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EuroHealthNet consultation response

EU Gender Equality Strategy 2026–2030

Outcomes-first, life-course, and whole-of-society

Executive summary (priority outcomes 2026–2030)

- Increase and reduce inequality in healthy life years for women and men by improving social, economic, environmental and digital determinants of health and well-being – including through life-course prioritizing early interventions and investments in early years, adolescence, young adulthood, working life, healthy and active ageing in old age.
- Reduce (in-work) poverty, material deprivation, and gender gaps in participation and protection (pay/pensions, skills, minimum income, safety).
- Inclusive digital and green transitions: affordable connectivity, skills, precaution against algorithmic bias, gender-responsive and socially-just delivery of digital and climate change mitigation and adaptation actions.
- Reduce access gaps to health promotion and disease prevention, diagnosis, treatment and follow-up by income, geography, disability, migration status and age.
- Fix the data-to-policy and action pipeline: sex-/gender-/age-disaggregation, as well as intersectional variables in surveillance/EHDS; SGBA in research/HTAs/AI; annual equity dashboards.
- Embed gender-sensitive, trauma-informed care pathways in integrated primary/community care—including a strong, violence-informed response to gender-based and domestic violence against women and girls (VAWG/DV).
- Value and redistribute care: better jobs in care; men's uptake of parental leaves; portable care credits; recognition and support for informal carers.
- Boost governance for health and gender equality: Gender and Health Equity Impact Assessments, gender-responsive budgeting/procurement; EU funding tied to equity key performance indicators (KPIs) and participation of people with lived experience.

1) Key challenges and gaps

- Gendered, intersectional health equity gaps persist—sharper for women facing low income, lone parenthood, migration, Roma status, disability, rurality, undocumented status, LGBTQIA+, or precarious/atypical work.
- Unpaid/informal care remains concentrated among women with knock-on effects on health, earnings and pensions; men under-utilise family leaves.
- Inconsistent gender mainstreaming across health, climate, digital and economic reforms risks widening gaps.
- Data deficits: sex/gender rarely paired with age (often upper-capped), disability, migration, socio-economic status, or carer status; gender identity seldom captured where lawful/appropriate.
- Digital & AI risks (online GBV, algorithmic bias) and climate/energy measures without gender/poverty lenses can have regressive effects.
- Backlash and stigma around caregiving, menopause, ageing and men's mental health undermine progress.

Evidence snapshot (EU-27, latest available)

- Healthy life years vs longevity: In 2023, HLY at birth were 63.3 (women) vs 62.8 (men); life expectancy was 84 vs 78.7. Women live longer but spend more years with activity limitations. [1]
- AROPE by sex (2024): 21.9% of women vs 20% of men were at risk of poverty or social exclusion in the EU. While higher overall (24.2%), the sex disaggregation of child poverty mirrors this. In-work poverty is higher for men (9%) than women (7.3%). [2]
- Single-parent households: In 2023, 31.9% of people in single-parent households were at risk of poverty vs 16.2% overall; most single-parent households are female-headed. [3]
- Gender pay gap: In 2023, women's gross hourly earnings were on average 12% below men's (unadjusted). [4]
- Gender pension gap: EU-wide gap 26% in 2022. [5]
- Unpaid vs paid work: EU-27 (2021) – men 6 more paid hours/week; women 13 more unpaid hours/week; total workload higher for women. [6]
- Digital divide: In 2023, 56% of adults had at least basic digital skills; men 57% vs women 54% overall, with the largest gaps among older adults. [7]

- Men's suicide risk: In 2021, the EU standardised death rate for intentional self-harm was 10.2 per 100,000; the male rate was 3.7× the female rate. [8]
- Cardiovascular disease burden: In 2022, circulatory diseases accounted for 32.7% of all EU deaths—the leading cause for women and men. [9]
- VAWG as a public health & social issue: The FRA 2024 EU-GBV survey finds 1 in 3 women (31%) have experienced violence in their lifetime. [10]

2) Priorities and suggested actions

A. Make prevention and health promotion gender-transformative

- Mandate sex-disaggregated and intersectional variables (age, disability, migrant and carer status, deprivation indices; gender identity where it's supported by law) in surveillance/EHDS; publish annual equity dashboards.
- Scale community-led prevention and health literacy in disadvantaged areas (social prescribing, health mediators, schools/workplaces); ring-fence programme lines with gender-responsive budgeting.
- Embed cancer prevention (HPV incl. catch-up; self-sampling cervical screening, male cancers) and perinatal and trauma-informed mental health in primary care; prioritise women and men's mental health and male suicide prevention; work toward and implement LGBTIQ+ health promotion and prevention care pathways.

B. Tackle wider determinants with concrete levers

- Commercial determinants: restrict marketing of alcohol/ultra-processed foods to girls/women; workplace standards (menstrual/menopause policies, breastfeeding/lactation spaces, psychosocial risk prevention).
- Environment and climate: gender impact assessments in Social Climate Fund plans; prioritise single-parent (often women-led) households for energy-efficiency upgrades and clean mobility.
- Digital: enforce platform risk-mitigation for digital tech-facilitated GBV; require bias testing and transparency for AI used in screening/triage; fund gender-sensitive digital literacy.

C. Care, income and work

- Implement the EU Care through Life-Course agenda via national action plans: affordable quality LTC; respite; decent and healthy life supportive wages/training/staffing; carer identification in primary care with referral to supports.
- Design family leaves and flexible work for men's uptake; introduce portable care credits toward pensions/insurance; remove tax/benefit cliffs penalising carers and second earners.
- End in-work poverty via adequate minimum income and stronger collective bargaining; fully implement pay transparency to close pay/pension gaps.

D. Violence-informed health and social systems

- Recognise VAWG/DV as a public health and social issue. Ensure routine, safe identification across primary, maternity, emergency and mental health services; confidential referral and follow-up; staff training and protection protocols; links to housing, legal and income supports.

3) Delivery architecture, finance and coherence (including the next MFF)

- Next MFF (post-2027): set gender equality and health equity as explicit objectives. Create social & public-health investment windows and shift to outcome-based budgeting tied to equity KPIs.
- EU Competitiveness Fund (proposed): ring-fence envelopes for gendered and equity proofed health promotion and disease prevention, workforce skills, digital inclusion, and social/health infrastructure that raise labour and societal productivity and reduce inequalities.
- Programme alignment under the next MFF: coordinate EU4Health, ESF+, ERDF/cohesion, Horizon Europe, Digital Europe/EHDS, Social Climate Fund, RRF/TSI, InvestEU and national reforms to scale integrated primary/community care and community-rooted prevention; invest in skills and safe staffing; deliver digital

inclusion and bias-tested AI; modernise social and health infrastructure; empower and enable civil-society co-delivery and funding.

- Policy coherence: cross-reference the EU Anti-Poverty Strategy, EU Civil Society Strategy, Action Plan for implementing the EPSR, and an EU CVD Action Plan; use shared indicators, mutual conditionality and joint reporting to prevent siloed action and maximise impacts.
- Conditionality & tools: require Gender & Health Equity Impact Assessments (G-HEIA), gender-responsive budgeting/procurement, and participation of people with lived experience as access conditions for EU funding.

4) Data standards and governance

- EHDS minimum dataset: sex at birth; (where lawful/appropriate) gender identity; pregnancy status; disability; migrant-status proxies; carer status; deprivation indices; age without upper cap.
- Sex- and Gender-Based Analysis (SGBA) by default: apply sex- and gender-based analysis in all EU-funded research, HTAs, and AI/clinical decision tools; publish study results disaggregated by sex/gender and key intersectional variables.
- Local delivery capacity: fund municipal/regional health-promotion alliances (public health, social services, NGOs, community groups) with technical assistance and peer learning.

5) Sectoral policy actions (illustrative)

- Health and prevention: mandatory sex/intersectional reporting for EU-co-funded prevention; HPV expansion and self-sampling; perinatal mental health and male suicide prevention; trauma-informed services; deprescribing/polypharmacy reviews for older women; timely cancer detection for men and women.
- Care systems: implement LTC recommendations with quality, access and affordability standards; integrate carer identification/support; develop respite and community-based offers; improve workforce conditions to support both women and men's careers in line with work-life balance.
- Digital and AI: enforce platform duties against online GBV; audit AI used in clinical/triage tools for bias/explainability; support survivor-centred digital services; review pro's and con's of care delivery via digital means that are most user appropriate and effective (young people's preference for online support).
- Education, skills and employment: life-course upskilling for women and men into green/digital jobs; right to flexible work without long-term/pension care penalty; menopause-friendly workplaces; recognise/accredit informal care competencies.
- Climate, mobility and housing: gender-responsive Social Climate Fund plans; target women-led and single-parent households for retrofits and clean mobility; scale Housing First for survivors of GBV and homeless women (with children).
- Social protection and income: adequate minimum income; care credits; pension adequacy; improve benefit take-up among marginalised groups.

6) Monitoring, dashboards and targets

Annual, public dashboards (disaggregated by sex, gender, age and intersectional variables) tied to the European Semester/CSRs and the EPSR Social Scoreboard, tracking:

- Healthy Life Years, amenable mortality/morbidity; mental health conditions and CVD prevention and control.
- Access and affordability: waiting times (gynaecology/oncology/mental health), coverage, out-of-pocket share; continuity/retention.
- Digital: access and use of eHealth; AI bias/performance audits by sex/gender.
- Care and work: informal care hours; decent-work metrics in care; men's share of parental/carer leave; return-to-work and wage recovery after care breaks; pension savings across life-course.
- Safety: VAWG/DV screening in priority settings; completed referrals; time to support; survivor-reported safety/satisfaction.
- Poverty and housing: energy/transport poverty reductions among women-led and single-parent households; Housing First exits to stable housing.

Conclusion

A Strategy that is outcomes-first, intersectional and delivery-ready—and aligned with the next MFF and a Competitiveness Fund designed for social and public-health investment—will move the EU from equal access on paper to equity of outcomes in practice. It will improve well-being, participation and protection for women, men and people of all genders, enabling everyone to live, learn, work and age in good health in every community.

Sources (web)

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[6] Eurofound – Working time (EU27, 2021 time-use synthesis). https://www.eurofound.europa.eu/en/topic/working-time

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