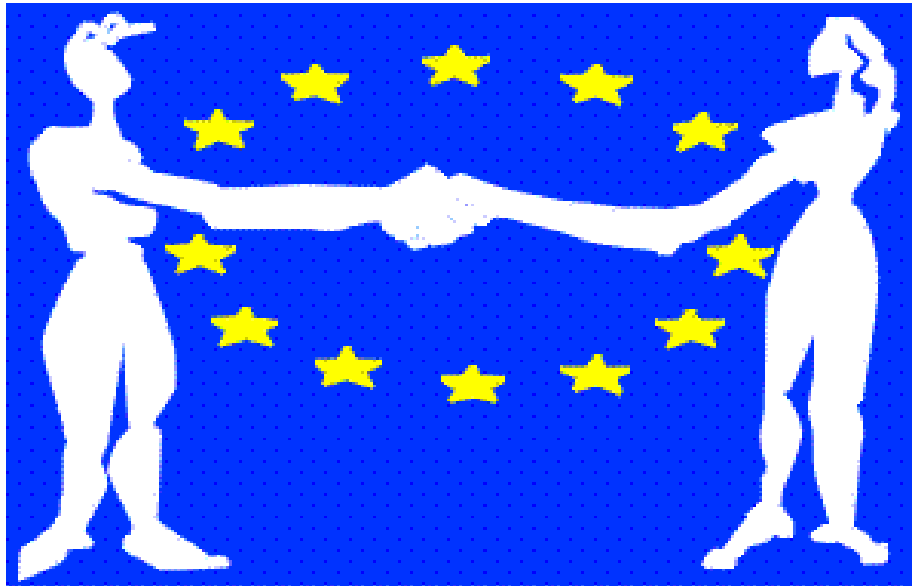


EWHNET
European Women's Health Network



Women`s Health Network:

**State of Affairs, Concepts, Approaches, Organizations in
the Women`s Health Movement**

Country report Sweden

June 1999

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1. Summary

In this report, characteristics of the Swedish health care system are presented and certain information regarding the women's equal opportunity and health movement are summarised. Women's health and ill health in Sweden are discussed in particular in terms of gender-sensitive perspectives. The health paradox and women's health problems are considered and some of the models proposed to explain gender differences in health and morbidity are examined in terms of their applicability in Sweden. The importance of such determinants of women's health as the conditions and course of their lives are stressed, factors that have often been neglected in traditional medical research. Examples of women's subordinate position in professional life and in health care contexts in Sweden are given. Patient-centred consultation and feminist consultation/practice are also touched upon. Some examples of gender-sensitive or feminist research in Sweden are provided.

2. Population and characteristics of the Swedish health care system

2.1 Population

The population of Sweden has increased over the past several decades, due mostly to immigration. In the 1980s, the immigration of political refugees increased. Since 1995, the increase in population has been lower. This can be explained in terms of the immigration rate and the birth rate being lower (Statistics Sweden).

Table: Population in thousands

Year	Population		Birth		Death	
	Women	Men	Women	Men	Women	Men
1990	4300	4200	60	64	46	49
1997	4500	4400	44	46	47	47

2.2 Characteristics of the Swedish health care system

In Sweden, health service is a public matter and is largely financed by public spending and through a compulsory health insurance scheme. Patients are charged a certain amount for treatment and for pharmaceutical products. The county councils (in what were recently 24 counties and 3 city-counties, the number of counties now decreasing) are responsible for providing satisfactory health care, hospital services, primary health care and public dental care (primarily for children and young people) within their area. The National Board of Health and Welfare is the central supervising authority for health services, for primary health care and for hospital services. The board has six regional units, responsible for surveillance of the quality of care.

The most important governmental statute pertaining to the health care system is the Health and Medical Services Act. It states: "The aim of health care is good health and care on equal terms for the entire population". A report by the Swedish Parliament Priorities Commission

was published in 1995 (Priorities in health care. Ethics, economy, implementation; SOU 1995:5). The political/administrative priorities given resulted in proposals concerning five priority groups. Group I: Care of life-threatening acute diseases and diseases which, if left untreated, will lead to permanent disability or premature death. Treatment of severe chronic diseases. Palliative terminal care. Care of people with reduced autonomy. Group II: Prevention having a documented benefit. Habilitation/rehabilitation etc. as defined in the Health and Medical Services Act. Group III: Care of less severe acute and chronic diseases. Group IV: Borderline cases. Group V: Care of reasons other than disease or injury.

In 1997, the first report of the parliamentary enquiry appeared, "HSU2000: The patient's rights" (SOU 1997:154) in which proposals are given for strengthening the patient's position. These proposals have resulted in a range of county measures aimed at strengthening democracy and effectiveness at the regional and county level.

Hospital services. The county councils run hospitals at three different levels: the regional level, the county level and the local level. The counties cooperate in six treatment regions, each with one or more regional hospitals. The regional hospitals, often university hospitals, are responsible for complex and specialised services within the region, and are also local hospitals for inhabitants of the municipalities near the regional hospital. The county hospitals also have a higher degree of specialisation than the local hospitals.

Primary health care. Primary health care is provided in community health centres with general practitioners (family physicians, district physicians), maternal and child health centres, district nurses, district physiotherapists and sometimes occupational therapists. Community health centres may be staffed in rural areas by one general practitioner but more often in towns and cities by 4-7 general practitioners. At a community health centre, the number of health professionals (district nurses, midwives, assistant nurses, biomedical technicians, physiotherapists, occupational therapists and administrative staff) is often two or three times as great as the number of physicians. The purpose of primary health care is to work for public health either within a geographically defined area or for those persons the community health centre is responsible for or within the patient groups dealt with by individual general practitioners.

The community health centres provide a wide range of preventive measures, diagnosis and treatment of symptoms, illnesses and diseases, and rehabilitative care as well as home visits, mostly to nursing homes and homes for the elderly. Approximately half of all consultations with doctors are visits to a general practitioner, the remaining consultations being with other specialists or with hospital physicians. Health centres are responsible for providing 24-hour emergency call services.

Maternal health care traditionally includes ante- and post-natal screening, advice to prospective parents, family planning advice, general health education and cervical screening. Midwives, assistant nurses and physicians are involved, the latter participating either as general practitioners or as specialists in gynaecology and obstetrics. Almost all deliveries take place in hospitals.

In Sweden, it is solely up to the pregnant woman to decide whether an abortion is to be performed. Women usually consult a hospital out-patient clinic or a youth clinic for abortion. Medical abortion has been carried out more frequently during the last few years than earlier, reportedly in more than 50% of all abortions in several clinics.

Child health care is aimed at children below 7 years of age and includes health education, immunisations, and screening for physical and psychosomatic development. At centres for this, there is usually a district nurse and a physician (a general practitioner or a paediatrician), and less frequently a paediatric nurse.

In all towns and cities, there are youth clinics where young people can obtain advice on different methods of birth control and on common health problems. The teams there consist of midwives, social workers and sometimes psychologists on a full time basis and physicians on a part-time basis.

The county councils have the responsibility for open medical care and for psychiatric treatment in hospitals. The municipalities have assumed increasing responsibility for the housing of patients with psychiatric diseases, of the mentally disabled and of persons with alcohol and drug problems.

Occupational health. The occupational health services fall under the jurisdiction of labour inspection authorities. Occupational health services are the economic responsibility of the employer. The occupational health professionals are often linked to the companies involved or are employed in joint occupational health services. The services encompass screening, working environment supervision and various therapeutic and rehabilitative activities.

Health services in the municipalities. School health services are under the auspices of the municipalities, which also are responsible for local nursing homes, homes for the elderly and home services for the elderly.

Private hospitals, health centres and clinics. Publicly financed health care in private companies or clinics is provided on a limited scale. There are very few private hospitals and few private nursing homes. Private practice involving other specialists than general practitioners has been rather prevalent in the large cities. During the last decade, the work of private general practitioners at community health centres (together with various other health professionals) or in small clinics (with no or few other health professionals) has become more common. Today, approximately 20% of all visits to physicians are to private practitioners, either general practitioners or other specialists. There are also private physiotherapists. Approximately half of the dentists are in private practice.

2.3 Health care resources and costs

Health care is one of the largest components of the public sector. Until the beginning of the 1990s, the costs of health services in Sweden grew more rapidly than the gross domestic product. Since then, expenditures for the health care sector have started to fall, as has the share of the gross domestic product these expenditures represent. In recent years, the expansion of health care has gone down. The number of hospital beds, for example, has declined sharply ever since 1985. The number of health professionals employed by the counties, especially assistant nurses, has been reduced. The reduction in costs is also explained by the fact that in the middle of the 1990s the costs for the care of the elderly and the disabled were transferred from the counties to the municipalities.

The county councils decide on the local patient fees, which vary from one county to another. Fees for consultations by hospital specialists are often higher than fees for consultations at community health centres and with general practitioners. Maternal, child and school health

care is free of charge, as are youth clinic consultations. The counties are responsible for the costs of pharmaceutical drugs for in- and out-patients. Out-patients have to pay their prescribed drugs up to a certain level, a rebate being given for costs exceeding this. At higher cost levels resulting from repeated treatment or drug needs, patients can be given a free pass for the remainder of the year. Free dental treatment is provided for children and teenagers.

2.4 Social benefits and services

During the first half of the 1990s, Sweden experienced large social changes involving high unemployment, structural changes and cutbacks in the traditional welfare system. Nevertheless, the decrease in total public expenditures for social benefits and services was relatively small. However, the distribution of poor living conditions has been affected negatively by these changes. A combination of unemployment, taxation reform and changes in the social insurance programmes has had negative effects of living conditions, particularly for young people, immigrants and single mothers.

3. Equal opportunity and health for women and men in Sweden

In Sweden until 1859, midwives were the only women who held official job positions. Women's health issues were discussed by the first women physicians in the late 1800s and early 1900s. Since they did not obtain the opportunity to hold official positions until the 1920s, several of them were active as lectures and as private physicians for women.

Women gained suffrage for municipal elections and the right to hold positions at county and local level in 1919. National suffrage and the possibility of women to have an employment at the national level were achieved in 1921. In this respect, Sweden was several years later than other Nordic and European countries. In 1927, public upper secondary schools were opened for girls. Some years later, maternity insurance benefits and pensions on an equal basis for women and men were introduced. In the 1930s, the childbirth rate became very low, which was probably due to bad economic conditions for most people in society. Social reforms were proposed to increase childbirth. Maternal and child health care was introduced by midwives and physicians. Legalisation of contraceptions was introduced in the end of the 1930s. At the same time, laws were passed stating that women with a gainful employment could not be dismissed due to marriage or pregnancy. In the 1940s, equal pay for equal work for national state employees was introduced. Women were entitled to six months allowances for childbirth (without pay). In the 1950s, employed women were given the right to three months of paid maternity leave for childbirth. In the same decade, women were allowed to be ordained within the Swedish state church.

In the 1960s, primary and secondary schools were encouraged to promote equal opportunities for girls and boys. Birth control pills were approved after several years of discussions. Separate income taxes for wives and husbands were introduced in the 1970s, which was of great importance for women, since the earlier tax system had made it of little economic value for women to have an income of their own. In that decade, it became possible for the mother and the father to share parental allowances upon childbirth. A new abortion law was passed providing women the right to decide for abortion up until the 18th week of pregnancy, largely an adjustment to the practice already introduced. (After the 12th week a medical examination

concerning risk factors was to be performed.) As a result, legal abortions increased, replacing the previous practice of illegal abortions, especially among young women. The right to six-hour working day for mothers or for fathers was introduced and employers and unions arrived at settlements providing equal opportunities for women and men.

The law against sex discrimination in employment was introduced in 1980s. All positions were opened up for women, including the armed forces. New settlements between employers and unions were reached providing equal opportunities for women and men. It became possible to obtain social security benefits for periods of approximately a year to care for children at home and with the opportunities to stay at home for longer periods too and still retain employment. A new law, the cohabitation law, was introduced concerning the property of cohabiting and unmarried couples. All assault and battery against women, even if committed in the private household, was subject to public prosecution. There was also a ban on live pornographic shows in public.

In the 1990s, a statute on registered partnership was passed. In 1992, a new equal opportunities act was introduced, which some years later was made more stringent concerning sexual harassment. After many rounds of discussions, it was stated in 1994 that at least one month of parental leave had to be taken by the father (and at least one month by the mother). In 1998, a new act on violence against women was passed as was an act on prohibition against female genital mutilation. A recent law, which had been discussed for two decades, prohibited the purchase of sexual services.

In the 1990s, certain efforts were made in the public sector to increase the percentage of women holding management and other positions of leadership, one of those most discussed being regulations to increase the number of women university professors. A total of 30 university professorships were created for the underrepresented gender, all of them given to women. Another six professorships in gender research were created and the Swedish Secretariat for Gender Research was established.

The Swedish parliament also decided that all official statistics related to persons should be disaggregated in terms of gender. This was seen as an important means for attaining a society providing equal opportunities for women and men. Thus, results in Sweden's Public Health Report (1997) have generally been presented by gender for the different groups reported on.

Sweden joined the European Union in 1995.

In Sweden, women's liberation movements have been limited. Ad hoc activities have developed concerning certain women's matters such as abortion, prostitution, pornography and violence against women. On the other hand, women have tended to join organisations within political parties, resulting in women issues being incorporated into the agenda of the political parties. The political system has had a high degree of continuity. These circumstances have promoted a system in which women's issues and women's health problems have been integrated within existing family, social and health policies. One could argue that a greater number of independent gender-sensitive perspectives and debates on gender issues are needed in order to stimulate developments towards achieving shared power and shared responsibility. The official measures put forward to achieve such goals involve research on women's and gender issues, analysis of proposals and decisions at national, regional, county and municipal levels from a gender perspective in various political areas, use of experts and advisers on gender issues and training in gender issues at universities and colleges.

4. Women's health and ill-health in Sweden from a gender-sensitive perspective

4.1 The health paradox: the longer lifespan but greater morbidity of women

The health paradox is a term used to describe the phenomenon of women living longer than men but also having higher rates of health problems and of illnesses than men. In Sweden, there is a 5-year difference in life expectancy between men and women. During the last few years, women's life expectancy has been 81.5 years and men's 76.5 years. Men's relatively higher mortality is largely a function of cardiovascular diseases, lung cancer, suicide and accidents. In women, the occurrence of tumours was the most important cause of death before 75 years of age.

Table 2:5. Lost years per 1,000 inhabitants through death before 75 years of age, 1995, and decrease 1980–1995, men and women.

	Number of lost years per 1,000 1995		Decrease 1980–1995			
	Men	Women	Number of years per 1,000		Percent per year per 1,000	
	Men	Women	Men	Women	Men	Women
Cardiovascular diseases	20,0	6,9	14,1	4,1	2,8	2,5
Tumours	16,3	18,5	3,0	2,3	1,0	0,8
Accidents	6,5	2,1	4,5	1,2	2,7	2,4
Suicide	7,8	3,0	3,5	1,4	2,1	2,1
Digestive system diseases	2,5	1,2	2,0	0,8	3,0	2,7
All causes of death	64,0	35,9	29,6	12,2	2,1	1,7

Source: Causes of Death Register. EpC/National Board of Health and Welfare.

From Sweden's Public Health Report 1997

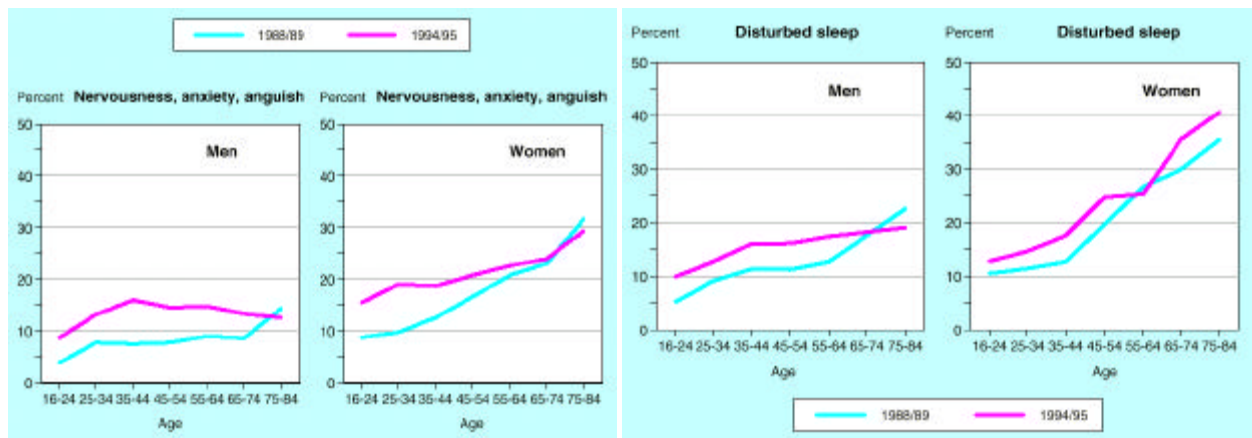
4.2 Women's health problems in Sweden

Women consult a doctor more often than men do. This can be at least partly explained by morbidity rates being higher for women. Respiratory tract infections, for instance, are significantly more common among women than men, owing to child-to-adult infection in the home and at day-care centres, for example. We have found that women with throat infections have the same frequency of streptococci in throat specimens as men, which indicates that women with such infections do not consult a physician for more minor symptoms than men do. Urogenital infections are several times as common among young and middle aged women than among men. Other factors of significance here may be that women are more aware of their bodies and more concerned about their health than men are. It may also be that for men an avoidance of admitting to weakness is a factor contributing to their seeking medical aid and reporting problems less than women.

In Sweden, women have more sick leave than men do. There are some indications that the workplace environment is a more important determinant of absence due to illness in women than the family situation is.

Women use more prescription drugs in Sweden than men do; this is particularly true of psychotropic drugs and pain killers.

Women tend to report complaints and symptoms more often than men do. This is particularly true for such problems as worry and anxiety. Among women, these problems increase in frequency with age. Disturbed sleep shows similar gender and age differences as anxiety does. Headache is characterised by quite a large gender difference in age distribution, being three times as common among young women than among young men.



From Sweden's Public Health Report 1997

Eating disorders are approximately 10 times as common among women as among men in Sweden, and are associated with social influences related to attractiveness, sexuality and youthfulness.

Neck and shoulder problems are significantly more common in Sweden among women than among men, while differences in back pain are quite small. Female muscles may possibly be more vulnerable than those of men, although the gender-related differences here may also be due to the fact that women tend to have more monotonous and simple and sometimes less meaningful jobs. In addition, women often have little chance to influence their work situation, their workload often being twofold as well - involving both employment and domestic work and duties. It is possible that employment and household work strain the same muscle groups. Another factor may be that the kitchen is often a poor workplace.

Pains / aches from the musculoskeletal system (45 - 54 years)				
	Back-hip Symptoms		Neck-shoulder Symptoms	
		Severe symptoms		Severe symptoms
Women	36%	14%	47%	16%
Men	37%	12%	31%	8%

Clear differences are seen between socio-economic groups of women in the problems reported. The proportion of poor general health, long-term illness and impaired working ability is greater in blue-collar and lower white-collar workers than in middle and upper

white-collar ones. According to the Gothenburg population study of women, factors such as foreign origin, low education, different forms of isolation (not working outside of the home, for example), as well as being divorced or widowed seem to increase the risk of experiencing different symptoms and health problems.

Table 2:9. Proportions with poor general health, long-term illness and greatly impaired working ability in different socioeconomic groups. 16–84 years. Age-standardised.

Socio-economic group	Poor general health		Long-term illness		Greatly impaired working ability owing to long-term illness	
	Men	Women	Men	Women	Men	Women
Blue-collar	7,0	6,8	47,6	48,3	12,6	14,9
Lower white-collar	2,8	7,0	38,7	48,4	7,4	13,0
Mid.+upper white-collar	2,8	4,3	39,5	40,0	5,3	7,1

Source: Survey of Living Conditions, Statistics Sweden.

From Sweden's Public Health Report 1997

In Sweden, certain groups of immigrant women are particularly susceptible to health problems. Their symptoms when arriving in Sweden have been reported to be quite similar to those of Swedish women. However, after some years in Sweden they often report many health problems and symptoms. They are also over-represented in low paid jobs.

4.3 Models proposed to explain gender-related differences

Genetic and biological factors

There is some evidence for women enjoying a biological advantage over men in health terms and it has been proposed that women would live two years longer than men if all other factors

were the same. Due to women's more complex reproductive processes, however, they are at greater risk than men for certain forms of ill health. Moreover, in European cultures at least, events associated with pregnancy, menstruation, and the climacterium have tended to be interpreted as morbid manifestations. In conjunction with comparisons of male and female physiology as presented in textbooks, it has been pointed out that purely biological phenomena in women, such as menstruation, tend to be described in negative terms, while corresponding phenomena in men, such as spermatogenesis, tend to be described in positive terms. Thus, the respective biological manifestations tend to be interpreted in an evaluative manner.

Traditionally, medical research has been biologically oriented, psychological, social and cultural factors having been subordinated to genetic and biological factors.

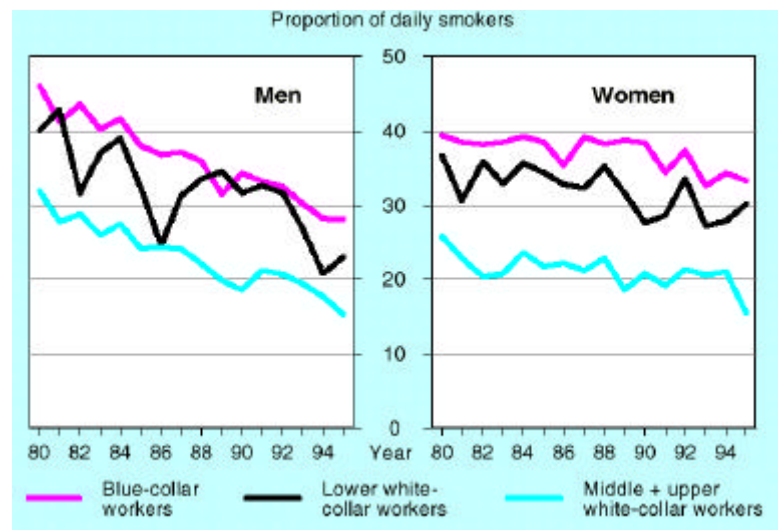
Socio-cultural factors

Differences between male and female patterns of health or ill health have been found to be due, in addition to biological causes, to socialisation, behaviour and lifestyle, living conditions and women's subordination.

The greatest difference in mortality between women and men in Sweden is to be found in the ages 16-25, men having a much higher mortality than women, due especially to accidents and to suicide. A decrease in such mortality during the last 20 years is one factor explaining the decrease in the difference of life expectancy between women and men in Sweden.

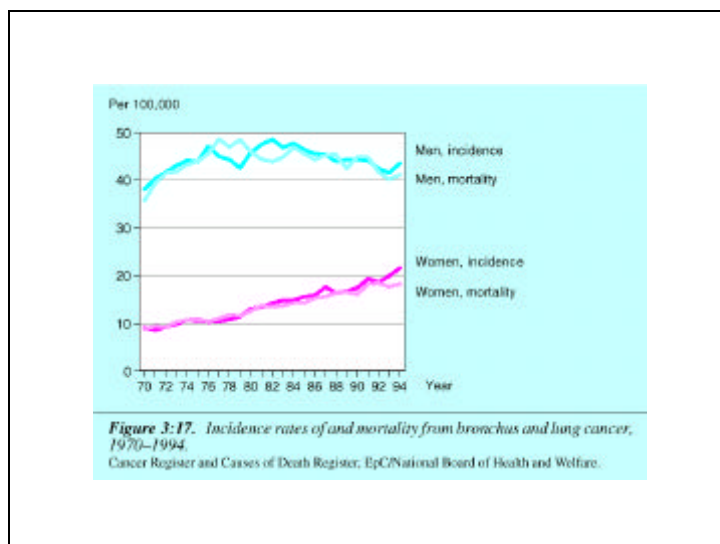
Behaviour/lifestyle

Sweden has a world record concerning smoking. The record is that young women smoke in much higher frequency than young men. Smoking is much more common among blue-collar workers than among white-collar workers.



From Sweden's Public Health Report 1997

Lung cancer has been considerably more common among men than among women and is still twice as common among men. However, women are shortening this lead. The increase for women is over 3% annually.



From Sweden's Public Health Report 1997

According to a population study of the alcohol habits of women (38 – 60 years of age) in Gothenburg, the daily intake of wine and spirits was about equally common in 1968, 1980 and 1993, whereas the moderate intake of wine and spirits was more common in 1980 and 1993 than in 1968. Thus, women have not taken over the habits of men concerning heavy consumption of alcohol. The over-representation of men in mortality statistics due to high alcohol consumption and alcohol damage has been discussed less than that due to cardiovascular diseases.

Socialisation

Another issue of great importance in this context is that of the differences between girls and boys in identity development and socialisation. Girls' socialisation has been characterised by a relationship orientation. Boys' upbringing has been characterised by a greater emphasis on achievement and independence. Women are brought up to be understanding and to accept weakness, anxiety and depression, characteristics readily described as symptoms of diseases, whereas hostility and anger are not regarded as a symptom. The problem here is that until now masculinity has generally been more highly valued than femininity.

Circumstances and course of life

Reproductive work. Reproductive work - childbirth and breastfeeding - constitutes a significant determinant of women's health. Biological work is a term proposed for this work, which can only be carried out by women. It might also be a term that physicians and health professionals can accept.

Women's living conditions and life course

- *Childbearing and breastfeeding/ biological work (according to G Carlstedt)*
- *Gender-segregated working life (horizontal and vertical segregation)*
- *Lower classification of women's professions than of men's*
- *Unpaid work / responsibility work / relationship-oriented work*
- *Men's violence against women*

Working life. Swedish women have at present the highest frequency of registered gainful employment in the world; nearly half of the labour force is female. Of the women with children 7 - 16 years of age, 90% work outside the home today. About half of the women on the labour market work full-time, the others working part-time, often extended part time. Women have increased their working hours during the last decade. Women in Sweden work in the public sector as much as in the private sector, whereas men work mainly in the private sector.

Unemployment is about the same for women as for men.

Sweden 1997		
	<i>Women</i>	<i>Men</i>
<i>Paid work</i>	78%	84%
<i>Full time</i>	45%	70%
<i>Unemployment</i>	6%	7%

The labour market in Sweden is characterised by manifest sex segregation, both horizontal and vertical. The horizontal segregation is evident, for example, from a study in a university city of Sweden (Umeå). The most common work for men there was of university teaching, whereas for women it was office work, nursing and cleaning. In the statistics presented, 25% of the men were found in the 10 most common occupations for men. For the women, in contrast, 50% were found in the 10 most common occupations for women. This can be taken to indicate that the classification of the predominantly female occupations is significantly less precise than is the classification of predominantly male occupations, thus complicating the analysis of occupationally related morbidity. For example, it would seem to not be too complicated a matter to be specific regarding the classification of various occupations typical for women, such as those of assistant nurses in homes for elderly, community health centres and so on.

A higher proportion of women than men have psychosocial and physical problems at work. During the last decade, stress factors women experience at work have increased. Approximately 50-60% of women feel that they have too much to do at work and that their work is psychologically stressing.

In Sweden, women working in occupations dominated by men, as well as men working in occupations dominated by women, have been reported to manifest higher morbidity and sick-listing.

The labour market in Sweden is also characterised by strong horizontal segregation. Women have climbed up the ladder to some extent, but as a rule men have a larger share of management and of other high paid positions. Even among unskilled workers, women tend more than men to be allocated routine tasks and to remain at the same job.

Unpaid work. Women's entry into the labour market has not been matched by men's entry into domestic labour. For men and women of comparable age, women are characterised by longer working hours. This is attributable to their unpaid work at home. They spend 31% of their time at household work. Men have more time for personal needs and leisure time than women.

How women and men spend their time		
<u>Activity</u>	<u>Women %</u>	<u>Men %</u>
Gainful employment	8	12
Studies	2	2
Housework	31	18
Personal needs	13	15
Leisure time	45	52

From the study "At all odd times of the day – How women and men spend their time 1990-91"

Women's unpaid work and relationship-oriented work at home are associated with added stress. Frankenhauser (1989) found that the most striking difference between women and men of the same profession in stress hormone levels was found at the end of working day. Stress hormones and blood pressure decreased among men when it was time to go home to relax. For women these hours were the most stressful. These findings show the importance of including unpaid work in research on work-related health.

A substantial part of women's work in Sweden is unpaid work, as well as work involving responsibilities for others and relationship-oriented work. Thus, for example, women always or for the most part have the responsibilities of planning for the day-to-day life of the family, keeping the children neat and clean and having contacts with the school and with day-care, such responsibilities also being assigned to women by their husbands.

Responsibility for keeping the children neat and clean, according to gender, for parents living together with children under the age of 13

	<u>Women %</u>	<u>Men%</u>
Always / mostly the informant	91	5
Share equally	7	9
Always / mostly the partner	1	85

From the study: "At all odd times of the day - How women and men spend their time 1990-91"

Responsibility for contacts with the children's schools, day-care, etc. according to gender, for parents living together with children under the age of 16

	<u>Women %</u>	<u>Men%</u>
Always / mostly the informant	62	9
Share equally	28	34
Always / mostly the partner	3	48

From the study: "At all odd times of the day - How women and men spend their time 1990-91"

Men's violence against women. Relationships between women and men may include violence. In a survey in a Swedish university city it was found that 14 % of the women questioned had experienced violence from a man with whom they had or had had a relationship. In a study of employed women aged 16-64 years (The working environment), 17% reported violence or threat of violence during the last 12 months. Mobbing was reported by both women and men in 8% of the cases, whereas 2-5% of the women were exposed to sexual harassment at work or from other people. Currently, we are very much limited in our knowledge of the consequences of such violence - in terms of physical abuse of women, rape and sexual harassment. Nonetheless, there are increasing numbers of reports suggesting exposure to violence to be a particularly important determinant of ill health in women. It can be a question of chronic pain, depression, neurosis, sleeping disorders, or disorders of the reproductive tract.

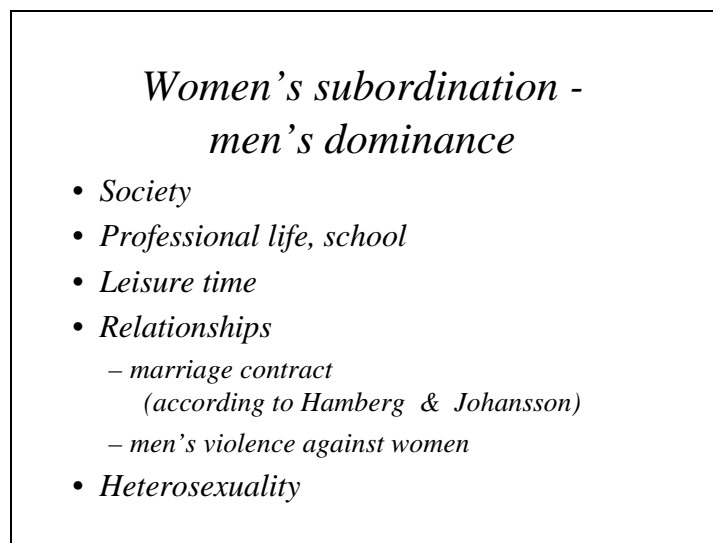
In cases of abuse or sexual harassment, women have a manifest tendency to assume their problems to be their own fault. The "normalisation process" is a central concept in the area of women's research. This is the process of women gradually coming to consider the violence to which they have been exposed as being normal.

Abused women often come to the general practitioner or gynecologist with vague symptoms and complaints. According to Hamberg and Johansson, abuse is difficult for women to disclose, due to shame, fear of the doctors' preconceptions and fear of the abuser. At the consultation, such a woman may give some hint of being abused to test the physician's tacit

knowledge before admitting to it. When such hints are given, it is important for the physician to avoid either blaming or doubting the woman, and to persist in asking about it and not forget that the woman may be in real danger.

4.4 Women's subordination – men's dominance

A woman's life conditions are characterized by a subordinate position in society, in school, in professional life and in leisure time. The existence of a power imbalance in these respects is well known and recognized. The dependency and power balance in relationships are more complicated. In the Swedish study by Hamberg and Johansson, women on sick leave due to chronic undefined musculoskeletal pains were followed for 2 years. The authors found the marriage contract to be useful as a basis for consultations. Discussing the marriage contract enabled the doctor and the woman patient to take note of the one-sided distribution of workload and make the hidden subordination visible. As a rule, a woman does not subordinate herself because her husband demands it, but rather the expectations placed on a woman make her readily adjust to a more subordinate position. The marriage contract was found to be important for rehabilitation measures taken with women who were in pain. For the women coping with the contract, three types of strategies were evident: accepting the terms, negotiating for new terms and breaking the contract.



Clinics for teenagers and young adults in Sweden, that are provided with special nurses concerning questions of pregnancy and sexuality, along with social workers and physicians, deal to high degree with the sexual health of young women. The most common visitor is a young woman who wants to discuss contraception and is prescribed the pill by a nurse.

Sexual health problems, sexually transmitted diseases and unplanned pregnancy affect young women to a higher degree than young men. Preventive measures in Sweden have tended to be quite gender-neutral, advice concerning use of the condom playing a central role in the information given. In my own work at a youth clinic, I have been convinced that young women tend to encounter a male-oriented view of sexuality, one that is achievement-oriented, concentrating on intercourse, penetration and orgasm. The sexuality of young women appears to me to be more relationship-oriented, with an urge for intimacy, solidarity and tenderness. Young men sometimes associate sexual pleasure with a certain amount of force or violence, the idea being that young women want to have sex even if they say no. The way we express

our sexuality is not something given by nature. Rather, it varies from time to time and from culture to culture. Sexual acts also mirror the gender power structure of a society.

Women's subordination within health care

- *Lack of knowledge of women's health, illnesses and diseases*
- *Differences between women and men have been invisible; the man has been the norm*
- *Differences have been exaggerated (genitals, hormones)*
- *Women's complaints have been ridiculed*
- *Sense of guilt and shame ("It's her/my own fault")*
- *Unwitting discrimination / gender bias*
- *Medicalisation*

4.5 Women's subordination within health care

Lack of knowledge of women's health and ill-health

Since medical research has generally been pursued by men and according to male terms of reference, there is a lack of knowledge of the health and illness patterns of women.

In Sweden, approximately 35% of physicians are women. Most of them are found in geriatrics, rehabilitation, psychiatry, gynaecology and family medicine. There are few women in surgery, especially thoracic surgery. How women physicians are affected by their double socialisation as women and as physicians has been discussed in various contexts.

Unwitting discrimination and negative treatment of women researchers by the Medical Research Council in Sweden have been described in a paper in Nature.

Wold and Wennerås found that the competence score given to women and to men applicants by the reviewers were correlated with their scientific productivity measured as impact factors. However, to get a grant a woman had to publish approximately 10 papers more than a man had to. This was especially true of the most competent women.

My own university, Lund university, has two medical units, Lund University Hospital and Malmö University Hospital. In Malmö, I am the only professor among approximately 35 professors at the medical faculty. As shown in the Table, there are few applications from women for clinical research time. Women submitted 6% of the applications in 1998, and their share of the research time was only 1.36%.

**Clinical research time-
Malmö University Hospital
(Lund University)**

	1997	1998
<i>Women</i>		
Applications	8,1%	6,0%
Grants/months	0,45%	1,36%
 <i>Grants/applications</i>		
Women	1/5(20%)	3/5(60%)
Men	41/57(72%)	60/78(77%)

Thus, there are "glass ceilings" for women at medical faculties in Sweden, just as there are in professional life throughout the world. These often stop qualified women from advancing to higher organisational positions. At universities, women take on greater teaching loads and do less research than men. Research experience has been valued higher than education. At medical faculties, women have been characterised as having more limited contact networks, both formal and informal. There is an urgent need to develop opportunities for women physicians, nurses and health professionals to devote more time to research focused on the improvement of health care.

Women's studies / gender research

In general, women's studies have been based on women's own life experiences and women's knowledge and skills. Research has been directed in particular at women's situation - that is, at the conditions under which women live. In Sweden, a gender-centred research perspective has been introduced by women researchers. This perspective in scientific research in medicine and in public health involves elucidating the relationships between women and men in terms of bodily, social, psychological and cultural factors. Gender-centred research includes a power perspective and a focus on the relationships and dependencies between women and men, which tend to be characterised by male ascendancy, male supremacy, and a male-oriented interpretive bias.

Examples of gender-centred research which has contributed to new knowledge in Sweden are found in a variety of areas, such as abuse of women, pain in women, unemployment, menopause and doctor-patient relations.

Differences between women and men have tended to be rendered invisible

The male has been the norm. In research reports, results have often been presented without differentiation between the sexes, manifest sex differences thus being masked. Research has often been performed on men, and the results have subsequently been assumed to apply to women as well. Moreover, gender differences that have been shown to exist have often been left without being further analysed. Recommendations applicable to both sexes have been issued both by physicians and by authorities. Some physicians - mostly of them women - have drawn attention to the risks associated with this approach. One example of this approach in Sweden concerns cardiovascular diseases, cholesterol and diet. However, the lipid risk profile appears to be different in women than in men. In women, serum triglyceride concentration appears to be of greater importance than cholesterol. Nevertheless, it has been said to also be

beneficial for women to change their dietary habits, since it is they who prepare the food and who can thus help to ensure improvement in their menfolk's diet.

Biological differences have also been exaggerated

Traditionally, many mental problems in women have been attributed to complaints of the reproductive tract and to stages in the menstrual cycle. Currently, hormones are viewed as being of major importance in explaining women's complaints.

Women's complaints have been ridiculed

In the health care sector, it is not unknown for women's complaints to be ridiculed. Some years ago, the Swedish medical journal, *Läkartidningen*, carried an advertisement for a course in gynaecology for general practitioners, where one of the items in the course was listed as "the climacteric old biddy". This is particularly remarkable, since those responsible for the course were male gynaecologists whose professional lives were dedicated to the care of women. In advertisements for oestrogen products, also in the Swedish medical journal, a series of sex stereotypes have been used. Oestrogen deficiency has been described as a disease despite the fact that reduction in oestrogen levels is a normal post-menopausal event. It has also been stated in the advertisements that the products would "normalise bleeding patterns", which is quite incorrect as it is not normal for a woman to menstruate after the menopause.

In a questionnaire study, we found the effects of menopause on quality of life to generally be of minor importance. Post-menopausal women displayed a similar or a higher quality of life and a similar or lesser number symptoms than pre-menopausal women. Older women with no history of hormone replacement therapy showed a higher quality of life, especially regarding physical and mental as well as social well-being, and a lesser number of psychological symptoms, than younger women with no such history and not on hormone contraceptives. This was especially true for women without experience of hormone therapy. A history of hormone therapy in the climacterium was generally associated with lower well-being and quality of life and a greater number of symptoms.

Unwitting discrimination/gender bias

Another phenomenon is that of unwitting discrimination or gender bias - for example that women and men are sometimes treated differently for the same disease, and for no good reason. Gender bias has been reported in cardiovascular diseases, women sometimes receiving inferior care. In Sweden, this has been shown in connection with cardiac failure. A Swedish study of medication in conjunction with hypertension showed women to have been prescribed the cheaper and more traditionally approved drugs. However, this is probably not of any disadvantage for women. Another Swedish study showed that women were disfavoured in their treatment in connection with rehabilitation. There were more decisions about education and work made on the behalf of men than of women.

Medicalisation

Medicalisation is a phenomenon affecting both men and women, such as in conjunction with preventive measures. . Medicalisation can in itself constitute a threat to health. Owing to women's position in society, they are particularly prone to be transformed into patients, with medical surveillance and treatment based on this (for example, use of oral contraceptives, mammography and cervical smears, and the diagnosis of premenstrual syndrome and "oestrogen deficiency"). In Sweden, there is a discussion about the value of screening by use of mammography, which is introduced in all counties for women 45-60 years of age.

Physicians tend to be more prone to give women patients an unclear diagnosis, or to assign them a diagnosis of mental disorder. General practitioners have been reported to define the typical troublesome patient as a woman with vague symptoms. When people were asked to think of someone they knew who was very healthy, the majority of both men and women mentioned a man. That is, the definition of what is a medical problem is itself gendered.

Instead, women's survival knowledge and skills - concerning lifestyle, diet, health care and hygiene, for example - ought to be made manifest, be developed and be used for the purpose of promoting the health of both men and women.

4.6 Patient-centred consultation

In medical consultation research, the distinction has been made between a patient-centred and a physician-centred or diagnosis-centred approach. In patient-centred consultations, the patients' share of the task is to provide the history of their problems, as well as their own ideas, their concerns and expectations and their views regarding the effects of their problems. The doctor's share includes examination and tests. The negotiation between the patient and the physician involves a sharing of understanding and the patient's cooperating in both the actions taken and the management of the health problem. Thus, the aim of a good consultation is to understand the patient, not simply to diagnose the disease.

There are few studies relating the working style of general practitioners to the health status of their patients. One investigation, which in my view was important, is that by Huygen and co-worker, which often has been cited in Sweden. They observed 75 general practitioners and classified them as being patient-centred to a maximum, to an intermediate or to a low degree. Twenty women of the same age were selected from each general practitioners list of patients. They were interviewed and examined by independent physicians. Women with general practitioners who showed a patient-centred style in their practice were found to feel more healthy, have more realistic expectations regarding professional help, tend to visit their doctor less frequently and have fewer symptoms. Removal of the uterus was also found to not have been performed as frequently as in women with physicians who showed a patient-centred style to only an intermediate or a low degree. The results of this study indicate that physicians can play an important role in health promotion and in the prevention of unnecessary medicalisation.

As a physician at a youth clinic, I meet young women with genitals problems such as those of discharge, itching and burning. Is it possible to have a gender-oriented consultation for such simple everyday problems? It is worthy of note that many of the young women describe their symptoms in negative terms, saying for example that they feel dirty, unclean or disgusting. Genital discharge is often associated with a sense of shame or impurity. How is this to be interpreted?

Freud felt that a sense of shame and guilt was related to "femininity" and that women wanted to hide their genitals, feeling them to be so incomplete compared with the genitals of men. From a gender perspective, a young woman's sense of impurity regarding her genitals can be interpreted as an expression of women's subordination and of women being less valued than men. In Sweden, young women often lack words for their genitals and some of them have very limited knowledge of their lower abdomen. This can result in a lack of their feeling proud and happy regarding their bodily development.

Together with groups of young women, we have prepared written advice and ideas concerning vaginal discharge and itching. We have used these women's proposals for how their problems could be solved and have aimed at providing young women names for their genitals. In addition, we have attempted to avoid the somatization and medicalization of normal physiological conditions and events.

In a study of women with chronic pain, Hamberg and Johansson found that women used a number of strategies to catch the doctor's attention. They described their symptoms very carefully and in considerable detail. They presented their own needs in an indirect way, often with crying or begging. These women also had various strategies to maintain their self-respect. They mystified their symptoms, and were critical toward their physicians.

4.7 Feminist practice/consultation

Gender research on consultation is of particular importance. Gender-specific patterns in patient-doctor relations in general practice have been reported to exist regarding continuity, consultation length, and communication. Evidence exists suggesting women physicians to have a more patient-centred approach than men physicians, particularly with regard to women patients. According to available research findings, as well as my own experience and that of others, gender-oriented consultation with women patients should be characterised by such features as the following:

Regard for the circumstances and the course of the woman's life - since the symptoms or signs that are found may be normal or appropriate responses to the conditions present in the woman's life;

Mobilisation of the woman's resources;

Providing the woman with knowledge appropriate to women (recall that the first women physicians saw this as their primary task);

Promotion of self-esteem, self-confidence and a positive self-image in women through respecting the woman's experience, expectations and anxiety;

Encouragement of autonomy, and of the woman's own solutions;

Avoidance of medicalisation;

An emphasis on cooperative endeavours (both the physician and the woman being experts, but in different areas);

Taking advantage of the woman's power, strength and courage;

Supportive empowerment of the woman in the family, in the workplace and in the community.

In summary, I hope that gender and feminist perspective in the area of women's health and ill-health will become a natural feature of research and practice, in Sweden and elsewhere, and not an isolated or a separatist trend.