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DRUŽBENE NEENAKOSTI V ZDRAVJU ŽENSK V SLOVENIJI

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Uvodnik

V tematski številki analiziramo različne vidike neenakosti v zdravju žensk v Sloveniji. To temo obravnavamo na pobudo Evropskega urada WHO za vlaganje za zdravje in razvoj, ki je spodbudila razpravo in kritično analizo dejstva, da je v mednarodnih primerjavah enakost v zdravju žensk v Sloveniji zelo visoka. Grobi statistični in epidemiološki podatki res kažejo, da so neenakosti v zdravju žensk v Sloveniji majhne (1).

Samoocene zdravja v javnomnenjskih podatkih v Sloveniji pa kažejo večje razlike v zdravju med moškimi in ženskami v škodo žensk. Še večje razlike pa se kažejo med različnimi kategorijami žensk, če jih primerjamo po različnih socialno-demografskih merilih. Te razlike so družbeno ustvarjene in nepravične (2, 3). Hipoteza, iz katere izhajamo in jo na različne načine preverjamo v tematski številki Zdravstvenega varstva, je, da prehod v neoliberalno tržno družbo prizadene in ogroža zdravje žensk v Sloveniji. Na klasičnih epidemioloških kazalnikih, kot so:umrljivost, rak, srčno-žilne bolezni in druge, se ta slabši položaj še ne kaže. Ne kaže se tudi na medicinskih kazalnikih kakovosti življenja. Zato smo preverjali neenakosti s pomočjo posrednih kazalnikov, kot so: samoocene zdravja, ocene dostopnosti do zdravstvene oskrbe, povezave med delovnimi obremenitvami in oceno zdravja žensk, vloga kulturnega kapitala v oceni zdravja in kakovost življenja žensk, posledice nasilja nad ženskami v samooceni zdravja žensk.

Razlike v objektivnih in subjektivnih perspektivah zdravja žensk kažejo, da moramo uporabiti različne tipe podatkov, da bi razumeli težave glede na enakosti v zdravju žensk (4). Predvsem neokonservativne politike pogosto reducirajo zdravstvene težave žensk na tiste, ki so povezane z njihovo reproduktivno vlogo, in ignorirajo njihove zdravstvene težave zunaj reprodukcije. To prispeva k brisanju identitete žensk in pravic zunaj materinstva. Predvsem feministična akademska literatura o zdravju žensk je razvila kritiko medikalizacije ženskih teles in osrediščenje zdravja žensk na reproduktivne teme, kot so: nosečnost, rojevanje, menstruacija ali menopavza (5, 6, 7). V nasprotju s temi temami so težave, ki jih v samooceni zdravja in bolezni največkrat navajajo sodobne ženske vseh starosti, stres, fizična in psihična izčrpanost, izgorelost, tesnoba itn. (8). V tematski številki neenakosti v zdravju žensk obravnavamo predvsem skozi mehanizme, ki te neenakosti povzročajo. Izhajamo iz predpostavke, da družbeni pogoji, v katerih ženske živijo, močno vplivajo na njihove možnosti biti zdrave in ostati zdrave.

Da smo se osredinili na težavo neenakosti v zdravju žensk v Sloveniji, obstaja nekaj pomembnih dejavnikov. Če jih hočemo razložiti, moramo poseči po razlagi položaja žensk in tudi ureditve javnih zdravstvenih ustanov pred tranzicijo in med njo v Sloveniji. Položaj žensk se je v drugi polovici dvajsetega stoletja iz desetletja v desetletje izboljševal. Množično so se zaposlile in se materialno osamosvojile. Množično so vstopile v visokošolsko izobraževanje in zadnji dve desetletji zaznavamo višji odstotek diplomantk v primerjavi z moškimi diplomanti. V sedemdesetih letih prejšnjega stoletja se je v Sloveniji razvilo tudi močno žensko in feministično gibanje, ki se je vedno aktiviralo, kadar so bile ogrožene temeljne pravice žensk. Tako smo ubranili pravico do izbire (do splava) v začetku devetdesetih let prejšnjega stoletja pri pripravi nove ustave. Prav aktivna ženska gibanja so vplivala na to, da smo imeli družinsko zakonodajo, ki je zagotavljala ženskam več pravic in zaščite. Že sredi sedemdesetih let prejšnjega stoletja smo med prvimi v Evropi povsem izenačili zunajzakonske skupnosti z zakonskimi, kar pomeni pomembno zaščito žensk in otrok.

Imeli smo tudi dobro razvit in urejen sistem javnega zdravstva, ki je posebej ščitil družbeno ranljivejše skupine, kot so ženske in otroci. V javnem zdravstvu so bile vzpostavljene vsem ženskam dostopne ginekološke ambulante, v katerih so delovale izjemne ginekologinje, ki so se zavzemale za reproduktivno zdravje žensk, zdravstveno in spolno vzgojo v šolah, neposredni dostop do ginekoloških pregledov in kontracepcije tudi za mladostnice, za pravico do splava. Zahvaljujoč temu, imamo v Sloveniji najnižjo stopnjo mladoletnih nosečnosti v Evropi, znižali smo stopnjo splava. Res pa je, da se takšne spremembe niso pojavljale v zasebni sferi. Kot so kazale javnomnenjske raziskave, je bila delitev vlog v družini precej patriarhalna, tako da so ženske s prehodom v delovno sfero sprejele svojo dvojno obremenitev (9).

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V novem neoliberalnem, ekonomskem in političnem sistemu socialno državo (»welfare state«) vse bolj zamenjuje država dela (»workfare state«). Zanjo je značilna ideologija individualne odgovornosti za lastno preživetje in lastno socialno varnost, ki pelje v zmanjševanje splošne in vsem dostopne ravni socialne in tudi zdravstvene zaščite (10). Ta temeljni obrat ponovno vzpostavlja večje družbene neenakosti, pri katerih imajo več pravic tisti z več denarja. Preostali pa ostajajo na robu in so izpostavljeni tveganjem, od katerih so tveganja za zdravje ena najobčutljivejših. Visoka raven enakosti v pravicah, ki je bila značilna za Slovenijo, se zmanjšuje, kar je posledica sprememb v zavarovanju, pravic iz obveznega zavarovanja in pospešene privatizacije v zdravstvu. Te spremembe zmanjšujejo občutek varnosti in zaupanje, da bomo lahko ohranili zdravje, ne da bi zanj morali plačati, kar povzroča stiske zlasti pri tistih skupinah ljudi, ki si tega ne morejo privoščiti, vendar tudi pri drugih, ker ne vedo, kaj se lahko zgodi v prihodnosti (11).

Povsod po svetu zdravstvene reforme potekajo v znamenju hegemonije neoliberalnega tipa razmišljanja v povezavi z zdravjem. Izginja pa princip zdravja kot človekove pravice. Gre za poraz zdravstvenih politik, ki bi temeljile na pravicah (12). Obrat od uveljavljanja enakih pravic k ideologijam učinkovitosti in nove pravičnosti (kolikor materialnih sredstev imaš, toliko pravic lahko uživaš) se ne dogaja le z bolj ali manj transparentnimi politikami, ampak tudi z neformalnimi praksami, kot na primer da univerzalistični javni sistem socialnega in zdravstvenega varstva nadomeščajo različne oblike dobrodelnosti, ki so pogosto oblika pranja vesti za bogate.

Ženske so največja ranljiva družbena skupina, ki jo spreminjanje standardov vsem dostopnega javnega zdravja zaradi tradicionalne skrbstvene vloge najprej prizadene. Že danes so starejše ženske poleg migrantk in Rominj v Sloveniji zdravstveno najbolj ogrožene skupine. Z nižanjem pokojnin, z zmanjševanjem socialnih transferov bodo ravno te skupine še bolj prizadete. Ženske so zaposlene predvsem v storitvenih dejavnostih in javnem sektorju (trgovke, negovalke, učiteljice). Zniževanje plač v tem sektorju in negotove zaposlitve prizadevajo predvsem ženske. Raziskave kažejo, da imajo ženske v Sloveniji najdaljši delovni urnik od vseh žensk v Evropi. Poleg tega so ženske v Sloveniji izjemno vpete v neplačano gospodinjsko in skrbstveno delo. Socialno, materialno in predvsem čustveno oskrbujejo otroke, mladostnike, starejše, partnerje. V Sloveniji imamo tudi visoke standarde skrbi za gospodinjstvo in dom, oskrbe otrok in starejših; vse to je neplačano delo žensk. V Sloveniji se prepleta sredozemska katoliška kultura ženske skrbi za druge z nemško protestantsko kulturo čistosti in urejenosti doma. Vse to obremenjuje ženske. Že zdaj podatki kažejo, da imajo v primerjavi z moškimi daleč manj prostega časa, da imajo manj čustvenih opor in omrežij kot moški, da je stopnja depresivnosti večja v vseh skupinah žensk v Sloveniji v primerjavi z moškimi, da narašča uporaba anksiolitikov, pomirjeval in sredstev proti depresiji (13).

Do zdaj sta bila sorazmerno dobra izobrazba žensk in zaposlitev sicer varovalna dejavnika, ker sta ženskam omogočala samostojnost in nadzor nad svojim življenjskim potekom, vendar so se v sedanjem času zaposlitvena razmerja bistveno spremenila in otežila. Ženske poročajo o izčrpanosti in izgorelosti, ki ju klasična epidemiološka merila ne zaznajo in so posledica dvojne obremenitve (zaposlitev in neplačano gospodinjsko delo) ter večje zahtevnosti znotraj plačanega dela. Večajo se tudi pritiski znotraj delovne sfere, mobbing, grožnje z odpuščanjem, ki spetbolj prizadenejo ženske, ker so na delovnih mestih večinoma odvisne od moških nadrejenih, imajo slabša podporna omrežja. Na zdravstveno stanje ljudi ne vplivajo samo neposredne razlike v dohodku, ampak tudi to,kako posameznik občuti socialni status, ki mu ga omogoča njegov dohodek. Če nekdo dela v razmerah, v katerih nima nadzora nad svojim delom, kjer je pod stalnimi pritiski prekinitve delovnega razmerja itn., se gotovo počuti zelo negotovo, kar lahko hitro vpliva na njegovo subjektivno počutje in zdravje (14).

Tržno orientirane zdravstvene politike hočejo premakniti stroške biološke in socialne reprodukcije iz države in trga na družino, kjer bodo spet najbolj prizadete ženske zaradi svoje skrbstvene vloge v družini. Tako imajo na videz nevtralne politike lahko visoke konsekvence za ženske. Dramatično rezanje socialnih služb kot način reševanja ekonomsko-finančnih težav pomeni, da država prelaga odgovornost za preživetje in blagostanje z države in lokalnih skupnosti na ženske (15).

Kot kažejo podatki javnomnenjskih raziskav, se ljudje v Sloveniji konsenzualno zavzemajo za javni zdravstveni sistem, ki bi temeljil na enakosti, dostopnosti, pravičnosti za vse. Zavzemajo se za sistem, ki pripoznava spolno specifične zdravstvene potrebe žensk in moških in ki preprečuje neenakosti v zdravstveni oskrbi, v kateri ženskam pripada največje breme in obenem najmanjša stopnja pripoznavanja pomembnega skrbstvenega dela. Javnost se torej zavzema za ravnotežje med delitvenimi (distributivnimi) in pripoznavnimi sestavinami enakopravnosti v zdravstvenem sistemu. Delitvene sestavine so na primer enaka zemljepisna dostopnost do zdravstvenih storitev, ekonomsko dostopne

storitve za vse občane, enakopravna delitev dela v zdravstvenem varstvu med moškimi in ženskami, upoštevanje različnih zdravstvenih potreb ljudi in zagotavljanje enake kakovosti zdravstvenih storitev za vse. Pripoznavne sestavine pa so spoštovanje individualnih razlik med pacienti, enakopravno vrednotenje neplačanega skrbstvenega dela (to običajno pretežno pripada ženskam) in tradicionalnega plačanega dela, pripoznavanje različnih zdravstvenih potreb glede na socialni položaj posameznika, ohranjanje skupne človečnosti in upoštevanje pacientov kot akterjev in ne le objektov zdravstvenih storitev.

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SOCIAL INEQUALITIES IN WOMEN'S HEALTH IN SLOVENIA

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Editorial

This thematic issue analyses the different aspects of women's health inequalities in Slovenia. The discussion of this topic arose at the initiative of the WHO European Office for Investment for Health and Development that encouraged discussion and critical analysis of the fact that in international comparisons, women's health equalities in Slovenia are rather high. Rough statistical and epidemiological data indicate that women's health inequalities in Slovenia are low (1).

Opinion polls on self-rated health conducted in Slovenia however show bigger differences between the health of men and women to the detriment of women. Even bigger differences can be found among different categories of women if compared according to various socio-demographic criteria. These differences are socially produced and unfair (2, 3).

The hypothesis from which we proceeded and which is being tested in diverse ways in this thematic issue of Slovenian Journal of Public Health is that the transition to a neoliberal market society affects and endangers women's health in Slovenia. Classical epidemiological indicators, such as mortality, cancer, cardiovascular diseases and others, do not yet show this deteriorated situation, which is also not evident in medical indicators of the quality of life. We thus verified inequalities employing indirect indicators such as self-rated health, rated accessibility of health services, connections between workloads and self-rated health of women, the role of cultural capital in self-rated health and the quality of women's life and the consequences of violence against women on women's self-rated health.

The differences in objective and subjective perspectives of women's health namely show that we need to use different types of data in order to understand the problems of women's health inequalities. (4). It is mostly neoconservative policies that often reduce women's health problems to those related to their reproductive role and ignore their non-reproduction related health problems. This contributes to women's identities and rights outside of motherhood being erased. The feminist academic literature on women's health has mainly focused on the critique of the medicalisation of women's bodies and centring of women's health around reproductive issues such as pregnancy and childbirth, menstruation or menopause (5, 6, 7). In self-rated health and diseases, modern women of all age groups however mostly emphasise stress, physical and psychological exhaustion, burnout, anxiety, etc. as their problems (8). This thematic issue deals with women's health inequalities predominantly through the mechanisms causing them. We derive from the assumption that social conditions in which women live strongly affect their chances of being and staying healthy.

There are several important factors as to why we focused on the issue of women's health inequalities in Slovenia. In order to explain them, we need to explain the position of women and the regulation of public health institutions before and during the transition process in Slovenia. In the second half of the 20th century, the position of women improved with every passing decade. They were massively employed and became materially independent. They massively entered higher education and in the last two decades we have been recording a higher percentage of female graduates than male. In the 1970s, Slovenia also saw the development of a strong women's and feminist movement that was spurred to action every time women's fundamental rights were being endangered. We thus defended the pro-choice position (the right to having an abortion) in the early 1990s when the new constitution was being prepared. Active women's movements also ensured a family legislation that provided women with more rights and protection. Already in the mid-1970s, Slovenia was among the first in Europe to have a de facto union on par with marriage, thus providing substantial protection to women and children.

We also had a well-developed and regulated public health system that provided protection especially to socially vulnerable groups, such as women and children. The public health system provided all women with access to gynaecological clinics employing exceptional gynaecologists, who stood up for women's reproductive health, health and sex education in schools, direct access to gynaecological exams and contraception for minors and the right to abortion. Slovenia thus has the lowest teenage pregnancy rate in Europe and has also reduced the abortion rate. It is however true that

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such changes did not take place in the private sphere. As shown by opinion polls, the division of roles in the family remained rather patriarchal, so that by entering the work-life sphere, women took on double burdens (9). In the new neoliberal economic and political system, the welfare state is increasingly being substituted by a workfare state. The latter is characterised by the ideology of individual responsibility for one's survival and social security, which leads to a reduction in the general level of social and health protection that is available to all (10). This fundamental change re-establishes greater social inequalities, where those with more money have more rights. The others remain on the margins and are exposed to risks, with health risks being among the most sensitive. The high level of equal rights that was typical for Slovenia is being reduced due to changes in insurance, the rights stemming from compulsory insurance and facilitated privatisation in healthcare. These changes reduce the feeling of security and trust that we will be able to preserve our health without having to pay for it, which causes distress especially in those groups of people who are unable to afford it but also in others who are unsure of what might happen in the future (11).

Everywhere across the globe, health reforms are being conducted marked by hegemony in neoliberal thinking in relation to health. The principle of health as a human right is disappearing. This represents a defeat of health policies based on human rights (12). The turn away from enforcing equal rights towards ideologies of efficiency and new fairness (you can enjoy your rights to the extent of your material assets) does not take place only with more or less transparent policies but also with non-formal practices such as the universal public social and healthcare system being replaced by different forms of charity that are often only a way for the rich to ease their conscience.

Women are the largest vulnerable social group and feel the changes in standards of publicly available health services the most, mostly due to their traditional role as caretakers. Already today, in terms of their health, older women, next to migrant women and Roma women, are the most vulnerable groups in Slovenia. By reducing pensions and social transfers, these groups will become even more vulnerable. Women are mostly employed in service activities and in the public sector (in shops, as nurses or teachers). Salary reductions in this sector and uncertain employment mostly affect women. Studies show that women in Slovenia have the longest work schedule of all European women. Furthermore, women in Slovenia are very busy with unpaid housework and caretaking. They provide for children, youth, the elderly and their partners socially, materially and above all emotionally. In Slovenia, we also have high standards of taking care of one's household and home, children and the elderly and all this is the unpaid job of women. In Slovenia, the Mediterranean catholic culture of a woman's care for others intertwines with the German protestant culture of a clean and well-kept home. All this takes a claim on women. Current data already show that compared to men, women have much less free time and less emotional support and networks than men and that depression rates in Slovenia are higher in women than in men in all groups and that the consumption of anxiolytics, sedatives and antidepressants is growing (13).

So far, a relatively high education and employment of women used to be protective factors that enabled women's independence and control over their lives. However, in current times, employment relationships substantially changed and deteriorated. Women speak of exhaustion and burnout which classical epidemiological criteria do not detect and which are the result of double burdens (employment and unpaid housework) and increased demands of the paid job. Pressures within the work domain are also increasing; mobbing and dismissal threats again affect women more, as women mostly depend on their male superiors in their jobs and have poorer support networks. People's health is not affected only by direct income differences but also by how an individual perceives the social status that his or her income allows. If someone works in conditions where they have no control over their work and are under constant pressures of having their employment relationship terminated or similar, they undoubtedly feel very insecure, which may affect their subjective wellbeing and health (14).

Market-oriented health policies strive to transfer the costs of biological and social reproduction from the state and the market to the family, which will again mostly affect women due to their caretaking role in the family. The seemingly neutral policies thus might have serious consequences for women. The dramatic cuts in social services as a means of solving economic and financial problems thus mean that the state is transferring the responsibility for survival and welfare from the state and local communities to women (15).

Opinion polls show that there is a consensus among the Slovenian people that the public healthcare system should be based on equality, accessibility and fairness for all. They are in favour of a system that recognises gender-specific needs of women and men and that prevents healthcare inequalities, where women carry the largest burden yet at the same time have the lowest

level of recognition for the importance of their caretaking work. The public is thus in favour or having a balance between distributive and recognised components of equality in healthcare. Distributive components are for example equal geographic accessibility of health services, economically accessible services for all citizens, equal division of labour in healthcare between men and women, consideration of the diverse health requirements of people and the provision of health services of equal quality for all. Recognised components are the consideration of individual differences between patients, equal evaluation of unpaid caretaking (this usually predominantly pertains to women) and traditional paid work, recognition of diverse health needs with regard to the individual's social position, the preservation of common humanity and the consideration of patients as actors and not merely as objects of healthcare services.

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