code for Female Genital Mutilation, 2021, available in French and Dutch at https://igvm-iefh.belgium.be/fr/documentation/manuel-relatif-au-code-de-signalement-des-mutilations-genitales-feminines.

642 Comissão para a Cidadania e a Igualdade de Género (2024), Guide to good practices for the media in preventing and combating obstetric violence' (Guia de boas práticas para os órgãos de comunicação social na prevenção e combate à violência obstétrica) https://www.cig.gov.pt/wp-content/uploads/2024/01/Guia-APDMGP-para-OCS-Violencia-Obstetrica-.pdf.

643 Croatian Ombudsperson, Case PRS-17-01/22-15.

644 Decision of the Office of the Equal Opportunities Ombudsman No. (24)SN-197)SP-88, 12 December 2024.

645 Greek Ombudsman, Quarterly bulletins January-April 2020, p.36, https://www.synigoros.gr/el/category/ygeia/post/deltio-5:-ianoyariosaprilios-2020.

gender discrimination in insurance (**Greece**,[646] **Romania**),[647] abortion (**Poland**, **Greece**),[648] and intersectional discrimination related to sexual orientation in IVF (in vitro fertilisation) and in blood donation (**Slovenia**.)[649]

9.4 Enforcement

Difficulties with enforcement have already been highlighted. In particular, it is notable that there is very little case law bought either by individual claimants or other bodies on their behalf. Most experts reported that they had been unable to find any published cases on discrimination (on any ground). Where cases do exist, they tend to relate to other protected characteristics. In addition to the well-known difficulties in enforcing discrimination law in general, experts considered that the reasons for this may include:

- *Difficulties faced by claimants in recognising and in proving discrimination*. It is plausible that the nature of medical expertise, the power dynamic between medical professionals and patients, and the complex health economic and clinical data on which resourcing decisions are made, mean that patients and their carers (and indeed their lawyers) may not be well placed to access or assess the evidence in order to determine whether discrimination has taken place. These problems are well explained in the 2025 report of the **French** equality body, the Defender of Rights, which noted that 'it is still difficult to identify, recognise and punish discriminatory acts in the healthcare process, especially when they occur in the context of care. The ethical requirement to treat all patients, and the seemingly neutral medical knowledge that underpins medical practices, contribute to making discrimination in care invisible. Similarly, the asymmetrical therapeutic relationship between, on the one hand, a healthcare professional with exclusive knowledge and, on the other hand, a patient in a vulnerable situation, makes it more difficult to identify the discrimination experienced'.[650]

- *A lack of visibility*. Several experts report that even where discrimination is reported, or proceedings brought, the treatment in question is not always characterised or recognised as gender discrimination and so the discrimination remains 'hidden' or 'invisible'. It is also possible (and accords with findings of the Union's Fundamental Rights Agency 2013 research)[651] that when patients do complain about treatment which amounts to gender discrimination, they are more likely to use complaints mechanisms for those who experience 'poor healthcare' or to bring claims for clinical negligence (where remedies are often better, for example in **Ireland**) meaning that the gender discrimination aspect of the claim is lost and remains invisible.

[646] This complaint concerned the exclusion from coverage of the diseases of female genitals and their complications in a private insurance health contract for outpatient care. Discrimination on the grounds of sex was found by the Consumer Ombudsman, who is responsible for monitoring the implementation of Directive 2004/113 in the private sector. See the consumer ombudsman yearly report 2019, p.42, https://www.synigoroskatanaloti.gr/el/etisia-ekthesi-2019. The Greek expert notes that this division of responsibility between the monitoring of the Directive in the public sector (Equality Ombudsman) and the private sector (Consumer Ombudsman) is likely to undermine effective implementation, particularly in relation to matters such as sexual harassment.

[647] Romania, NCCD, Decision No. 121 of 20.03.2024.

[648] Greek Ombudsman, Quarterly bulletins January-April 2020, p. 9, https://www.synigoros.gr/el/category/ygeia/post/deltio-5:-ianoyariosaprilios-2020.

[649] Slovenia, Decision No. 0700-41/2020/15 of 3 December 2021.

[650] French Defender of Rights (2025) 'Prévenir les discriminations dans les parcours de soins 2025' (Preventing discrimination in healthcare pathways), https://www.defenseurdesdroits.fr/sites/default/files/2025-05/ddd_rapport_discriminations-parcours-de-soins_20250430.pdf, p.5.

[651] European Union Agency for Fundamental Rights (2013) *Inequalities and multiple discrimination in access to and quality of healthcare*, Publications Office of the European Union, Luxembourg.

- *Fear of victimisation.* In instances of sexual harassment, in particular, fear of victimisation, together with a lack of awareness that others have had the same treatment, can act as a barrier to individual complaints. This is a widely publicised problem in **Greece**.[652]

- *Alternative complaints mechanisms are ineffective.* Experts note that, while alternative avenues for complaints (such as to health authorities or to regulatory bodies) exist, these are often fragmented and difficult to navigate, are not well understood to cover discrimination, and are not necessarily able to deliver a remedy for the victim of discrimination (although are potentially a useful channel for prompting structural and institutional reforms). Regulatory bodies often lack powers, and resources, to perform enforcement functions effectively.

9.5 Public and political discourse

The comparative data on public and political discourse about gender equality in access to healthcare shows significant variation across the states surveyed. In some countries experts reported a lack of visibility of this issue in public debate. On the other hand, many countries have identified problems with gender equality and discrimination in access to healthcare and various governmental and other institutions, including equality bodies, have reported on it. The activity of the equality bodies in this respect is discussed in section 9.3.3.

Some issues have received particular attention: obstetric violence has been the subject of research and debate in **Germany**,[653] **Croatia**,[654] **Estonia**,[655] and **Hungary** (although the expert in **Hungary** notes that this is not always framed as a gender equality issue);[656] and of recent legislation in **Portugal**.[657] Abortion is a frequent subject of debate and political discourse in **Ireland**, **Malta** and in **Poland** (particularly during the period before elections) and **Luxembourg** has introduced recent legislation to remove the three day reflection period.[658] Some states have also taken recent action to improve the diagnosis and treatment of endometriosis. For example, a thematic session of the **Croatian** Parliament in 2022 recognised the lack of medical specialists, and consequent delays or failures in diagnoses. A resolution called for improvements in education and training, an increase in sub-specialisms, and changes in evaluation and funding of endometriosis surgeries; and declared a

[652] See: Iefimerida (2021) 'Gynaecologist files lawsuits against women who accused him', 13 September 2021, https://www.iefimerida.gr/ellada/rodos-19-agoges-eis-baros-gynaikon-poy-ton-kataminysan-gynaikologos, Alfavita (2021), 'Rhodes: 19 lawsuits filed by gynaecologist accused of rape', 13 September 2021, https://www.alfavita.gr/koinonia/353514_rodos-19-agoges-askise-o-gynaikologos-poy-katigoreitai-gia-biasmoys.

[653] Fabian, L. (2023) Gewalt in der klinischen Geburtshilfe. Der Einfluss von Gewalterfahrungen unter der Geburt auf die postpartale Befindlichkeit von Müttern (Violence in clinical obstetrics: The influence of experiences of violence during childbirth on mothers' postpartum well-being), Wiesbaden; Hahn, D. (2024) Reproduktive Gesundheit, APuZ www.bpb.de/shop/zeitschriften/apuz/reproduktive-rechte-2024/553552/reproduktive-gesundheit/#footnote-target-26.

[654] Croatian Ombudsperson for Gender Equality (2020), Annual Report for 2019, p. 260. Throughout 2022, the Ombudsperson for Gender Equality reported many instances of obstetric violence. See Ombudsperson for Gender Equality (2023), Annual Report for 2022, pp. 185-186.

[655] Part K, Laanpere M, Ringmets I, Eltermaa M, Hein M, Kond K, Tõniste G, Alafrange M, Paju K, Lõhmus L, Karro H. (2025) Estonian women's Health 2024: sexual and reproductive health, health behaviour, attitudes and use of health care services. Survey report. Tartu: University of Tartu, Department of Obstetrics and Gynaecology and Sexual Health Research Centre, 2025, forthcoming.

[656] Hungarian Equal Treatment Authority (Egyenlő Bánásmód Hatóság) Decision No. EBH/349/2016. Equal Treatment Authority (Egyenlő Bánásmód Hatóság) Decision No. EBH/349/2016. See the description of the case in English: https://www.equalitylaw.eu/downloads/4069-hungary-roma-woman-harassed-in-hospital-while-giving-birth-pdf-110-kb. See also: Balogh, L., Gellér, J. (ed.) (2020): Reproductive rights of Romani women in Hungary: Cause of action, European Roma Rights Centre, Brussels, http://www.errc.org/uploads/upload_en/file/5228_file1_reproductive-rights-of-romani-women-in-hungary.pdf.

[657] Portugal, Law No. 110/2019 of 9 September 2019 https://diariodarepublica.pt/dr/detalhe/lei/110-2019-124539905.

[658] Luxembourg, Bill No. 8490 on the Criminal Code and abortion. Website: https://wdocspub.chd.lu/docs/exped/0151/143/303439.pdf. Bill No. 8490 on criminal Code and abortion. Website: https://wdocs-pub.chd.lu/docs/Dossiers_parlementaires/8490/20250515_Dep%C3%B4t.pdf.

national endometriosis 'awareness day'.[659] In **Denmark** in 2024, the Danish Parliament adopted a resolution recognising endometriosis as a serious illness and calling for improved access to treatment nationwide including clinical guidelines, research and specialist services. However, no decision was made on financing, which, as the expert notes, is likely to limit the resolution's practical impact. [660] In **France**, an action plan to train more doctors to diagnose and treat endometriosis was adopted in 2019[661] and endometriosis was recognised as a long term chronic disease in 2022.[662] In **Iceland**, the Endometriosis Association led a campaign 'It's all in your head' in 2025 to appeal for better services, for funding, and for healthcare practitioners to listen to, and not diminish, the experiences of women with the condition.[663] A new specialist clinic for the treatment of endometriosis was announced in **Malta** in 2025.[664] In **Portugal**, a new law was approved in 2025 in order to improve access to healthcare for those with endometriosis and adenomyosis.[665]

Other topics which have received some prominence in national debates include, menopause, menstruation and sexual health (**Portugal**,[666] **Spain**).[667] In **Greece**, there has been recent focus on intersectional discrimination – particularly on disabled women, Roma women, migrant women and trans people.[668]

In some countries wide-ranging debate is evident. In the **UK** in 2022, the Government conducted a review on women's health resulting in the publication of a Women's Health Strategy.[669] This includes proposals for reform, including steps to increase the participation of women in research, standardisation of medical professional training to improve knowledge about women's health, the creation of women's health hubs and encouraging disaggregation of relevant data by sex. Funding for some of these commitments is now in doubt in the context of wider reorganisation of the NHS in England by the current Government. A wide-ranging debate has also taken place in **Denmark** where examples of women who have suffered serious injuries in childbirth being denied by private insurance companies has provoked recognition of systemic gender inequality in healthcare and insurance.[670] A debate is ongoing in **France** where a 2023 Senate report on the health of women at work

659 Decision on declaring 1 March as 'Endometriosis awareness day in the Republic of Croatia', NN No. 18/2023.
660 The Danish Parliament (2024), *Forslag til vedtagelse: V 17 Om tiltag mod endometriose*, (Proposal for adoption: V 17 On measures against endometriosis, https://www.ft.dk/samling/20241/vedtagelse/V17/index.htm.
661 Action Plan by Minister of Health Agnes Buzin on endometriosis, 8 March 2019, https://www.info.gouv.fr/actualite/endometriose-mieux-prendre-en-charge-la-maladie.
662 Launch of national strategy to fight against endometriosis (2022-2025) (*Lancement d'une stratégie nationale contre l'endométriose de 2022 à 2025*, https://endofrance.org/nos-actions/endofrance-ministere-affaires-sociales-sante/strategie-nationale-de-lutte-contre-lendometriose/#:~:text=Lancement%20d'une%20strat%C3%A9gie%20nationale,un%20enjeu%20de%20sant%C3%A9%20publique.
663 Endometriosis Association Iceland (2025) 'Over 500 signatures delivered to the Minister for Health', https://endo.is/2025/04/10/heilbrigdisradherra-tekur-a-moti-yfir-5000-undirskriftum/.
664 TVM News (2025) 'New centre for women suffering from endometriosis', 8 March 2025, https://tvmnews.mt/en/news/new-centre-for-women-suffering-from-endometriosis-that-affects-fertility/.
665 Portugal, Law 32/2025 of 27 March 2025 https://diariodarepublica.pt/dr/detalhe/lei/32-2025-912653920.
666 See: https://www.cig.gov.pt/2025/04/escolas-e-uls-disponibilizam-produtos-menstruais-gratuitamente/.
667 Spain, Organic Law 1/2023 modifying Organic Law 2/2010 on sexual and reproductive health and voluntary termination of pregnancy https://www.boe.es/buscar/act.php?id=BOE-A-2023-5364.
668 National Confederation of Persons with Disabilities (2019), Disability Issues Observatory, 'Women and Disabilities: Multiple identities, multiple challenges', https://www.paratiritirioanapirias.gr/storage/app/uploads/public/5f8/6e8/1d3/5f86e81d3bcd6847322511.pdf; Tanabassi, P. (2017), 'Roma Women and Health: Exploring perceptions and access to health services', www.apothesis.eap.gr/archive/item/90298; DIOTIMA (2022), 'Right to Health Right to Life - An assessment of access to health care services for applicants and beneficiaries of international protection in Greece', https://diotima.org.gr/wp-content/uploads/2022/06/DTHRT-DikaiomastinYgeia_Report-GR.pdf.
669 UK Department of Health and Social Care (2022) 'Women's Health Strategy for England', Women's Health Strategy for England - GOV.UK.
670 Danish Institute for Human Rights (2022*), Forsikringer må ikke diskriminere på grund af graviditet og fødsel* (Insurance must not discriminate on due to pregnancy and childbirth), https://menneskeret.dk/files/media/document/Tilsynet%20med%20diskrimination%20i%20forsikringer%20b%C3 %B8r%20styrkes

included recognition of the need for further research and improvement in gender-sensitive healthcare.[671] There are conspicuously fewer reports on men's health. In the **UK**, following the publication of the Women's Health Strategy in 2022, the Parliamentary Health and Social Care Committee is currently conducting an inquiry into men's health.[672]

There is, therefore, what appears to be increasing visibility of gender inequalities in access to health, especially the above-listed specific issues, in several countries; although this is not true everywhere. In **Romania** for example, the expert notes that, while there has been some research and reports, these are small scale because of limited resources and have not been able to ignite a national debate.

9.6 Overall assessment of the comparative data

It is clear from the comparative data that there are significant and persistent problems of gender inequality in access to healthcare. These include gaps in provision and funding, especially in reproductive healthcare; a lack of gender-sensitive healthcare; and a prevalence of obstetric violence and sexual harassment in healthcare settings. It is also clear from the comparative data that there are some gaps in national legal frameworks and a lack of certainty over scope of relevant provisions that has not been resolved by case law, both of which may undermine the potential of existing law to address these problems. In particular, experts raised a concern that existing anti-discrimination law may be poorly equipped to address structural and systemic issues that give rise to discrimination and create inequalities. Such issues include lack of research and data collection (both data on gender and health and data on experiences of gender discrimination in access to healthcare); poor institutional coordination; a lack of gender mainstreaming; and a need to improve the training of healthcare professionals and the provision of information to the public. The earlier chapters of this report have identified several legal tools that have the potential to be deployed to address these structural concerns. The report makes key recommendations as to ways in which the scope of Union anti-discrimination law (including, but not limited to, Directive 2004/113) could be clarified so as to provide certainty for national courts, legislatures and the equality bodies.

Other important problems with the existing national legal frameworks include weaknesses in protection from, and enforcement of, intersectional claims and (in a number of countries) the barriers to reproductive healthcare created by the law itself. The legal frameworks in the states which govern some forms of obstetric violence (including the criminal law and law governing matters such as informed consent) were beyond the scope of this comparative analysis. However, the data suggests that there is an urgent need to take action to address obstetric violence and supports the recommendation made in section 3.2.4 above, to consider the potential of the Violence Against Women Directive to address violence against women in a healthcare setting.

These difficulties aside, many experts expressed a view that national anti-discrimination laws in the states surveyed are otherwise broadly adequate and that the most significant challenges lie elsewhere. The key difficulties identified are as follows:

.%20Policy%20brief%2C%20maj%202023.pdf;" *Birth without insurance"* ("Fødsel uden Forsikring), Danmarks Radio, 7 september 2023 https://www.dr.dk/drtv/episode/kontant_-foedsel-uden-forsikring_407307.

671 Senate Committee on Rights for Women (2023) Health of women at work: invisible ailments, Information Report n°780, (Délégation droits des femmes, Rapport d'information n°780 : Santé des femmes au travail: des maux invisibles), 27 June 2023, Santé des femmes https://www.senat.fr/rap/r22-780-1/r22-780-1_mono.html.

672 UK Parliament, Health and Social Care Committee, Men's health inquiry, Men's health - Committees - UK Parliament.

Lack of enforcement including difficulties faced by individual patients in raising a complaint or litigating; a lack of powers/resources for equality bodies; a lack of attention to gender inequality and intersectional inequality by other professional regulators; a lack of coordination between relevant organisations so as to identify and address causes of discrimination and inequality; and a lack of data on the extent of discrimination experienced in the healthcare system and complaints raised in respect of it.

Recommendation: The European Commission should identify mechanisms to improve enforcement of existing legislation in the Member States, including through equality bodies. Where possible, this would include improvement in complaints mechanisms for patients experiencing discrimination in a healthcare setting; and collation of relevant data (including ensuring that instances of gender discrimination are identified as such) so that healthcare providers and regulatory bodies are better able to understand the challenges to be addressed.

Lack of awareness by the public/patients of rights and also of key aspects of their health and healthcare.

Recommendation: The Commission should consider mechanisms to promote awareness among the public of health conditions that are experienced only or mainly by one gender (such as endometriosis, menopause or cancers of the reproductive system) or which are experienced differently by men and women (such as myocardial infarction).

Lack of training of healthcare professionals both in relation to gender-sensitive healthcare (such as conditions which effect only or mainly one gender or conditions which present differently for different genders) and in relation to harassment/stigma and stereotyping.[673]

Lack of visibility and lack of attention by governments and other relevant organisations. Instances of gender discrimination are not always recognised as such.

[673] See also discussion and recommendation in section 4.3, above.

10 Conclusions

Women and girls across Europe experience inequality in access to healthcare in multiple ways. These include lack of access through the national healthcare system to treatments specific to women (or, more accurately, to people with a uterus), such as, for example, reproductive care, including contraception; treatment of endometriosis; and care related to childbirth. In some instances, men experience disadvantage, for example in lack of access to prostate cancer screening. Gender-affirming healthcare is excluded from many national healthcare systems, leaving trans and intersex people significantly less able to access healthcare than cis-gendered people. A general lack of investment in national healthcare provision has a disproportionate effect on women, especially in rural areas. Exclusions are worse for those suffering from intersectional disadvantage, such as migrant women and girls, even though healthcare such as basic pregnancy and maternity care falls within the concept of 'essential treatment', which is part of the 'right to healthcare' that all Member States are obliged to respect under international law. Even private healthcare insurance sometimes discriminates against women by excluding some treatments, especially concerning pregnancy and childbirth.

Systemic disadvantage in access to healthcare for women includes the lack of prestige of 'women's diseases', leading to lack of specialist medical professionals and facilities providing for treatment of, for example, gynaecological conditions. Clinical bio-medicine is predominantly based on studies of male bodies, leading to a lack of professional and public understanding about how common diseases present in women. The 'gender pain gap', a function of widespread unconscious bias against women, means that women are treated with less respect in healthcare settings, affecting their practical access to healthcare. Endometriosis, for example, which affects far and away more women (or people with a uterus) than men, is regularly incorrectly diagnosed, or diagnosis is delayed, because women's and girls' account of their pain is discounted and diminished by healthcare professionals. These interconnected instances of structural discrimination lead to a lack of gender-sensitive healthcare. Worse, violence against women (and especially those with intersectional disadvantage on grounds of race/ethnicity, religion, migration status and age) in healthcare settings, especially obstetric violence, is prevalent across Europe. Some of these acts of obstetric violence constitute criminal behaviour; others, such as disrespect, disregard for consent, gaslighting and abuse, are tortious harms. All are instances of gender inequality in access to healthcare.

This report shows the many possibilities available to deploy Union law to tackle gender discrimination and promote equality in access to healthcare. The report covers Union law that *directly* covers gender equality in access to healthcare: the Goods and Services Directive 2004/113/EC; the Social Security Directive 79/7/EEC; and the Recast Directive 2006/54/EC. It sets out the detail of how these provisions apply to healthcare, and illuminates gaps, inconsistencies and lack of clarity in how these instruments apply in healthcare settings. Some Union law covers gender equality in aspects of access to healthcare for certain (vulnerable) women and girls: the Violence Against Women Directive 2024/1385; the Victims' Rights Directive 2012/29/EU; and the Human Trafficking Directive 2011/36/EU.

The report also covers Union law which *indirectly* affects gender equality in access to healthcare. This includes the Recast Directive 2006/54; the Self-Employment Directive 2010/41; and the Work-life Balance Directive 2019/1158, as instruments making it easier for women to be employed or self-employed and therefore less likely to need to access healthcare. It also includes measures such as the Pregnancy and Maternity Directive 92/85; Directive 97/81 on part-time work; and Directive 99/70 on fixed-term work, which play a similar role. Where women are enabled to be in the healthcare workforce, as healthcare professionals, the quality of

healthcare experienced by (women) patients is likely to be improved. These instruments of Union law all also support equal access to the healthcare profession.

The report also considers a wide range of other provisions of Union law which, coupled with the gender mainstreaming obligation in Article 8 TFEU, could lead to greater gender equality in access to healthcare. These are found in Union internal market law (including patients' rights and social security for migrant workers); Union asylum and refugee law; Union law on substances of human origin, Union data law, regulation of medicines and medical devices, Union law on products and services harmful to health and Union communicable diseases law; and Union law incentivising investment in national healthcare systems.

The nature of this report – as a first scoping of the field – is such that depth can only be offered in a few selected areas. Drawing on comparative national expertise from the European Equality Law Network, the report focuses in more depth on personal and material coverage by national healthcare systems, gender-sensitive healthcare, obstetric violence, and sexual harassment/assault in healthcare settings. The report's recommendations include calling for greater legal clarity, especially where directives intersect and overlap when applied in healthcare settings; some suggestions for consideration of amendments to the law; and instances where more effective enforcement of Union legal obligations may be necessary. Recommendations also involve further investigation, data-gathering and sharing of best practice; training and public education; and the use of Union incentive measures to support these actions.

The key finding is that the opportunities for Union law to contribute to tackling gender discrimination and inequality in access to healthcare are under-appreciated and full of untapped potential.

Annex 1: Key recommendations

In the order they appear in the report

Chapter 3

Recommendation 3.1.1: European Commission to issue interpretative guidance confirming that the scope of the Goods and Services Directive 2004/113 extends to healthcare services.

Recommendation 3.1.2a: European Commission to commission further study to explore the scope of Union law, and especially the Goods and Services Directive 2004/113, in terms of its application to structural discrimination in healthcare.

Recommendation 3.1.2b: Relying on the lawfulness of positive action under the Goods and Services Directive 2004/113, Union incentive measures for healthcare projects, trials, protocols, and other national measures which involve such 'specific measures' permitted under Goods and Services Directive 2004/113 Article 6.

Recommendation 3.1.3a: In considering the recommendations in the 2025 Report on Gender Equality in Statutory Social Security, the European Commission should take into account that distinctions between social insurance and taxation-based national healthcare systems are not meaningful distinctions in the context of Union law. As a minimum, a Commission interpretation of Directive 79/7 should clarify that the scope of the Directive applies to all national healthcare systems, irrespective of how they are funded and irrespective of whether they involve reimbursement or are based on provision of benefits in kind. A more holistic approach, also recommended in the 2025 Report, involves a new directive; or, even better, a new 'architecture', bringing together 'the statutory, occupational and private social security provisions that are currently covered by Directives 79/7, 2006/54 and 2004/113'.

Recommendation 3.1.3b: European Commission to undertake a review of national co-payment requirements, to ensure that 'women's medicines' do not attract higher co-payments than 'men's medicines', taking into account that 'contributions' and 'benefits' as per Directive 79/7 include co-payments in the context of healthcare.

Recommendations 3.1.4: European Commission to review and clarify how Directives 79/7, 2004/113 and 2006/54 relate to one another in the context of discrimination in national healthcare systems. To include a review and clarification of the application of risk pooling obligations that emerge from all Union equality law in the context of national healthcare systems. Clarify whether the exception in Directive 2004/113, Article 4 (5) and the provisions of Directive 2006/54, Article 9(h) apply in the context of discrimination covered by Directive 79/7. Clarify the extent to which Directive 2006/54, and/or Directive 2004/113, have impliedly replaced Directive 79/7 in the context of healthcare.

Recommendation 3.1.5: European Commission to clarify the relationship between the WHO definition of 'obstetric violence' and the concept of 'sexual harassment' in Directive 2004/113.

Recommendation 3.1.6: European Commission to clarify the scope of Directive 2004/113 in the context of determination of the healthcare services that are available in a national healthcare system (the 'basket of care'). National implementing bodies to seek transparent information about how decisions are made, and their outcomes, to determine whether indirect discrimination has taken place, in the sense of including more

medicines or medical treatments that are more likely to be needed by men, than those which are likely to be needed by women.

Recommendation 3.2.2a: European Commission to clarify interpretation of Article 9(1)(c) of the Victims' Rights Directive 2012/29/EU to include an obligation to provide all victims of crime with comprehensive mental healthcare. Note this would be an interpretation against the literal wording of the Directive, but in line with its spirit and changing scientific understandings. It would also be consistent with the obligation in the Human Trafficking Directive 2011/36/EU.

Recommendation 3.2.2b: After 15 July 2026, European Commission to review provision of training of healthcare professionals to ensure obligation to gender (disability and child-centred) training under the Human Trafficking Directive 2011/36/EU, and disseminate best-practice.

Recommendation 3.2.3c: European Commission to undertake further review of compliance with obligations in the Victims' Rights Directive to include ensuring that implementation in healthcare settings is complete.

Recommendation 3.2.3a: European Commission to gather and disseminate best-practice examples in its work on national implementation of both the Victims' Rights Directive and the Violence Against Women Directive. Best-practice examples to include training of healthcare professionals in their reporting obligations under the Directive; training of criminal justice officials in their obligations to refer to healthcare professionals.

Recommendation 3.2.3b: European Commission to review compliance with obligations to provide healthcare to women and girls within the scope of the Violence Against Women Directive at the earliest opportunity, given the vulnerability of the women and girls involved.

Recommendation 3.2.4a: In any future assessment of the implementation and adequacy of the Directive, the European Commission should investigate the potential of the Violence Against Women Directive to address violence against women in healthcare settings. Following such an investigation, the European Commission should consider whether there is a need to (i) issue guidance clarifying the Directive's scope and application in that context; (ii) encourage Member States and national equality bodies to launch investigations; (iii) collect data and conduct research; or (iv) to amend the text of the Directive.

Recommendation 3.2.4b: European Commission to investigate compliance with Victims' Rights Directive in the context of violence against women in healthcare settings.

Chapter 4

Recommendation 4.1: European Commission should continue to support/encourage Member States to enforce rights to equal access to employment, and equal treatment within employment and self-employment. Disseminate best practices in enforcement.

Recommendation 4.2a: European Commission should review how general Union law on (gender) equality is implemented and enforced in specific healthcare workforce domains, perhaps through commissioning a further report with comparative data on women in the healthcare workforce.

Recommendation 4.2b: Secure more effective enforcement through incentivising (using Union project funding) collaboration between equality organisations and healthcare professional organisations/organisations that oversee quality of healthcare provision within the Member States.

Recommendation 4.4: Commission further research into the position of women in the healthcare workforce in the Union, good practices, and effects on gender equality in access to healthcare.

Chapter 9

Recommendation 9.6a: European Commission to identify mechanisms to improve enforcement of existing legislation in the Member States, including through national equality bodies. Where possible, this would include improvement in complaints mechanisms for patients experiencing discrimination in a healthcare setting; and collation of relevant data (including ensuring that instances of gender discrimination are identified as such) so that healthcare providers and regulatory bodies are better able to understand the challenges to be addressed.

Recommendation 9.6b: European Commission to consider mechanisms to promote awareness among the public of health conditions that are experienced only or mainly by one gender (such as endometriosis, menopause or cancers of the reproductive system) or which are experienced differently by men and women (such as myocardial infarction).

Key recommendations by type of action recommended

Clarify the legal position

Recommendation 3.1.1: European Commission to issue interpretative guidance confirming that the scope of the Goods and Services Directive 2004/113 extends to healthcare services.

Recommendation 3.1.2a: European Commission to commission further study to explore the scope of Union law, and especially the Goods and Services Directive 2004/113, in terms of its application to structural discrimination in healthcare.

Recommendation 3.1.3a: European Commission interpretation of Directive 79/7 should clarify that the scope of the Directive applies to all national healthcare systems, irrespective of how they are funded and irrespective of whether they involve reimbursement or are based on provision of benefits in kind.

Recommendations 3.1.4: European Commission to review and clarify how Directives 79/7, 2004/113 and 2006/54 relate to one another in the context of discrimination in national healthcare systems. To include a review and clarification of the application of risk pooling obligations that emerge from all Union equality law in the context of national healthcare systems. Clarify whether the exception in Directive 2004/113, Article 4(5) and the provisions of Directive 2006/54, Article 9(h) apply in the context of discrimination covered by Directive 79/7. Clarify the extent to which Directive 2006/54, and/or Directive 2004/113, have impliedly replaced Directive 79/7 in the context of healthcare.

Recommendation 3.1.5: European Commission to clarify the relationship between the WHO definition of 'obstetric violence' and the concept of 'sexual harassment' in Directive 2004/113.

Recommendation 3.1.6: European Commission to clarify the scope of Directive 2004/113 in the context of determination of the healthcare services that are available in a national healthcare system (the 'basket of care'). National implementing bodies to seek transparent information about how decisions are made, and their outcomes, to determine whether indirect discrimination has taken place, in the sense of including more medicines or medical treatments that are more likely to be needed by men, than those which are likely to be needed by women.

Recommendation 3.2.2a: European Commission to clarify interpretation of Article 9(1)(c) of the Victims' Rights Directive 2012/29/EU to include an obligation to provide all victims of crime with comprehensive mental healthcare. Note this would be an interpretation against the literal wording of the Directive, but in line with its spirit and changing scientific understandings. It would also be consistent with the obligation in the Human Trafficking Directive 2011/36/EU.

Recommendation 3.2.4a: In any future assessment of the implementation and adequacy of the Directive, the European Commission should investigate the potential of the Violence Against Women Directive to address violence against women in healthcare settings. Following such an investigation, the European Commission should consider whether there is a need to (i) issue guidance clarifying the Directive's scope and application in that context; ….

Consider amending the law

Recommendation 3.1.2a: European Commission to commission further study to explore the scope of Union law, and especially the Goods and Services Directive 2004/113, in terms of its application to structural discrimination in healthcare.

Recommendation 3.1.3a: In considering the recommendations in the 2025 Report on Gender Equality in Statutory Social Security, the European Commission should take into account that distinctions between social insurance and taxation-based national healthcare systems are not meaningful distinctions in the context of Union law. … A more holistic approach, also recommended in the 2025 Report, involves a new directive; or, even better, a new 'architecture', bringing together 'the statutory, occupational and private social security provisions that are currently covered by Directives 79/7, 2006/54 and 2004/113'.

Recommendation 3.2.4a: In any future assessment of the implementation and adequacy of the Directive, the European Commission should investigate the potential of the Violence Against Women Directive to address violence against women in healthcare settings. Following such an investigation, the European Commission should consider whether there is a need to … (iv) to amend the text of the Directive.

Enforcement

Recommendation 3.2.2b: After 15 July 2026, the European Commission to review provision of training of healthcare professionals to ensure obligation to gender (disability and child-centred) training under the Human Trafficking Directive 2011/36/EU, ….

Recommendation 3.2.3c: European Commission to undertake further review of compliance with obligations in the Victims' Rights Directive to include ensuring that implementation in healthcare settings is complete.

Recommendation 4.1: European Commission continue to support/encourage Member States to enforce rights to equal access to employment, and equal treatment within employment and self-employment. Disseminate best practices in enforcement.

Recommendation 4.2b: Secure more effective enforcement through incentivising (using Union project funding) collaboration between equality organisations and healthcare professional organisations/organisations that oversee quality of healthcare provision within the Member States.

Recommendation 9.6a: European Commission to identify mechanisms to improve enforcement of existing legislation in the Member States, including through national equality bodies. Where possible, this would include improvement in complaints mechanisms for patients experiencing discrimination in a healthcare setting; and collation of relevant data (including ensuring that instances of gender discrimination are identified as such) so that healthcare providers and regulatory bodies are better able to understand the challenges to be addressed.

Further investigation / data creation

Recommendation 3.1.2a: European Commission to commission further study to explore the scope of Union law, and especially the Goods and Services Directive 2004/113, in terms of its application to structural discrimination in healthcare.

Recommendation 3.1.3b: European Commission to undertake a review of national co-payment requirements, to ensure that 'women's medicines' do not attract higher co-payments than 'men's medicines', taking into account that 'contributions' and 'benefits' as per Directive 79/7 include co-payments in the context of healthcare.

Recommendation 3.2.3a: European Commission to gather and disseminate best-practice examples in its work on national implementation of both the Victims' Rights Directive and the Violence Against Women Directive. Best-practice examples to include training of healthcare professionals in their reporting obligations under the Directive; training of criminal justice officials in their obligations to refer to healthcare professionals.

Recommendation 3.2.3b: European Commission to review compliance with obligations to provide healthcare to women and girls within the scope of the Violence Against Women Directive at the earliest opportunity, given the vulnerability of the women and girls involved.

Recommendation 3.2.4a: In any future assessment of the implementation and adequacy of the Directive, the European Commission should investigate the potential of the Violence Against Women Directive to address violence against women in healthcare settings. Following such an investigation, the European Commission should consider whether there is a need to … (ii) encourage Member States and national equality bodies to launch investigations; (iii) collect data and conduct research; …

Recommendation 3.2.4b: European Commission to investigate compliance with the Victims' Rights Directive in the context of violence against women in healthcare settings.

Recommendation 4.2a: Review how general Union law on (gender) equality is implemented and enforced in specific healthcare workforce domains, perhaps through commissioning a further report with comparative data on women in the healthcare workforce.

Recommendation 4.4: Commission further research into the position of women in the healthcare workforce in the Union, good practices, and effects on gender equality in access to healthcare.

Recommendation 9.6a: European Commission to identify mechanisms to improve enforcement of existing legislation in the Member States, including through national equality bodies. Where possible, this would include improvement in complaints mechanisms for patients experiencing discrimination in a healthcare setting; and collation of relevant data (including ensuring that instances of gender discrimination are identified as such) so that healthcare providers and regulatory bodies are better able to understand the challenges to be addressed.

Healthcare professional training and public education

Recommendation 3.2.2b: After 15 July 2026, the European Commission to review provision of training of healthcare professionals to ensure obligation to gender (disability and child-centred) training under the Human Trafficking Directive 2011/36/EU, and disseminate best-practice.

Recommendation 3.2.3a: European Commission to gather and disseminate best-practice examples in its work on national implementation of both the Victims' Rights Directive and the Violence Against Women Directive. Best-practice examples to include training of healthcare professionals in their reporting obligations under the Directive; training of criminal justice officials in their obligations to refer to healthcare professionals.

Recommendation 9.6b: European Commission to consider mechanisms to promote awareness among the public of health conditions which are experienced only or mainly by one gender (such as endometriosis, menopause or cancers of the reproductive system) or which are experienced differently by men and women (such as myocardial infarction).

Other Union incentive measures

Recommendation 3.1.2b: Relying on the lawfulness of positive action under the Goods and Services Directive 2004/113, Union incentive measures for healthcare projects, trials, protocols, and other national measures which involve such 'specific measures' permitted under Goods and Services Directive 2004/113 Article 6.

Recommendation 4.2b: Secure more effective enforcement through incentivising (using Union project funding) collaboration between equality organisations and healthcare professional organisations/organisations that oversee quality of healthcare provision within the Member States.

Key recommendations by topic/subject matter

Scope of Union law in context of access to healthcare

Recommendation 3.1.1: European Commission to issue interpretative guidance confirming that the scope of the Goods and Services Directive 2004/113 extends to healthcare services.

Understanding (structural) discrimination in healthcare

Recommendation 3.1.2a: European Commission to commission further study to explore the scope of Union law, and especially the Goods and Services Directive 2004/113, in terms of its application to structural discrimination in healthcare.

Recommendation 9.6a: European Commission to identify mechanisms to improve enforcement of existing legislation in the Member States, including through national equality bodies. Where possible, this would include improvement in complaints mechanisms for patients experiencing discrimination in a healthcare setting; and collation of relevant data (including ensuring that instances of gender discrimination are identified as such) so that healthcare providers and regulatory bodies are better able to understand the challenges to be addressed.

Recommendation 9.6b: European Commission to consider mechanisms to promote awareness among the public of health conditions which are experienced only or mainly by one gender (such as endometriosis, menopause

or cancers of the reproductive system) or which are experienced differently by men and women (such as myocardial infarction).

Employment as a vector for better health (and less need to access healthcare)

Recommendation 4.1: European Commission continue to support/encourage Member States to enforce rights to equal access to employment, and equal treatment within employment and self-employment. Disseminate best practices in enforcement.

The healthcare workforce

Recommendation 4.2a: European Commission to review how general Union law on (gender) equality is implemented and enforced in specific healthcare workforce domains, perhaps through commissioning a further report with comparative data on women in the healthcare workforce.

Recommendation 4.4: Commission further research into the position of women in the healthcare workforce in the Union, good practices, and effects on gender equality in access to healthcare.

Mental healthcare for (women) victims of crime

Recommendation 3.2.2a: European Commission to clarify interpretation of Article 9(1)(c) of the Victims' Rights Directive 2012/29/EU to include an obligation to provide all victims of crime with comprehensive mental healthcare. Note this would be an interpretation against the literal wording of the Directive, but in line with its spirit and changing scientific understandings. It would also be consistent with the obligation in the Human Trafficking Directive 2011/36/EU.

Violence against women and girls in healthcare settings

Recommendation 3.2.3c: European Commission to undertake further review of compliance with obligations in the Victims' Rights Directive to include ensuring that implementation in healthcare settings is complete.

Recommendation 3.2.3b: European Commission to review compliance with obligations to provide healthcare to women and girls within the scope of the Violence Against Women Directive at the earliest opportunity, given the vulnerability of the women and girls involved.

Recommendation 3.2.4a: In any future assessment of the implementation and adequacy of the Directive, the European Commission should investigate the potential of the Violence Against Women Directive to address violence against women in healthcare settings. Following such an investigation, the European Commission should consider whether there is a need to (i) issue guidance clarifying the Directive's scope and application in that context; (ii) encourage Member States and national equality bodies to launch investigations; (iii) collect data and conduct research; or (iv) to amend the text of the Directive.

Recommendation 3.2.4b: European Commission to investigate compliance with the Victims' Rights Directive in the context of violence against women in healthcare settings.

Annex 2: Questionnaire

Question 1 – (Non-exhaustive) evidence of problems of gender inequality in access to healthcare.

Is there evidence in your country (reports, case law, published research, press reports – taking a broad notion of 'evidence') of problems of gender inequality (for example, direct or indirect sex discrimination, or harassment) in access to healthcare?

Please think about access broadly, as outlined in the definitions section above. Include examples of intersectional discrimination and inequality if relevant (for example, racism in access to maternity care). We are not expecting a comprehensive review here – it is too big a subject – and so we do not expect your responses to be exhaustive. Rather, we are hoping to gather some useful examples with the aim of identifying the key issues anti-discrimination and equality law may need to address. Where you can, please give examples you are aware of in line with as many of the different categories below as possible (or others if you find them), which are drawn from the existing literature on gender equality and health:

- Lack of coverage, or limited coverage (such as part coverage or application of eligibility requirements), under national health insurance or taxation-based systems whether benefits in kind or reimbursement, of medical conditions which affect only or mainly one sex/gender?

- Examples of gender discrimination in *privately funded* healthcare coverage (such as premiums being different on the basis of gender; medical conditions related to one gender being excluded from private insurance coverage)?

- Barriers to access to healthcare, other than funding/insurance, which disadvantage patients in ways related to their gender (such as, for example, administrative barriers, or barriers such as the location or timing of available services.)

- Barriers to accessing reproductive healthcare (reproductive healthcare include the health or the reproductive system across the lifespan so relevant barriers may include access to contraception, maternity care, screening for cancers of the reproductive system or access to hormone replacement therapy.)

- Stereotyping or stigma or harassment at the point of supply/delivery of healthcare or medical treatment.

- Failure of diagnosis or treatment because of lack of understanding of medical conditions that affect one gender (such as endometriosis) or conditions that may present differently in different genders (such as pain.) If you are aware of any evidence of underrepresentation of women (or certain groups of women such as older women) from clinical trials, please let us know about this too.

- Gender-related medical treatments that are unlawful in the sense of criminal law (such as access to reproductive care, access to gender affirming care).

Question 2 – Legal Framework (for each question, please include details of any relevant case law)

a. Is there a constitutional guarantee of (gender/sex) equality or non-discrimination in access to healthcare? If yes, does this expressly include, or exclude, access to any particular form of healthcare?

b. Does legislation prohibit gender (or sex) discrimination (direct discrimination, indirect discrimination and harassment) in supply of and/or access to healthcare? If yes, is this explicit? Please check both

- whether access to healthcare is within the scope of anti-discrimination/equality legislation
- whether discrimination is prohibited (or equal treatment guaranteed) in legislation guaranteeing rights to healthcare (such as legislation on patients' rights).

c. What national legislation implements Directive 2004/113 and does this legislation cover healthcare? Is this explicit in the legislation or is there any case law which confirms that healthcare is included within its scope?

d. Directive 2004/113 sets out a number of circumstances under which different treatment of women and men, generally or in relation to healthcare specifically, may be permitted.[674] These include: Article 4(5) which provides that the Directive 'shall not preclude differences in treatment, if the provision of the goods and services exclusively or primarily to members of one sex is justified by a legitimate aim and the means of achieving that aim are appropriate and necessary'; Recital 12, which states that 'differences between men and women in the provision of healthcare services, which result from the physical differences between men and women, do not relate to comparable situations and therefore, do not constitute discrimination'; and Article 6 which permits positive action. Further, Article 3(1) excludes from the scope of the Directive services which 'are offered outside the area of private and family life' which may be understood to exclude some services related to reproductive health.

- Does legislation in your country include any specific provisions to allow different treatment of men and women in access to healthcare? If yes, under what circumstances? Are you aware of examples where these provisions have been used to justify a lack of provision of healthcare for one sex?
- Are there any explicit exclusions from prohibition on gender discrimination in access to healthcare (such as some forms of reproductive healthcare)?
- Does legislation either permit or require positive action in relation to access to healthcare? If yes, are you aware of any examples of positive action in this respect?

e. Does legislation prohibit gender discrimination by private health insurance in determining what treatments to fund or amounts of reimbursement?

f. Please provide details of any relevant case law not already discussed above.

[674] See: Directive - 2004/113 - EN - EUR-Lex.

Question 3 – Regulatory and Supervisory Bodies

a. Healthcare regulatory and supervisory bodies (see definitions section for details)

- Which body or bodies in your country are responsible for monitoring the quality and safety of healthcare provision? Do these bodies have any responsibility for monitoring discrimination (whether gender discrimination or discrimination more generally) in access to healthcare and what powers of enforcement do they have? Are these monitoring and enforcement mechanisms considered effective?

- Do bodies responsible for the regulation of medical professionals issue any guidelines or codes of practice which include guidance on discrimination (whether gender discrimination or discrimination more generally) including, for example, on stereotyping?

- Are there any examples of enforcement action taken by healthcare regulatory bodies in respect of gender discrimination?

b. Equality bodies

- Do the national equality bodies in your country cover healthcare?

- If they do, can you give examples of recent reports or other work (including enforcement work) that they have done in this area?

Question 4 – Gaps

Are you aware of any gaps in your country's legal framework governing gender discrimination in the supply of or in access to healthcare which you have not noted above? In particular, are there any examples of gender discrimination/inequality which you identified in Question 1 which you do not believe would or can be adequately addressed within the existing legal framework?

Question 5 – Enforcement

Other than in respect of matters already raised under Question 3, is enforcement of the relevant legislation or other regulatory provisions effective in your country in your view?

Question 6 – National legal, political and societal discourse, debate or discussion

In your jurisdiction, are there any current or recent legal, societal or political debates on gender inequality in access to healthcare?

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